

# The Leadership Forum

*an ACGIM publication for leaders in  
academic general internal medicine*

## Essential Skills for GIM Chiefs: Building Your War Chest

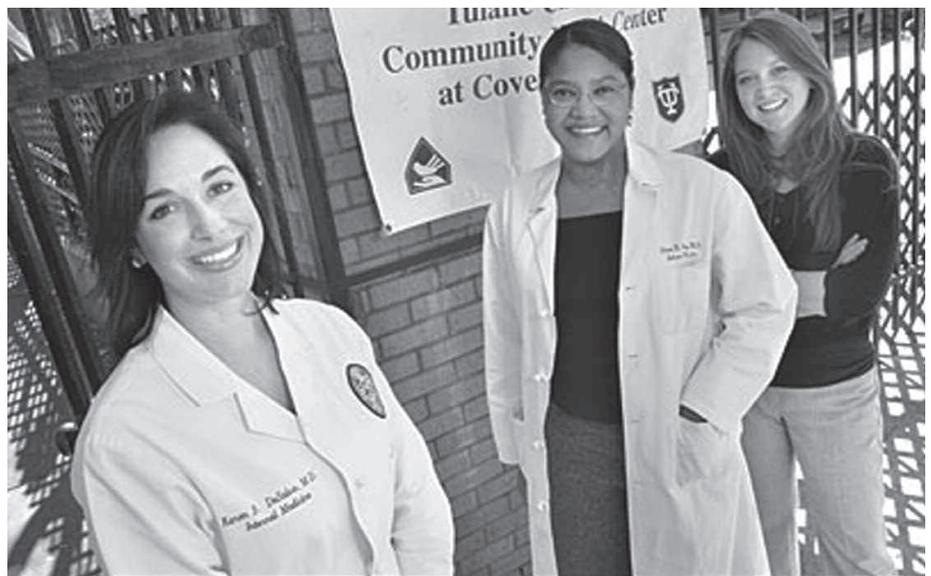
Karen B. DeSalvo, MD, MPH, MSc

*C. Thorpe Ray Endowed Chair in Internal Medicine, Vice Dean, Community Affairs and Health Policy, Tulane University School of Medicine*

In the armamentarium of tactics used by general internal medicine chiefs and leaders to build their programs, fundraising through development venues can be overlooked. When we accept our leadership positions, we negotiate a package which, hopefully, includes a “dowry” that will give us flexibility—not just for recruiting new faculty—but also to develop the existing group and build programs. This dowry was likely acquired by the chairs or other leaders in the school as a gift from a willing donor. The process for this fundraising is often not transparent to the chief and is a missed opportunity to replenish that fund or build additional resources.

There are examples of success in fundraising through donor engagement in the GIM leadership world. Since Hurricane Katrina, our own success at fundraising has been good, but with the waning economy and changing “ask” as the city and Tulane recover from the flooding, I wanted to learn more and improve not only my “ask” but also my stewardship of those gifts.

So, to advance my own understanding and skills in fundraising, I recently attended a training session organized by the AAMC and given principally by a firm called Advancement Resources and key leaders/staff



**Dr. Karen DeSalvo on the left with team members.**

from the AAMC. It was one of those sessions where with every nugget of information they handed out, I could think of a recent situation in which I could have used that knowledge to improve my fundraising activities. I thought I would share some of what I learned. Some was intuitive, some surprising, but I found it all was helpful and motivating.

### Why do People Give?

The presenters described two major categories of major gifts: loyalty and

passion. To quote from their handouts:

- “Loyalty gifts are about helping the organization achieve their goals.”
- “Passion gifts are about helping the donor achieve their goals.”

This key distinction is critical to keep in mind. The session presenters emphasized the fact that we often give to our college or other favored institution out of loyalty, but generally don’t give as much as we might if we were able to see a program for which we have passion come to fruition.

## Officers

### **Karen DeSalvo, MD, MPH, MSc**

New Orleans, LA  
*President*

### **Thomas McGinn, MD, MPH**

New York, NY  
*President Elect*

### **Fred L. Brancati, MD, MHS**

Baltimore, MD  
*Past President*

### **Larry McMahon, MD**

Ann Arbor, MI  
*Secretary/Treasurer*

### **Joseph Li, MD**

Boston, MA  
*At Large Member*

## Ex-officio Council

### **Alpesh Amin, MD, MBA**

Anaheim Hills, CA  
*Communications Chair*

### **Stewart Babbott, MD**

Kansas City, KS  
*ASP Liaison*

### **Mark Linzer, MD**

Madison, WI  
*Development Chair*

### **Nancy Rigotti, MD**

Boston, MA  
*SGIM President*

### **Melissa McNeil, MD, MPH**

Pittsburgh, PA  
*Meeting Co-Chair*

### **Christopher Schiamanna, MD, MPH**

Hershey, PA  
*Meeting Co-Chair*

### **John Flynn, MD, MBA**

Baltimore, MD  
*Membership Chair*

### **Valerie D. Weber, MD**

*Editor*

### **Sandra A. Buckley**

*Managing Editor*

### **April S. Fitzgerald, MD**

*Associate Editor*

### **Patience E. Agborbesong, MD**

*Associate Editor*

They emphasized the importance of really getting to know donors and probing them beyond your initial assumptions about their interests.

## Who Gives?

According to the Giving USA Foundation, in 2007 a total of \$306.39 billion in fundraised contributions flowed in the US. Of this, 75% was from individual donors, 13% from foundations, 8% from bequests and 4% from corporations. For academic medicine (according to AAMC data) 35% of giving in 2007 was from individuals and 40% from foundations. This surprised me since I have always presumed the vast majority of institutional

giving was from foundations. The session coordinators were quick to point out that the foundations category includes family foundations (i.e., individual givers). This pool of individual donors is anticipated to rise precipitously in the next decade as baby boomers age and look for ways to give back some \$36 trillion. Yes, trillion.

Finding these potential donors can be a challenge. The presenters did encourage institutions to go the route of “grateful patient” and suggested simple strategies to help physicians with that awkward conversation. It seems many sites are using simple pocket cards to take some of the embarrassment and hassle out of the process. Beyond that, there is certainly value in networking locally and nationally outside of the medical realm. Most importantly is the notion of working closely with your own development office. The more they know about your programs, needs and vision, the more helpful they can be in linking you with potential donors.

## Preparing for the Ask.

The first element of good preparation involves having a well-developed vision document for the program. The vision should be well articulated and compelling enough to excite your donor. The bigger the vision, the bigger the donor. Be able to tell this story on demand and use brief bullet points (3-5 are best) to describe the plan. Connecting the vision to a personal story of the donor, as close to the “grateful patient” event as possible, is critical.

It seems clear that if one needs to be prepared for both gifts of passion and loyalty when going for an “ask” (given that one never knows for certain if the donor has a passion in the area of your program), a back-up plan is helpful. Additionally, though many of us are loath to connect our potential donor with another program in the institution, this is sometimes the right thing to do. Therefore, it is always prudent for the academic leader to know as much as possible about the array of development “asks” in their own group, as well as other groups.

This “ask” visit will be smoother and potentially more successful if you are well informed about your po-

tential donor. So much information is available online about people that there is really little excuse for not having some background information. The development office can generally help with a more substantial profile depending upon the planned level of giving. They advised that, even if you know a great deal about your potential donor, you should not necessarily reveal it all to avoid making them uncomfortable (i.e., avoid appearing like a stalker).

## Anatomy of an Ask.

The key considerations in the “ask” are who should come, where the meeting should take place, and how the meeting should flow. Regarding the invitees, the take-home points from this training session were that there is no set rule about who should attend meetings with donors. Whatever can be done to give the donor comfort and ensure that they can clearly understand the vision is ideal.

When working with a potential donor, there are stages toward continuing the relationship. It starts with a foundational meeting and hopefully ends with a successful gift that is rewarding to the program and the donor. That first foundational contact can be critical. As recommended by the session coordinators, the traditional hour-long meeting flow should generally follow these four steps:

1. Build rapport (10 minutes)
2. Articulate the vision (20 minutes)
3. Get the donor's story (20 minutes)
4. Agree on next steps (10 minutes)

Essential in this flow is the transition between the vision articulation and getting the donor's story. Watching for cues of interest and flat out probing for “what they find intriguing or exciting” are some suggested strategies to aid in this transition.

## Stewardship.

The key take-home point for me was how important it is to ensure that the donor has a gratifying gifting experience. A simple thank you is a good start. More compelling can be the impromptu call of enthusiasm from the chief about the impact of the gift. This is what donors mean when they

say they want to “hear from you”—not only at the specified intervals of reporting. Like most of us, donors want to know that what they have given is making a difference.

Times are lean, but it seems op-

portunities for giving from donors is on the rise. I believe that general internists have the interpersonal skills, vision and natural intuition to be successful fundraisers. If we better prepare our partners in development,

dream big and stay alert for opportunities, it seems that general internal medicine leaders have great opportunities to continue to build programs that will benefit our fields and the patients we serve.

AGCIM

---

## Becoming a Chief Medical Officer: I Didn't Know What I Didn't Know

David G. Fairchild, MD, MPH

*Chief Medical Officer, Tufts Medical Center and Floating Hospital for Children, Boston, MA*

**M**aking the jump from Chief of General Internal Medicine at Tufts Medical Center to the Chief Medical Officer (CMO) role three years ago seemed, at the time, like a very logical career move. Good people skills would be important. As a generalist, I knew my way around the inpatient and outpatient areas of the hospital and my clinical work created interfaces with almost every other department in the hospital. I thought I was a natural for the CMO role.

However, what I have found over the past three years is that, while being a general internist CMO has its benefits, it also has its shortcomings. Without a doubt, remaining clinically active both in the outpatient and the inpatient setting has been crucial to maintaining my credibility with other physicians. But I must work hard to develop credibility in areas where I do not have first-hand knowledge. For example, when I decided to develop a monitoring system to assess our surgeons' compliance with “time-outs” in the operating room, the reaction of our surgical leadership was “if you want to take over safety initiatives [in the OR], you had best learn some surgery”. This is where good

negotiating skills (honed as a division chief) enabled me to successfully work with these leaders in a partnership to improve “time-outs” in the operating room. While the CMO role frequently takes me beyond my clinical expertise, I have found that being a good listener and partnering with local content experts is an effective strategy in areas where I do not have immediate clinical credibility.

Another revelation is that being a CMO more closely resembles the life of a diplomat than it does the life of a Chief. Having had 30 physicians reporting to me as a division chief, I was promoted into a position where I have only one direct physician report. Success as a CMO depends on one's ability to influence others—even when no reporting relationship exists. Whether it was arbitrating between the chairs of anesthesia and pediatrics regarding who should control pediatric sedation outside of the operating room or rallying physicians to improve hand hygiene rates, strategies that utilize influence techniques are my most useful skills.

Despite any shortcomings, we general internists are in an excellent position to function well in the CMO

role. We are used to looking at problems from different perspectives, (much like weighing the surgical and non-surgical solutions to a patient's medical condition) and we are comfortable using available evidence to support our ultimate decisions. As we find in our clinical office, the CMO is often faced with problems for which there is no clear right or wrong answer. Where others may jump to the solution before asking questions, we internists are accustomed to evaluating a problem from all angles before responding. Of course, some circumstances call for quick executive decisions; my internist's intuition has served me well in this regard.

I still feel that, as a general internist, I was a natural fit for the CMO role. But I did not know that my clinical credibility would be challenged or that, as I rose up the organizational chart, my ability to lead would depend less on reporting relationships and more on influencing others. But in the final analysis, our skills as Chiefs of General Internal Medicine prepare us well to become CMOs, even if we don't know what we don't know about the role of CMO.

AGCIM

---

## Book Review

Valerie Weber, MD

*Chair, Department of Medicine, The Commonwealth Medical School, Scranton, PA 18510*

**T**he Art of Woo: Using Strategic Persuasion to Sell your Ideas, by G. Richard Shell and Mario Moussa: 2007, Penguin Group

What is woo? The authors of this book, co-directors of the Wharton School of Business Strategic Persua-

sion Workshop, describe “woo” as relationship-based persuasion...“a strategic process for getting people's attention, pitching your ideas, and obtaining approval for your plans and projects...” Why is this important? In short, to be effective as a leader, one

must learn how to rely less on one's formal authority and more on one's ability to persuade effectively. Being right does not make you more effective in selling your ideas! Although the word “woo” (sometimes de-

*continued on page 4*

# The Leadership Forum

*an ACGIM publication for leaders in  
academic general internal medicine*

2501 M Street, NW, Suite 575  
Washington, DC 20037  
www.sgim.org

## 4 *Book Review* continued from page 3

scribed as a talent for winning others over) is used in many contexts—from romantic relationships to business transactions. It is a skill that the authors contend is an art form that can be learned.

Although many management books of this type can be difficult to read straight through, this one is peppered with many compelling examples of skillful persuaders (both past and present)—from Abraham Lincoln to Bono. The authors engage the reader early on in two self-assessment tools geared to identify ones' preferred persuasion styles and how that style might clash within your or-

ganization. Armed with that knowledge, the reader learns how six channels of persuasion—interest-based, authority-based, political-based, rational-based, inspirational-based, and relationship-based can be used skillfully, depending upon the situation. A framework consisting of four steps—surveying the situation, removing the “BRICCs” (beliefs, relationships, interest, credibility, and channels), making the pitch, and securing the commitments—is presented to increase ones' chances of success.

Those who attended past ACGIM management institutes will remember Dr. Moussa as an engaging teacher

and the style of this book is similar. What is perhaps most engaging is that, unlike most books on negotiation, which often seem to be about winning over the other party, this approach focuses on persuasion in the context of maintaining a relationship. Thus, integrity, credibility and trust are stressed as key components of the strategies outlined in the book. The Art of Woo will be enjoyed by those who attended the 2008 Management Institute and want to explore the concepts Dr. Moussa lays out in more depth. Those that did not attend will benefit from learning the basics.

ACGIM