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CHAPTER TWENTY-THREE

Department of Family Medicine

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“Almost every one who goes to bed counts upon a full night’s rest: Like a picket at the outposts, the doctor must be ever on call.”

—KARL F. H. MARX (1796–1877)

The Specialization of Health Care

The famous Flexner report of 1910 resulted in the closing of many substandard medical schools and placed a long-needed emphasis on the scientific foundation for the practice of medicine. This shifted clinical instruction from a preceptorial, outpatient setting into the teaching hospitals. The report heralded the emphasis that was to be placed on full-time clinical faculty. As a result, most of the efforts in clinical teaching were directed to the study of life-threatening disease that necessitated hospitalization. Medical education and research dealt primarily with selected, serious problems from an unselected population. As more specific, organ-related knowledge developed, the various specialties evolved.

In the 1950s there was a tremendous infusion of federal monies into the medical schools for biomedical research and research training. Understandably, these efforts were primarily directed to the dread diseases that required hospitalization. The teaching hospitals, not the outpatient setting, were the clinical laboratories. Efforts were more directed toward the prolongation of life rather than the prevention of disease. Great strides in the technology of medicine were the result. Open-heart surgery was initiated and followed closely by dialysis and transplantation, just to mention a few of the exciting, almost miraculous accomplishments.

As a result of all of this activity and the seemingly endless supply of resources for research, the generalists in medicine began to disappear. There was a steady rise in the absolute number and proportion of specialists. The best students followed able medical school role models and were attracted to specialty careers, whereas those who were less talented became the generalists. Even the general internist, who generically viewed himself
as the “doctor’s doctor” or the diagnostician, began to disappear. Bright medical school graduates were attracted to specialties where the “action” and generous rewards existed. Specialty training programs forced more fragmentation of medicine, both from an organizational and practice standpoint.

By contrast, in Great Britain there were three primary care physicians for every specialist, whereas in the United States there were four specialists for every general practitioner. As a result, many United States citizens were concerned that they could not find a well-trained, available personal physician. Patients felt that the continuity and comprehensiveness of their care left much to be desired, and that medicine in general had become very fragmented and detached. Prevention, health care, and attention to the psychological needs and the effect of illness on the social unit were being ignored.

In 1964, all of this societal concern was formalized in the reports of two government-appointed commissions, the Willard and Millis Commissions. Both of these well-constructed reports proved to be a tremendous stimulus in making the medical community and the government formally aware that the disappearance of the generalist in medicine was having great negative implications. Furthermore, the allopathic physicians, most of whom were specialists and very dependent upon referrals from primary care physicians, were alarmed that such individuals were disappearing. Reluctantly, allopathic specialty physicians in urban areas had to be more and more dependent upon the primary care osteopaths, who were rapidly becoming the only referring primary care physicians in the community.

Nationally, the general practitioners were concerned lest they disappear from the scene of American medicine. They too felt that their presence was greatly needed, but in order to improve their stature and do away with the second-class label of the “local medical doctor” (LMD), they had to upgrade their image by improving the qualifications of those entering practice. Consequently, over a five-year period they were finally able to convince organized medicine that there should be a three-year specialty training program in family practice. The American Board of Family Practice was established in 1969. This was achieved after the American Board of Internal Medicine in 1964 refused to accept family practice as a legitimate discipline or specialty subdivision. Dr. Nicholas J. Pisacano, the first Executive Secretary of the American Board of Family Practice, was largely responsible for leading organized medicine through endless negotiations to recognize that the specialty of family practice would be good for academic medicine and for health care delivery in the United States.

Jefferson’s Dean, Dr. William F. Kellow, and Dr. Pisacano knew each other well, for they worked together on national committees. They respected each other, and Dean Kellow frequently consulted Dr. Pisacano about the new specialty and the possibility of establishing a new family medicine program at Jefferson.

Following these national discussions, Dean Kellow and the senior faculty decided to explore the possibilities of developing a program in family practice to help meet these manpower needs. In 1967 he invited Dr. Franklin C. Kelton from Ambler and Dr. David Kistler from Wilkes-Barre, two leaders and representatives of the Pennsylvania Academy of Family Physicians, to meet with him. They discussed how the training of the primary care physician might best be accomplished. Both of these family physicians spent a great deal of time and effort at Jefferson in attempting to explain how and why family practice should be a distinct program in the Medical College.

The Beginning of Family Medicine at Jefferson

In 1971 as a result of all the societal, political, and professional influences, the faculty under the leadership of Dean Kellow agreed to establish a Division of Family Medicine in the Department of Community and Preventive Medicine. Dr. Willard Krehl, the Professor and Chairman of that Department, was most enthusiastic, supportive, and helpful. With the assistance of Dr. Franklin Kelton and Dr. David Kistler, he established elective preceptorships in family practice. The Pennsylvania Academy of Family Physicians helped to recruit 25 family physicians as preceptors. In the
program's first year, 40 Jefferson students elected to take the six-week family practice elective. They were keenly interested, and the physician-preceptors were enthusiastic. Family practice had officially come to Jefferson. Shortly thereafter, in 1972 the Medical College and the University Hospital agreed to form a new Department of Family Medicine. This culminated a seven-year dialogue among all concerned, and a search committee was formed.

Dr. Joseph Gonnella, then Assistant Dean in Charge of Academic Affairs, was responsible for recommending Dr. Paul C. Brucker to the search committee for the Chairmanship. Dr. Brucker and Dr. Gonnella had worked together in helping to devise a system for the evaluation of medical care at the Chestnut Hill Hospital in Philadelphia. Over a four-year period they had established a strong professional relationship.

When Dr. Brucker was initially asked to be a candidate for such a position, he was not interested, for he was very content in his private group family practice in Ambler, Pennsylvania, a suburb of Philadelphia. There, in a 100-year-old practice, he and three other family physicians enjoyed a successful group family practice. One of his partners, Dr. Franklin C. Kelton, was the individual who had been so instrumental in helping Jefferson decide upon the formation of the new Department.

Dr. Gonnella convinced Dr. Brucker to at least meet with the search committee. Ironically, Dr. Brucker's first scheduled appearance before the search committee was well known to the entire committee, but not to Dr. Brucker. Dean Kellow discovered this oversight and called Dr. Brucker the evening before his scheduled appearance to apologize for not officially notifying him of the meeting. After a good chuckle with Dean Kellow, Dr. Brucker rearranged his schedule and appeared the next day. He was impressed by the composition of the committee and the depth of their understanding as to what a new Department would entail. This was a tribute to the preparatory work that the Medical College had done prior to deciding to form such a Department. After an enjoyable three-hour meeting with the committee, Dr. Brucker returned to Ambler, only to be called that same evening and be informed by Dean Kellow that the committee was extremely interested in him as a candidate. He wanted Dr. Brucker to meet with the various Chairmen in the College. Several stood out. Dr. Thomas Duane, the Chairman of the Curriculum Committee and Professor and Chairman of the Department of Ophthalmology, was most helpful in explaining the intent of the anticipated, revised curriculum, a curriculum that would provide a mandatory clerkship in family medicine. Dr. Robert Brent, Professor and Chairman of the Department of Pediatrics, lent additional encouragement. Dr. Robert Wise, the Magee Professor and Chairman of the Department of Medicine, cautiously supported the concept of the new Department, but did have reservations about the quality of training that the Department would be able to deliver.

Dean Kellow, Associate Dean Gonnella, and Dr. Kelton, plus the receptive atmosphere at Jefferson, all helped to convince Dr. Brucker that accepting the new position would be a true opportunity. On January 1, 1973, he was appointed the new Professor and Chairman of the Department, both in the Medical College and the University Hospital (Figure 23-1).
Almost simultaneously with Dr. Brucker's acceptance of the position, Richard Bennett, President of the Haas Community Fund, called Dean Kellow to see why a new Chairman had not been appointed and why the monies that the Foundation had donated to help form the new Department had not yet been used. When Dean Kellow informed him that Dr. Brucker had accepted the invitation to chair the Department, he was somewhat astounded, for Dr. Brucker had been his friend and personal physician for 13 years. Fortunately, this relationship continued even after Dr. Brucker moved from Ambler to Jefferson; Mr. Bennett was the first Family Practice patient at Jefferson.

The Beginning of the Department

When Dr. Brucker first arrived on campus in March, 1973, newly renovated space in the old Scott Library, located on the first floor of the 1025 Walnut Street Medical College, was just about completed. This new, attractive facility consisted of five offices for faculty members, one office for the Chairman, and adequate space for clerical help. The only furniture present, however, was an old army desk and chair, for the furniture that was ordered had not arrived on time.

Dean Kellow met with Dr. Brucker on the first day and charged him with establishing undergraduate, graduate, and postgraduate educational programs, a patient service program, and eventually a research program. He extended his hand of assistance to guide Dr. Brucker through the complexities of accomplishing this. He and the other members of the Dean's Office, including Dr. Gonnella and Mr. Thomas Murray, the Business Administrator for the College, were always available for assistance.

The Undergraduate Family Medicine Curriculum

The Department constructed a curriculum for the first mandatory Family Medicine Junior Clerkship, which was initiated in the fall of 1974. This curriculum paid attention to developing an ambulatory experience that would provide ready access for patients, allow for continuity and comprehensiveness of care, and pay attention to the psychosocial needs of the family. Simultaneously, a curriculum was designed for the senior-year elective track in Family Medicine.

Initially, a big problem was where to place 223 Junior students so that the ambulatory clerkship would fulfill the curricular goals. In order to accomplish this, the Department looked to existing Jefferson affiliated institutions. An approved family practice residency existed at the Wilmington Medical Center where Dr. Dene Walters was the Program Director. It soon followed that the Wilmington Medical Center became a site for a family medicine clerkship. Likewise, because Chestnut Hill Hospital was affiliated with Jefferson, plans were made to develop a family medicine affiliation there. After some discussion, Dr. Harry Kaplan became the first director of the program at Chestnut Hill.

With the assistance of Dean Kellow and Associate Dean John Killough, an affiliation discussion was started with the Richard K. Mellon Foundation and representatives of the Latrobe Area Hospital in Latrobe, Pennsylvania. The Latrobe Area Hospital wanted to establish a medical school affiliation in order to improve the quality of care, to attract even better medical staff, and to serve as a training site for sorely needed family physicians in their community. With the help of Drs. Robert Mazero, Joseph Govi, and Robert Gordon, the affiliation materialized in 1973, and shortly thereafter an affiliate family practice residency program was established. With generous funding from the Mellon foundation, the hospital built a clinical facility in which the students could see outpatients, and also established residential housing for the undergraduate students and residents.

Sufficient clerkship spots were located for all of the students, curriculum time was granted by the Curriculum Committee and approved by the professorial faculty, and the Department was off on its undergraduate educational mission.

The Latrobe affiliation, along with a societal concern for better distribution of family physicians, led to the establishment of the Physician Shortage Area Program (PSAP) in 1974. The Medical College agreed to preferentially accept up to 12 qualified students into the Freshman class who came from urban or rural underserved physician areas in Pennsylvania, who in turn would pursue the family medicine
curriculum, family medicine residency training, and upon finishing that training return to an underserved area. In 1978 the program was expanded to include 24 students. This unique program was most successful. Since 1978, many students have entered family practice in underserved areas of Pennsylvania.

- The Residency Program

Initially, an attempt to establish an approved family practice residency at the Thomas Jefferson University Hospital failed. The residency application was not approved when reviewed in September, 1973. The same day that Chairman Brucker received notice of this disapproval he arranged an immediate consultative appointment in Kansas City, Missouri, with Dr. Robert Graham, the educational representative of the American Academy of Family Physicians. He and Dr. Graham stayed up until the early hours of the next morning rewriting the application, which was then retyped and resubmitted the next day. Finally, provisional approval was gained in December 1973, and the Department made plans to initiate the first family practice residency at Jefferson in July, 1974.

After approval was gained, Dr. Brucker tried to obtain funding for the family practice residency positions, which represented a total of 18 spots for the three-year program. This was a frustrating struggle, since each Department and residency program also wished to expand and did not wish to give up any positions. The new Chairman met with many committees, administrative persons, and Chairman of Departments. All of this was to no avail, and no funds were allocated.

Dr. Peter Herbut, President of the University, asked Dr. Brucker to give a progress report about the new Department to the Board of Trustees. When it became apparent that sharing the information about a lack of funding for the residency positions would prove embarrassing to the President, Dr. Brucker met with him three days before the scheduled meeting and asked that he be excused from giving the report to the Board. With a single phone call Dr. Her but found the funds necessary for the residency, and Dr. Brucker was able to give a glowing progress report to the Board some three days later.

Unfortunately, the late residency approval and late source of funding did not allow the Jefferson family practice program to recruit vigorously across the nation. Consequently, in the inaugural class of residents only four out of six positions were filled through the traditional National Intern and Resident Matching Program. Two additional residents were enlisted outside of the Match. The full complement of six entered the residency in July, 1974. These pioneers in a completely new, three-year residency program and the medical schools that they graduated from were: David Cheli, M.D. (Medical College of Pennsylvania); Sandra Harmon, M.D. (Temple University); Franklin Kelton, Jr., M.D. (Jefferson, 1974); Allan Kogan, M.D. (Baylor School of Medicine); James Plumb, M.D. (Jefferson, 1974); and Margaret Stockwell, M.D. (University of Nebraska).

- Facilities

When the Department was started, it had neither clinical space nor patient population, two requisites for both the undergraduate and graduate programs. Monies were available from the Haas Community Fund and the Department of Health, Education and Welfare for the development of the overall program. The government's funds had to be used by July 1, 1973. In early June, 1973, Dr. Brucker requested that these funds be approved for the building of the first family practice center on the fifth floor of the Jefferson-owned Edison building at Ninth and Sansom Streets. Quickly, with the assistance of the University architect he helped to design a new 8,000 square-foot family practice center that had 28 examining rooms, a small laboratory, and conference rooms. The plans were hand-delivered to Washington, D.C., for approval. This was obtained some three days before the grant expired. Although hurriedly designed, this particular clinical facility worked out very well. It was extremely practical and functional. The Department occupied this facility until 1978, when it moved to the fourth floor of the new University Hospital.

- Faculty Recruitment

Once curriculum time, a residency program, and a clinical facility were established, Dr. Brucker had
to search for qualified faculty. He turned his attention to recruiting able, senior faculty. In addition to assuring that appropriate faculty be chosen to carry out the programs, he was aware that the entire University and its alumni would be viewing his choices with close scrutiny. Faculty selection was considered to be one of the key elements in ensuring the credibility and stability of the Department.

The first person to be contacted was a friend and professional colleague of Dr. Brucker, Dr. Edward H. McGehee (Figure 23-2). Dr. McGehee was trained as an internist, with additional training in pathology and hematology. A Jefferson graduate (Class of 1945), he practiced general internal medicine in the Chestnut Hill section of Philadelphia, where he was a respected, loved “family physician.” He worked long and hard, made house calls on his bicycle, had grateful students in his office almost continuously, and had chaired the Department of Medicine at the Chestnut Hill Hospital. He had also held the positions of Physician and Hematologist to the Pennsylvania Hospital and the Benjamin Franklin Clinic. It took many meetings to convince him to join the faculty. Again, Dr. Joseph Gonnella was most helpful in encouraging Dr. McGehee to join as a Professor of Family Medicine in 1974.

The next full-time faculty person to be recruited was Dr. William Mebane, a professional colleague of both Drs. Brucker and McGehee. He too required a great deal of encouragement to leave a very successful and satisfying private group pediatric practice in Chestnut Hill. In 1974 he joined the faculty until 1976, when he moved to the affiliate family medicine program at Chestnut Hill Hospital. There, he served as an Associate Director of the program until 1985, when he became the Director.

Recruiting two of Chestnut Hill’s most respected physicians to Jefferson had a marked impact on the Chestnut Hill community. Dr. Brucker received many troubled calls about his recruiting two of the more valued professionals from a single community into the Jefferson program. Fortunately, most of the Chestnut Hill residents understood the importance of good role models and the training of future physicians. Many requested that they be allowed to follow their personal physicians to Jefferson. This loyalty helped to form the initial panel of patients that was so necessary for the training of students and residents.

- Outpatients

In order to conduct the ambulatory care program, a large number of patients were required. Although a fair number of the full-time faculty’s private patient population followed them to Jefferson, a much larger number of patients was needed.

It was fortuitous that in 1974 the Hospital decided to disband the traditional clinic system and have the clinic patients seen in a more

![Fig. 23-2. Edward H. McGehee, M.D. (Jefferson, 1945); Ellen M. and Dale W. Garber Professor of Family Medicine.](image)
traditional “private system.” The Hospital felt fortunate that a Department existed that was so interested and so in need of adult ambulatory patients. Dean Kellow and Dr. Francis Sweeney, Vice President for Health Affairs, thought that it would be most appropriate for family medicine to assume the care of such patients. The Department of Medicine, long responsible for the Medical Clinic patients, debated about relinquishing this responsibility. Because of minimal interest in maintaining the Medical Clinic, they agreed to allow the Department of Family Medicine to care for these patients. Consequently, in 1974 the Medical Clinic was closed and the patient population referred to family medicine. Initially, the clinic population was skeptical that many of their medical needs could be cared for in a single facility. They were accustomed to many referrals to specialty clinics as well as the long waits because there was no appointment system. Family medicine developed an appointment system, provided coverage 24 hours a day, seven days a week, and attempted to assign a single doctor to each patient so that there might be continuity of care. The dramatic change was difficult for the patients to accept. When the Family Practice Center opened, 80 percent of the patients failed to keep their appointments. The faculty, the residents, and the students were disheartened. As the patients became more familiar with the system and trusted the family medicine staff, appointment compliance gradually improved. Approximately two years later, 60 percent of the patients kept their appointments.

Approximately 60 percent of the family practice patient population qualified for medical assistance. This meant that the Institution had to subsidize the family practice clinical operation. This subsidy was appreciated, but annually was the subject of considerable discussion at budget time. It was always difficult to justify how much effort was required for patient care, and how much more was required for student and resident education. It was apparent from the start that primary care training was expensive, and that the rewards for service, particularly for the indigent, were very low.

- Inpatients

From the very beginning of the program there were Department concerns about how the inpatients generated from the outpatient population should be managed. Dr. Robert Wise, Chairman of the Department of Medicine, was concerned that family physicians may not possess the necessary knowledge and skills to care for adult patients. Other members of the Department of Medicine envisioned family practice in the United States as being similar to that in the United Kingdom, where the inpatients were always referred to the more traditional specialists. This particular issue was the most difficult one encountered in the establishment of the Department’s programs. The members of the Department of Family Medicine in both the College and the Hospital felt that they were capable of handling general medicine inpatients. At no time did family medicine request obstetrical or surgical privileges. The inpatient issue resulted in many meetings. Dean Kellow and Vice President Sweeney convened the leaders in each Department in order to arrive at a satisfactory solution. Finally, thanks to Warren Lambright, M.D., who worked for Dr. Sweeney in the hospital’s administrative offices, an acceptable solution was found and agreed upon. The Department of Medicine and the Department of Family Medicine agreed that all inpatients would be admitted to the Hospital on the Internal Medicine service. All qualified faculty in the Department of Family Medicine would receive secondary faculty appointments in the Department of Internal Medicine. Dr. Brucker, the Chairman of Family Medicine, would be responsible for the quality of their care, but should this not meet the usual standards, Dr. Wise, the Chairman of Internal Medicine, would have the right to intervene. (Incidentally, this never happened.) On the other hand, Dr. Brucker was held responsible for all outpatient care, and a similar arrangement for outpatient care was established between him and the Department of Medicine. This compromise allowed both Departments to pass an almost insurmountable hurdle. After ten years, in 1984 this particular inpatient care arrangement was dismantled because Dr. Willis Maddrey, the new Chairman of the Department of Medicine believed that the Department of Family Medicine had clearly demonstrated that they were able to take
care of inpatients, and he suggested that family medicine have its own inpatient service.

By 1975 the Department had undergraduate and graduate programs, an outpatient facility with an adequate patient population, a faculty, and the privilege to admit and care for general adult medical patients. The first two years for the new Department were very busy. The Board of Trustees, the College, and the Hospital united in a commitment to the Department that was vital and solid.

Maturation Of The Department: Undergraduate Programs

The Department grew quickly. By 1976, six full-time faculty were recruited. In addition to the three already mentioned, they included Dr. Peter Amadio (Jefferson, 1958), Dr. Su Hain, Dr. Howard Rabinowitz, and Dr. Elmer Taylor (Jefferson, 1952). Three were trained in internal medicine, two in family medicine, and one in pediatrics (Figure 23-3). Such specialty representation lent itself well to the overall education programs. This particular faculty mix was one that attracted favorable attention nationally.

In addition to this complement of full-time faculty, the Department was always able to gain assistance from all of the other faculty in the College. Not one faculty person in the College refused to cooperate and contribute to the family medicine program. In fact, many volunteered. The result of this unparalleled cooperation was a very healthy integration of the Family Medicine Program into the University setting.

As the faculty number increased, the amount of undergraduate teaching responsibility also increased. The family medicine faculty became involved in clinical correlation courses in the first two years and eventually became responsible for a 16-week segment of the Sophomore Medicine and Society Course. Family medicine supervised the teaching of epidemiology, medicolegal and ethical issues, and health-care delivery issues, including the new emphasis being placed on the economic aspects of medicine. In addition to the mandatory Junior clerkship, a large number of students chose the Senior-year track in family medicine. In this track they were required to take an additional 12-week experience in an ambulatory setting. In order to accommodate all of the students who desired family medicine clinical experiences, the Department had to increase the number of student openings. With the help of federal funding, a rural preceptorship program was started. Students were assigned to carefully selected faculty physician preceptors in rural offices located from Vermont to North Carolina. Since 1976 this program has been supervised by Dr. Howard Rabinowitz, an Associate Professor of Family Medicine. The majority of students who take the rural preceptorship in their Senior year claim that it is one of the highlights of their medical school training. They see unselected problems in a defined community, live and participate in the community, and have one-on-one teaching. In order to ensure the quality of the teaching, the preceptors are visited on a regular basis in their offices. Each preceptor is invited back to the medical school for an annual preceptorship workshop, concerned with upgrading their medical knowledge and to discuss how the preceptorship can be improved.

Three other affiliate programs were added, bringing the total to six. The Underwood Memorial Hospital program was started in 1980, Bryn Mawr Hospital under supervision of Dr. Stratton Woodruff in 1975, and Franklin Hospital in 1978.

Residency Program

The pioneer group of Residents performed well. They proved to be excellent ambassadors for the Department. The Residency, from its beginning, enjoyed an excellent reputation both within and outside the Institution. Many applicants appreciated the advantages of training for family medicine in the medical school setting. Fortunately, the initial hurdle of recruiting Residents was overcome, and after the first year there was a large number of qualified applicants from all over the country, representing many different medical schools. All of the graduates of the Residency program have passed the American
Board of Family Practice certifying examination. They practice all over the United States and in two foreign countries.

In 1978 the Residency program received full accreditation. Nationally there was concern that family physicians trained in the northeastern part of the United States did not acquire sufficient skills to practice obstetrics and surgery. Dr. Brucker had many discussions with the Residency Review Committee about this particular issue. Finally, a compromise was reached. All of the residents received the minimal amount of training as specified in the Essentials for Family Practice, but for those who wished or were required to practice obstetrics, a six-month Obstetrical Fellowship was made available after the completion of the three-year Family Practice program.

As a result of the family medicine program, plus some national trends, the number of Jefferson graduates going into family medicine residencies increased from three per year in 1973 to 35 in 1976. As of 1986 approximately 16 percent of the Jefferson graduating classes go into family medicine residencies. This is considerably above the national average.

- **Postgraduate Programs**

In order to qualify for the mandatory recertification examination in family practice, all diplomats are required to take at least 150 hours of approved continuing medical education courses every three years. This particular requirement made it easy for the Department to conduct
successful annual continuing medical education courses. Some of these were in conjunction with the annual alumni trips, whereas others were conducted independently, both at Jefferson and in other places.

## Research Programs

After establishing successful teaching and patient care programs, the Department paid more attention to developing a research program. Although the faculty in the Department conducted some clinical trials, there was no concerted research effort until 1982. It was at that time that a Research Division was formed. Dr. Donald J. Balaban, M.D., MPH, was invited to join the Department as a Research Associate Professor of Family Medicine and to head the Department's Research Division. Dr. Balaban was no stranger to Jefferson, for he had taken some of his internal medicine training there. He then took additional training in epidemiology at the University of California, where he received his MPH. Before coming to Jefferson, Dr. Balaban carried out his research at the Leonard Davis Institute of the University of Pennsylvania. There he was intimately involved in health care delivery research, particularly as it applied to studying functional outcomes in chronic conditions. Dr. Balaban brought with him an enthusiasm and expertise to carry out similar research in the Department. He was supported by the outpatient clinical practice that the Department had established, and he was anxious to train fellows and junior faculty in research methodology in order to improve their research skills. The timing for the establishment of this Division was right. The Research Division's presence lent an important academic stimulus to the Department. Appropriate research questions began to be asked, and methodologies were developed in an attempt to answer them.

## Economic Influences

In 1982 with the advent of the Prospective Payment System for hospitalization, numerous significant impacts began to take place on the delivery of health care. It became readily apparent that society was going to impose limits on the cost of health care delivery. For the first time there were debates about the rationing of care and the effectiveness and efficiencies involved with certain types of care. The private corporate sector began to exert a significant effect on the organizational structure for delivering care. Medicine began to assume much more of a private enterprise or business posture. Different types of capitation systems sprung up for the well and employed. The government subsidies for the care of the poor and the elderly started to become limited. It became very apparent that hospitalization, the most expensive part of health care delivery, would be curtailed and that probably many small hospitals might be forced to close. This prospective payment system was a particular threat for teaching hospitals located in poor urban areas where so much of the care delivered was subsidized. With the medical schools turning out a surplus of physicians, “competition” and “doctor glut” came to be frequent conversation topics. For the first time in 60 years, the outpatient setting and ambulatory care took on a very new significance. Likewise, for the first time in the 1900s residents and students began to become concerned with finding a position after finishing their residency training.

Jefferson became very aware of all of these trends and in its long-range planning attempted to make sure that it would remain fiscally sound, but still heed its mission of education, research, and patient service. The Department of Family Medicine, in cooperation with the Hospital administration, began to participate in various capitation systems that were designed not only for the relatively well and employed, but also for the poor and elderly. In 1986, they established one primary care satellite in the Fairmount section of Philadelphia, and another in the South Philadelphia area. In 1988, a third satellite was started in Chinatown. Such satellites were an attempt to ensure an adequate patient population for training both in the inpatient and outpatient setting. The training of the students and the residents in a capitation model requires a great deal of skill, for intelligent use of resources and logical decision analysis are required in order to remain financially sound. It appears that this particular type of training will be even more important as the capitation models continue to grow and residency graduates become dependent...
upon them for employment. The Department continues to do research in this important area, so that there can be some factual basis for the decisions that will be required.

- Benefactors

In the first 13-year period (1973–1986) of the Department's existence there have been many generous contributions. In 1973 the Alumni Association of Jefferson Medical College voted to contribute $50,000 annually to help sponsor the Alumni Professor of Family Medicine. Dr. Brucker was named the first Alumni Professor of Family Medicine, and that honor along with an honorary lifetime membership in the Alumni Association were distinctions that he prized.

One outstanding contributor was Dr. Dale W. Garber (Jefferson, 1924). He was a respected general practitioner in Delaware County, Pennsylvania. Dr. Brucker had the good fortune to first meet him in 1976 on an Alumni-sponsored continuing medical education trip to the lowlands in Europe. He became very interested in the Department of Family Medicine. After several years of finding out more about the Department and how it functioned, Dr. Garber established a Professorship in Family Medicine. This endowed chair was awarded to Dr. Edward H. McGehee in 1984 when he became the first Ellen M. and Dale S. Garber Professor of Family Medicine. The esteem in which Dr. McGehee was held among the student body was manifested when the Class of 1976 presented his portrait to the College.

In 1982, Mrs. Nell T. Haac, who had been in Jefferson Hospital repeatedly over the past 50 years, left a generous sum to the Department that adequately ensured funding for the initial year of the Research Division.

As the Department's programs rapidly expanded they became very short of administrative space. The headquarters on the first floor of the College building were no longer adequate, but there was no funding to allow a move to larger quarters. In 1982, the Glen Meade Foundation provided a generous grant for renovations to be made on the fourth floor of the Curtis Building. The Department moved to these new headquarters in 1983.

In an increasingly restrictive financial climate, the Research Division had difficulties in funding stipends for Fellows and various research projects. Mr. Gustave Amsterdam, a member of Jefferson's Board of Trustees and a member of the Etelka J. Greenfield Foundation Board, became aware of this and interceded with the Foundation to contribute a generous gift to the Research Division. In order to recognize this and the importance of the gift, in 1984 the Research Division was called the Etelka J. Greenfield Research Center of the Department of Family Medicine.

All of these gifts, plus the dedicated efforts of many individuals in an Institution that has been most supportive of this new Department, have allowed a great deal to be accomplished in a relatively short time. A solid foundation has been established to further Jefferson's and Family Medicine's mission.