

11-29-2022

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Recommended Citation

Formal, Christopher and Ditunno, John F. Jr., "Anna Magee's Vision 100 Years Past 1923-2023!" (2022).
Department of Rehabilitation Medicine Faculty Papers. Paper 53.
<https://jdc.jefferson.edu/rmfp/53>

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Anna Magee's Vision 100 Years Past 1923-2023!

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Anna J. Magee's vision of contribution

We have seen how important family was to Anna Magee and understand her wish to commemorate her family name. This wish may have been particularly important to her as she realized her family would have no direct descendant.

She viewed service to society as a goal in itself, and also as a path to achieve a lasting legacy, as outlined in her will and its codicils, from 1917. Rather than contribute to an existing institution, or develop a new facility similar to others, she wished to establish something unique. Her creation was to be "The Magee Memorial Hospital for Convalescents". It would provide the sort of dynamic rehabilitation championed by her physician James Cornelius Wilson. It would receive patients from Philadelphia's "general hospitals".¹ The entire system of health care would benefit, as the hospitals were relieved from the burden of caring for patients whose acute illness had passed. Patients would be accepted without regard to gender, race, creed, or country of origin. The indigent would be welcomed and care for them was to be a priority. She wished the site to be inexpensive and, specifically, not on the Main Line. The Hospital was to be managed by a Board of 12 trustees: 11 from the city's "general hospitals" plus Dr. Wilson. Her vision was Philadelphia-based, non-discriminatory, and saw an institution apart from acute care hospitals, which she knew well from her work on several committees at Jefferson. Though her creation would be different from an acute, general hospital, it would work in concert with all such within Philadelphia.

The realization of Anna Magee's vision has occurred in three phases. The first spanned the writing of her will until groundbreaking of the new hospital. This was followed by the early years as an entirely independent institution. The third phase, which continues to this day, began with its association with Thomas Jefferson University, and integration into a complete system of care, education, and research. Each phase will be considered separately.

From will until groundbreaking

Having gained insight into the unique nature of Anna Magee's vision, we need to understand the difficulties faced in bringing it to realization. These account for the delay of 35 years between her death on December 12, 1923, and the opening of The Magee Memorial Hospital for Convalescents in 1958. There were economic and social factors at work during this time, and changes wrought by the evolution of health care. These, as well as the birth and maturation of a new medical discipline following World War II, contributed to the achievement of her dream.

A record of this epic is found in the Magee Estate papers of 1954² and summarized in Table 1. An initial delay from 1923 to 1937 was due to the determination in 1928 that funds needed to increase from \$1.25M to \$2.5M. By 1937, sufficient funds had accumulated. Another delay occurred when the intended site, at

¹ Protestant Episcopal, Presbyterian, Methodist, Episcopal, Pennsylvania, German (now Lankenau), Jefferson, University of Pennsylvania, Woman's, Samaritan (now Temple), Hahnemann, and Germantown

² Magee estate papers, Common Pleas Court of Pennsylvania, November 4 1954;
<https://www.leagle.com/decision/19544481padampc2d4471389>

the Philadelphia Orthopedic Hospital and Infirmary for Nervous Diseases, which was moving from its 17th and Summer Streets location (approximately the current southwest corner of 17th and Vine Sts.) to the Hospital of the University of Pennsylvania, was found physically unsuitable in 1938; the building was eventually demolished. A plot of 15 acres of land adjoining Fairmount Park, between Ridge and Henry Avenues, was purchased in 1939 and plans were drawn up, but building was then delayed, first by WWII, and immediately after the war, by prohibitive costs for labor and material.

As building continued to be delayed, the Board sensed a need for guidance regarding the specific nature of the institution it was charged to create and how such an institution would differ from a nursing home or a custodial convalescent center. In 1949 the Board authorized Dr. C. Rufus Rorem, the executive secretary of the Hospital Council of Philadelphia, to provide guidance. Dr. Rorem surveyed institutions in Philadelphia and reported back to the Board in 1950 regarding the need for active rehabilitation of those who had already received the maximum benefit from medicine and surgery. His ideas were similar to those of physicians decades earlier, such as Dr. McKenzie and Dr. Wilson (Ditunno & Verville, 2014) (Wilson, 1924), but now there was a medical specialty--Physical Medicine and Rehabilitation (PM&R)--that had grown in part from these ideas. Dr. Rorem saw a need for an institution that could provide rehabilitation care to patients, educate professionals in such care, and conduct research. The trustees approved the report in 1951.

The judge auditing the Board appointed an advisor ("amicus curiae")--Thomas Ringe, Esq.--to oversee the plans of the Board. Mr. Ringe sought input nationally, including that of Dr. William H. Schmidt who was an associate professor of physical medicine at Jefferson; Dr. Howard Rusk, from New York University College of Medicine; and Dr. Josephine Buchanan, from the George Washington University Medical Center. Testimony supported the efficacy of dynamic rehabilitation and included reports of cost-effectiveness of such programs. Mr. Ringe's reports in 1953 and 1954 supported the earlier recommendations of Dr Rorem from 1950.

The Board wished to proceed, and the auditing judge approved the petition of the Board on November 4, 1954. The judge emphasized the difference between Magee, as a Rehabilitation Hospital, and a more conventional Convalescent Home. The judge noted recommendations to accept unpaid and partially paid patients, and suggested that priority always be given to the poor.

The Board sought a local physician to serve as Director for the future hospital. After six months, on September 6, 1955, H. Frazer Parry assumed this position, while maintaining a practice at the Hospital of the University of Pennsylvania, and an office at 1500 Walnut St.

An appropriate physical plant was identified: a building at 1513 Race St., owned by the American Meter Company. The structure was strongly built, and as a former factory, it had an open floor plan without interior walls to demolish. It was bounded by Spring St. to the north, Hicks St. to the east, and Race St. to the south. Importantly, for future development, there was open space to the west, extending to 16th St. Plans involving the Fairmount Park site, which lacked such a fine physical plant, were abandoned. Announcement of purchase of the building on Race St. was made on January 27, 1956; renovation began on December 13. Opening Day was March 9, 1958. (Table 1)

Table 1. Reasons for 35-year delay.

1. 1923-1928. Financial assessment and determination to wait until trust grew to \$2.5M.
2. 1928-1937. Nine-year delay likely due to the "Great Depression 1929-1939", while trust grew to \$2.5M.
3. 1937-1940. Failed plans due to unsuitable location and facility.
4. 1941-1946. Postponed due to WWII.

5. 1946-1950. Postponed due to insufficient funds and reconsideration of nature of a rehabilitation facility.
6. 1950-1958. Extensive study defined need for modern rehabilitation hospital with academic and PM&R leadership.

Figure 1. Original hospital under construction



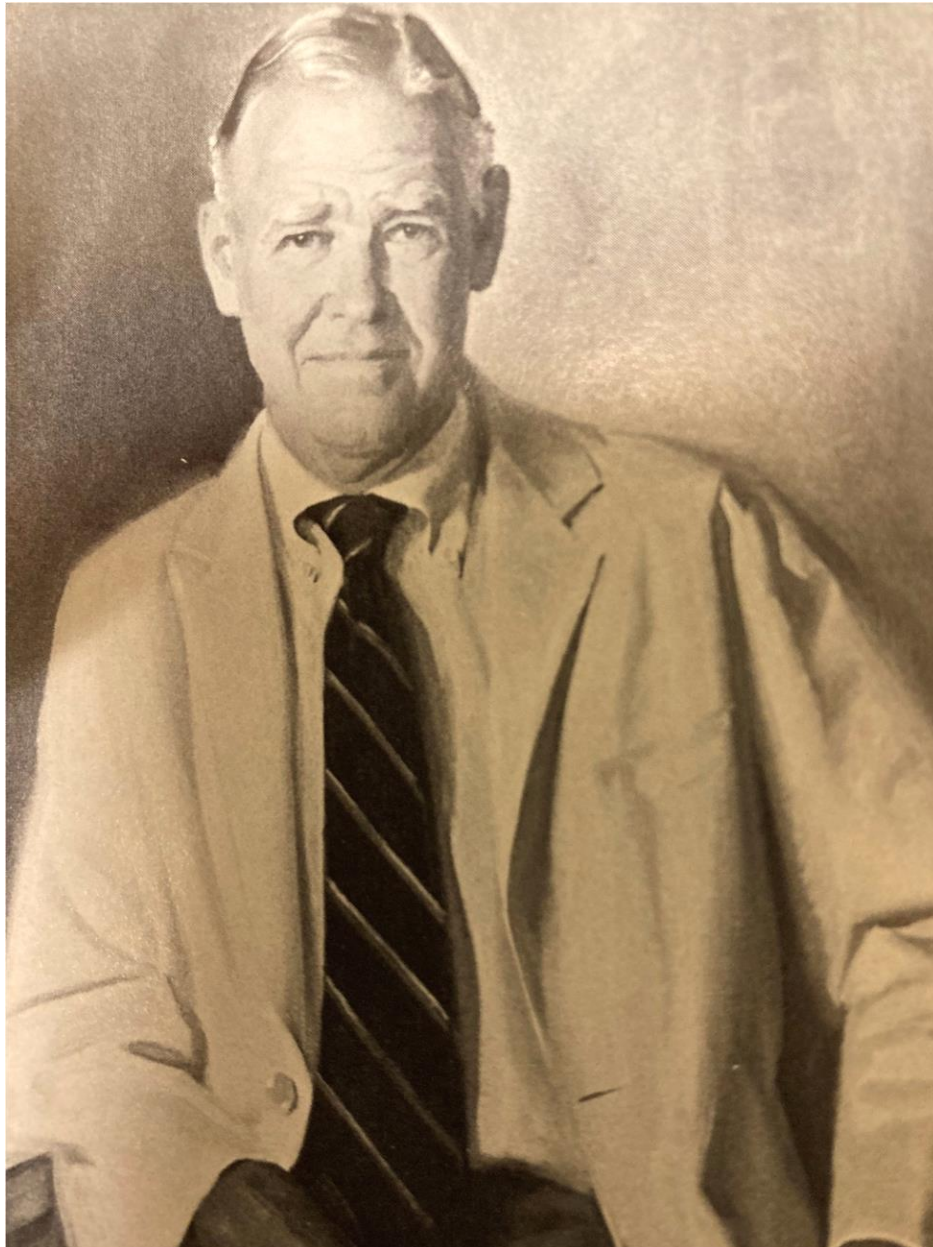
Early years as an entirely independent institution

The period following WW II gave birth to the new medical specialty of PM&R and a novel approach to the care and restoration of function to persons disabled by disease, trauma or birth defects. PM&R traces its origins to 1917 and WW I when R. Tait McKenzie published the first text on physical rehabilitation “Reclaiming the Maimed”, which Dr. Wilson cited in 1924 (Ditunno & Verville, 2014) (Wilson, 1924). However, it was not until the polio epidemics and WW II that a sufficient number of physicians (100) were able to establish the specialty in 1947. During this period, as reported earlier, the trustees of the Magee Estate determined, based on expert advice, that medical leadership should be vested in physicians trained in PM&R. When it opened, Magee was Philadelphia's sole inpatient rehabilitation hospital. Patients were attended by specialists in PM&R, also referred to as "physiatrists".

Magee Rehabilitation Hospital (MRH) originally had 39 beds, and provided interdisciplinary care, with all patients receiving daily treatment by Physical Therapy (PT) and Occupational Therapy (OT), and, in many cases, Speech Therapy (ST). PT and OT gyms were located on the second floor, as was the

cafeteria. Nursing care was specialized, with nurses actively engaged in encouraging patients to do as much as possible for themselves, rather than simply being ministered to by the nurse. Patients were out of bed much of the time, and had to travel between floors to therapies and to the second-floor cafeteria. Interdisciplinary teamwork was emphasized, in which any team member could contribute to the resolution of any problem, and Dr. Parry noted that large egos had no place in such a team.

Figure 2. Dr. Frazer Parry

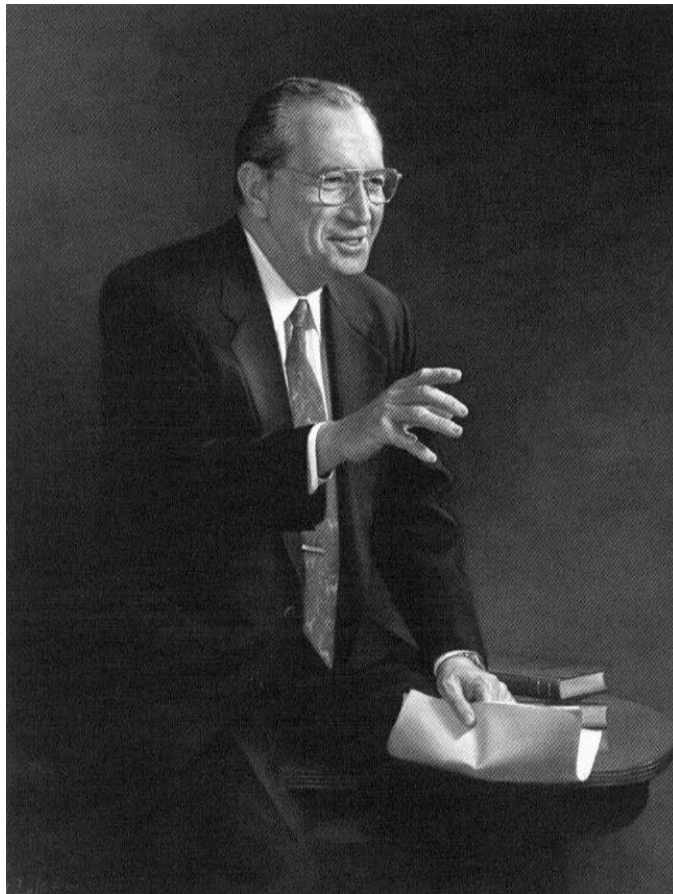


With its opening in 1958, MRH provided the first 39 beds in a Philadelphia health care facility devoted to the emerging field of PM&R. In the 1960s, the Piersol unit at the Hospital of the University of Pennsylvania opened, as did Moss Rehabilitation Hospital in north Philadelphia. The Medicare and Medicaid legislation of 1965 fueled the need for rehabilitation facilities to relieve the burden of care of

the disabled elderly in acute hospitals after injury such as hip fracture. The limited rehabilitation beds placed a demand on facilities such as MRH that did not relax until further expansion of rehabilitation beds in the 1970s. Thomas Jefferson University Hospital (TJUH) and Temple University hospital opened rehabilitation units in the late 1960s and early 1970s. Magee, during this time, expanded to 63 beds; 21 each on floors 3, 4 and 5, with the cafeteria on 2 and OT on 2, and PT, with a therapeutic pool, on 1.

The foundation of PM&R at Jefferson was established early. Dr. William H. Schmidt's practice, in the early 1900s, included electrotherapy, and he was a founding member of the American Board of PM&R, and served as president of the American Academy of PM&R. He was succeeded at Jefferson by Dr. John Goldschmidt, who became Division Head of PM&R in 1959. Under his direction, a 26-bed unit was established at Jefferson in the 1960s. Dr. Goldschmidt met Dr. John F. Ditunno, Jr., and had Dr. Ditunno come to Jefferson to lecture. Dr. Ditunno was recruited to Jefferson Medical College (now Sidney Kimmel College of Medicine) as its first department chair of Rehabilitation Medicine in 1969. His vision of the mission of the Department was similar to that of Magee's Board of the mission of Magee: patient care, education, and research. Dr. Ditunno shared Dr. Goldschmidt's vision of medical student and allied health professions sharing equal status in the education of the rehabilitation process.

Figure 3. Dr. John F. Ditunno, Jr.



Over time university hospital rehabilitation units developed streamlined procedures for admitting their patients to their own inpatient rehabilitation units. This absorbed patients formerly referred to MRH. Magee's occupancy suffered, and it appeared that a new direction was necessary. Meanwhile, the success of the Department of Rehabilitation Medicine at Jefferson Medical College in the teaching of

rehabilitation to medical students and PM&R residents created a need for additional training sites. With the combined needs for new leadership at MRH and expanded teaching sites for medical students and residents at Jefferson, the stage was set for a formal academic affiliation agreement between the two institutions. It appeared to be a natural evolution of the AJM endowment to name a JMC professor as Medical Director at MRH to integrate teaching and research into rehabilitative patient care.

Association with Thomas Jefferson University

Dr. William E. Staas, Jr., was a graduate of Philadelphia College of Pharmacy and Science. He went on to earn his medical degree at JMC in 1962. He subsequently entered general practice, later training in PM&R at the Hospital of the University of Pennsylvania, under Dr. William Erdman. Dr. Staas was inspired by the leadership of Dr. Goldschmidt, whom he had met in 1959 or 1960, and Dr. Erdman allowed Dr. Staas to train in part at Jefferson, and upon graduation Dr. Staas was recruited to Jefferson. When Dr. Ditunno assumed the role of Chair, Dr. Staas was appointed Director of Medical Student and Resident Education. Jefferson's President Herbert, Dean Kellow, Dr. Frank Sweeney (who had been an early attending in internal medicine at Magee), and Dr. Ditunno presented Dr. Staas as the ideal candidate to continue Magee's mission of patient care, education, and research, and he assumed the roles of President and Medical Director of MRH in 1977. Dr. Staas was thus the second of four chief officers who have directed Magee. (Table 2)

Table 2. Leadership of Magee

Years	Name	Position
1958-1977	H. Frazer Parry, MD	Director
1977--2005	William E Staas, Jr, MD	President and Medical Director
2005-2019	Jack Carroll Ph D, MHA	President and Chief Executive Officer
	Guy Fried MD	Medical Director
2019	Richard J Webster, RN, MSN	President
	Guy Fried	Medical Director

Figure 4. Dr. William E. Staas, Jr.



The early years of the association between Magee and Jefferson featured change in Magee's physical plant, and blossoming of programs for patient care, education, and research.

By the late 1970's, the building at Magee was beginning to feel crowded; Dr. Staas likened working there to working out of one's closet. Plans were made to expand the western side of the building out to 16th St, over an area that was serving as a parking lot. The project broke ground in May of 1981, and patients were able to enter in 1982. The addition was entirely contiguous with the original building. The new rooms were spacious and state of the art, proportioned to allow ease of mobility in a wheelchair, with shower areas capable of accommodating trolleys, and ceiling-to-floor windows so that a person sitting in

a wheelchair had a full vista view. Patient rooms were entirely located in the addition, 32 each on floors 3, 4, and 5, for a total census of 96. Gym and therapy areas were located on each floor, so that patients did not need to move between floors when traveling from room to therapy session. PT and OT services were provided in the same gym, and offices for the disciplines were together, facilitating teamwork, and an orientation to patient and challenge rather than to discipline. On the first floor of the original building, the therapeutic pool was filled in and converted to offices for outpatient visits. The addition was named the Alfred J. D'Angelo Pavilion, honoring Mr. D'Angelo's vision as Board Chairman.

Figure 5. Alfred J. D'Angelo Pavilion



The rooftop included in the 1982 expansion remained relatively undeveloped for years, despite its prime location. (There is no accessible rooftop on the original building.) The walls of this rooftop were four feet tall, and thus a person in a wheelchair could not enjoy the impressive sights. Improvements began in 1993. In 1994, "Jerry Segal Street", a replica of a city block, was completed. The inspiration came when Mr. Segal, a former patient and generous Magee benefactor, was walking in Philadelphia, and stumbled over a manhole cover. He concluded that Magee could better train its patients to walk outside of the hospital, so he brought his idea back to Magee and the Street was created, featuring real-life obstacles for patient training. Linda Ciccantelli, a horticulture therapist, had developed a thriving program providing plants throughout the hospital, but lacked a center for activity. A group of patients donated funds and a rooftop greenhouse opened in 1994. This presaged a huge development of the roof, including the Creative Therapy Center and Healing Gardens. This opened in 2017, and included the fabrication of multiple

specialty rooms, and refinement of the outdoor area, including provision of large windows in the surrounding walls, allowing all to fully enjoy the vistas.

Figure 6. Jerry Segal St.



Figure 7. The Greenhouse



Figure 8. The Roof Garden



The 1982 patient room layout functioned well for over three decades. A complete remodeling occurred in 2020, with 20 or 21 rooms on each of floors 2, 3, 4, and 5. Each room is now private, which is more attractive to consumers, as well as prudent given concerns for infection control. The total decrease in number of rooms is consistent with trends to discharge patients to home as soon as safely possible. A former patient, Dr. James George (like Mr. Segal, is a former patient and generous benefactor), provided over 200 original paintings as décor.

Figure 9. Painting by Dr. James George



Patient care has increased in complexity over the decades that Magee has been open. A particular area of expansion involved Magee's participation in Jefferson's Regional Spinal Cord Injury (SCI) Center of the Delaware Valley. The center was established at Jefferson, under PM&R direction, and designated a Model System in 1978, a title it retained until 2022. The requirements of a Model System include rehabilitation intervention from the moment of injury through to lifetime care. Such care of necessity involves multiple medical and allied health specialties that function in an interdisciplinary manner. Spine surgeons (from Orthopedic Surgery and Neurosurgery), Trauma Surgeons, Urologists, Plastic Surgeons, and medical specialists, from General Internal Medicine, Vascular Medicine, and Pulmonary Medicine are heavily involved. Jefferson physicians are international authorities, including Alexander Vacarro of

Orthopedic Surgery, James Harrop of Neurosurgery, and Geno Merli of Vascular Medicine. TJUH provides acute management and early rehabilitation intervention for system patients, who, when medically stable, are transferred to Magee to complete rehabilitation. They are then followed as outpatients. More than 5,800 patients have been admitted in the 42 years since the system's creation. There has been remarkable consistency and development of staff, exemplified by Mary Schmidt-Read, PT, DPT, MS, FASIA, a staff Physical Therapist in 1979, at the dawn of the Center, who advanced to Spinal Cord Injury Program Director at Magee in 1997, and who has been instrumental in research projects involving both Jefferson and Magee, and who is an international authority on the neurological examination of a person with SCI.

Figure 10. Mary Schmidt-Read, PT, DPT, MS, FASIA



Patient care facilities have expanded over the years at Magee. In part this expansion has occurred because of participation in body-weight support training research, for which Magee came to possess a traditional body-weight support system (a treadmill with a suspension system for the patient who would be guided and assisted by therapists). The system is housed on the fifth floor. Magee also has a robotic body-weight support system on the fourth floor, and overland support systems on the third and fifth floors, and several exoskeletal systems for use anywhere, making it one of the few facilities to have these four options for training.

Figure 11. Traditional body-weight support training



Figure 12. Robotic body-weight support training



Figure 13. Free overland body-weight support training (fixed-track systems are also present)



Figure 14. Lower limb external skeletal orthosis training



A patient, Buddy Marshall, and his family worked to fund the Buddy Marshall Assistive Technology Center to help all Magee patients learn how such technology can help them enjoy an active life despite challenges. Buddy's story--he had served as Navy Jet pilot--elicited donations that included \$50,000 from an anonymous person.

Patients M. Q. Wolfington and Mark Chilutti observed the difficulties of patients in traveling from Magee to an outside facility for dialysis, and thus teamed to fund and establish Magee's dialysis center, which opened in 2009. A Magee patient can travel in his or her own bed to the unit for dialysis. In 2010, the Norman Raab Foundation helped to establish the Center for Communication and Swallowing, with sophisticated state-of-the-art equipment support.

Magee was quickly adopted as a site for the education of Jefferson medical students and residents. Residents began rotations there in the late 1970s. At times second year students have come to Magee for teaching in Physical Diagnosis, third year students for required rotations in PM&R, and fourth year student for electives. Jefferson residents in PM&R may spend over a year in rotations at Magee. The Jefferson residency in PM&R has expanded in number to its current 21, with an additional five in the combined PM&R and Pediatrics program. Many graduates have had distinguished careers, and leadership roles within the specialty, some of which are noted in Table 3. With the recent closing of Jefferson's

inpatient rehabilitation unit in 2020, the beds at Magee provide an even greater source for resident and student experience.

Table 3. Examples of distinguished graduates of Jefferson's Residency in Rehabilitation Medicine

Name	Year of Graduation	Example of prominent position held or area of expertise
Gary Clark	1978	Department Chair, Case Western
Geno Merli (Resident for a year in Rehabilitation Medicine, then completed Jefferson Internal Medicine)	1980	International expert--vascular and thrombotic disease
Jay Seigfreid	1981	Chief of Division of PM&R at Main Line Health
Elizabeth Sandel	1984	President, American Academy of PM&R
Carolyn Kinney	1984	Executive Director of the American Board of Physical Medicine and Rehabilitation
Marca Lee Sipski	1986	International expert--Sexual function after spinal cord injury
Mitchell Freedman	1986	Founding physiatrist Rothman Institute
Ralph Marino	1987	Project Director of the Regional Spinal Cord Injury Center of the Delaware Valley
Greg Nemunaitis	1989	Director of Spinal Cord Injury Rehabilitation, MetroHealth
Kelley Crozier	1989	First woman vice-chair at Jefferson Medical College (now Sidney Kimmel Medical College)
Guy Fried	1989	Enterprise Vice Chair PM&R for Thomas Jefferson University Hospital
Karen Kowalske	1990	Department Chair PM&R, University of Texas
James McDeavitt	1991	Dean of Clinical Affairs, Baylor College of Medicine Chair, American Board of Physical Medicine and Rehabilitation
Steven Burns	1996	Director of Spinal Cord Injury Service, VA Puget Sound
Thomas Bryce	1997	Medical Director Spinal Cord Injury Program, Mt. Sinai

Michael Saulino	1997	International expert, spasticity management and neuromodulation Chair, Physical Medicine and Rehabilitation, Cooper University
Christina Oleson	2003	International expert, osteoporosis

Research activity has remained high. Magee's role in follow-up of persons with SCI makes it attractive as a site for following persons who have had acute interventions whose goal is to improve neurological outcome. Magee is also a source of subjects for studies involving persons with chronic SCI, including studies to, again, improve neurological function. Magee has served as a clinical site for research involving body-weight support training after SCI, gait quantification after SCI, and intervention to improve bone health after SCI.

Business models for medicine changed over the decades after Magee and Jefferson first associated academically. While Magee has continued as a resource for all acute, general hospitals in the Philadelphia area, several hospitals have established their own rehabilitation units. In addition, general hospitals have tended to group into systems. There thus arose a risk of loss of patient volume to providers from other systems. Further affiliation with an enterprise such as Jefferson was felt to provide protection from isolation and loss of referrals, and opportunity to make both Magee and the system stronger, with greater mutual resources and increased cooperation and mutual support. This led to Magee's closer association with Jefferson, first as part of the Jefferson Health System in 1995, and then as part of Thomas Jefferson University in 2018. Now all Magee patients enjoy the benefits of being patients in the Jefferson enterprise, and Magee continues to welcome patients from other systems.

The future

Jefferson's decision to close its wonderful inpatient rehabilitation speaks to its confidence in the ability of Magee to manage patients with combined medical and rehabilitation issues; patients on ventilators, patients with organs transplants, and patients with left ventricular assist devices. Magee will continue to rely upon Jefferson for close support, for example in areas such as physician specialist consultation, enhanced laboratory assessment, streamlined flow of patients between the two facilities, and melding of the two medical record systems.

Magee owes its existence to the philanthropy of Anna Magee. It continues to fortify her legacy and fulfill her vision of an institution where patients whose acute illness has passed can receive the rehabilitation necessary for return to the community. Philanthropy remains robust at Magee, with support from fundraising activities such as those pioneered by Gerald Segal, and donors such as Thomas Duffy and Dr. James George. Dr. Guy Fried, Magee's Medical Director, is poised to provide vision, not only for Magee, but for the Jefferson system, in the areas of rehabilitation and post-acute care. Anna Magee's ability, as a lay person, to grasp the importance of these over a century ago speaks to her wisdom and that of her physician, James Cornelius Wilson.

Bibliography

Ditunno, J., & Verville, R. (2014). Dr. R. Tait McKenzie: Pioneer and legacy to physiatry. *PM and R*, 866-75.

Wilson, J. C. (1924). The Care of the Convalescent. *Transactions of the College of Physicians of Philadelphia*, 155-171.