The Flexner Report, in 1910, introduced dramatic changes in the nature of medical education. Clinical instruction was shifted from physician-preceptor offices to much more organized, accredited teaching hospitals. There was an emphasis placed upon the role of full-time clinical faculty for training in both the clinical and basic sciences. Not surprisingly, the curriculum became increasingly influenced by the study of those diseases which necessitated the hospitalization of patients and intensive services. Examination of the selected, serious problems of hospital patients became the norm for training; and the problems that ambulatory patients had did not attract nearly as much attention or educational effort. As specific organ-related knowledge increased, the era of specialization came into its own.

By the 1950's, federal funds for medical research and training in research techniques became an accepted priority. Vast amounts of funds were directed toward the investigation of those diseases which typically required hospitalization. Studies directed toward the prolongation of life, rather than the prevention of diseases were carried out, with teaching hospitals serving as the clinical laboratories. Dramatic, almost miracle-like advances were made in medicine. Open heart surgery, organ transplantation and dialysis are just a few of the techniques that resulted from this concentration of effort.

In this climate of success and seemingly unlimited supply of research funds, there was a steady increase in the number of able students who followed their mentors into specialty careers. Even the general internist, traditionally the diagnostician or the "doctor's doctor," began to disappear. Many of the good students felt that the "real action" lay in specialty fields, not in general medicine, general pediatrics or in general practice. By 1974 there were four specialists for every general practitioner in the United States, while in Great Britain there were three primary care physicians to one specialist. Preventive medicine was not popular, and there was a tendency not to emphasize the psychological needs of patients and the effects of illness upon the social unit. Many persons came to feel that they could not find a well-trained personal physician who would allow easy entry into the medical system and would help monitor and manage their care—regardless of whether it be in the out- or in-patient setting. They expected and wanted a physician who could provide comprehensive and continuous care.

Allopathic specialty physicians became concerned as they found themselves increasingly dependent upon primary care osteopaths as the only referring primary physicians in their communities. They too sensed a lack of properly trained primary care physicians who could select appropriate, interesting and complex patients who would require specialized diagnosis or therapy.

The reports of the Willard and Mills Commission in the mid-1960's further called attention to these trends. Nationally, the general practitioners became concerned lest they disappear from the scene of organized and academic medicine. They sought to improve their stature and to do away with the pejorative, commonly used label of "the local medical doctor or the LMD." They recognized that they would have to upgrade the training and qualifications of those entering practice in the 1970's. In 1964 they went to the American Board of Internal Medicine and asked for approval of a new type of residency training for primary care physicians or family physicians. The American Board of Internal Medicine refused the request that family medi-
Paul C. Brucker, M.D. became a member of the Board of Family Practice in April 1983. During the next five years he served on the Content Validity Committee, the Long-Range Planning Committee, the Standard Setting Committee, the Research and Development Committee, the Credential Committee and the Executive Committee. From April 1986 through March 1987 Dr. Brucker served as Secretary-Treasurer and then from April 1987 through March 1988 as President of the American Board of Family Practice. He continues to be an active member of the Board's Item Writers Committee and the Editorial Board of the Journal of Family Practice, and serves as the representative of the American Board of Family Practice to the American Board of Medical Specialties.

Dr. Brucker

Jefferon's Dean, William F. Kellow, M.D., knew Dr. Pisacano well. He frequently talked with Dr. Pisacano about the new specialty of family practice and the possibility of establishing a family medicine program at Jefferson. He too was always mindful of the medical needs of the community and was concerned about the disappearance of primary care. In 1967, Dean Kellow invited Franklin C. Kelton, M.D., and David W. Kistler, M.D., two officer-leaders of the Pennsylvania Academy of Family Physicians, to join him in a discussion of how the training of the primary care physician might best be accomplished. Doctors Kelton and Kistler ably expressed their belief that family practice should be a distinct program at the College.

The Beginning of Family Medicine at Jefferson

In 1971, under Dean Kellow's leadership and with faculty approval, a Division of Family Medicine was established at Jefferson in the Department of Community and Preventive Medicine. Willard A. Krehl, M.D., then Professor and Chairman of that depart-
ment, was enthusiastically supportive of the venture. Doctors Kelton and Kistler helped him to establish twenty-five preceptorships in family practice. In the first year, 40 students chose the elective six-week preceptorship. In general, they were overwhelmingly enthusiastic about the experience!

Shortly thereafter, in 1972, with faculty and Board approval, formal arrangements were made to establish a separate Department of Family Medicine. A search began for the first chairman of the new department.

Joseph S. Gonnella, M.D., then the Assistant Dean in Charge of Academic Affairs, submitted my name to the Search Committee. Dr. Gonnella and I had worked closely for some four years in the development of a program for the evaluation of medical care. This work was subsequently published and presented at scientific meetings. When I was initially approached to consider the candidacy for the chairmanship I was flattered, but at the same time torn between the opportunity for such a position and the wonderful one that I had in a 100 year old group family practice in Ambler, Pennsylvania, a suburb of Philadelphia. One of my four partners was Dr. Kelton, one of the family physicians so instrumental in establishing the family medicine program at Jefferson.

Dean Gonnella was very persuasive! I agreed to accept an invitation to meet with the Search Committee. As far as I was concerned, the date of the first meeting was kept a secret. All of the members of the Committee knew about the time and date, but somehow, inadvertently, I was not informed. Fortunately, Dean Kellow discovered this, and the night before the meeting called to express his regrets about the oversight! We both had a good laugh, and after some hastily rearranged plans I was able to meet with the Committee the next day.

The Search Committee was impressive. They had an understanding of primary care, what the formation of a new department might entail, and the direction that they wanted the department to take. It was a tribute to the careful preparatory work that had gone into the decision to form such a department. After an enjoyable meeting with the Committee, I returned to Ambler, only to be called that same evening by Dr. Kellow to determine if I was willing to meet with some of the other chairmen in the College. Notable among those with whom I met was Thomas D. Duane, M.D., the Chairman of the Department of Ophthalmology, and also Chairman of the Curriculum Committee. Dr. Duane took a great deal of time in explaining the intent of the newly revised curriculum, which included a mandatory six-week clerkship in family medicine. Robert L. Brent, M.D., the Professor and Chairman of the Department of Pediatrics, in an unselfish manner was helpful and encouraging. Robert T. Wise, M.D., the Magee Professor and Chairman of the Department of Medicine, cautiously supported the concept of the new department and curricular changes; but he was concerned about the quality of medical student training that a new department with new faculty might make available. I appreciated his comments and concern about matters of quality.

After several weeks of discussions, the well-laid plans, the receptiveness of the senior faculty, and the encouragement of Deans Kellow and Gonnella, all convinced me that the new chairmanship would be a wonderful opportunity. I was pleased that the College saw fit to offer such a position, and on January 1, 1973, I became the first Professor and Chairman of the new department in both the Medical College and Hospital.

Parenthetically, almost simultaneously with my accepting the position the chairman of the Haas Community Fund, Mr. Richard Bennett, called Dean Kellow to ask why the funds which the foundation had awarded the Medical College in 1971 to establish the new department had not yet been used. When Dean Kellow told him that "at Dr. Brucker" had been invited to chair the department he was astounded, for I had been Mr. Bennett’s friend and personal physician for 13 years. Fortunately, this relationship has continued until today. Mr. Bennett was the first

One of the initial problems with the ambulatory clerkship was where to place 223 junior students. Sufficiently large outpatient activities with excellent supervision had to be identified.

The Beginning of the Department

By the time I arrived on campus in March 1973, renovations to the old Scott Library on the first floor of the College building were nearly complete. The attractive new facility included five offices for faculty members, an office for the chairman, and adequate space for clerical help. Missing, however, was the furniture, which had not arrived on time. I began my tenure with an old army desk and a search for a desk chair.

At our meeting that first day, Dean Kellow repeated the previous charge that I was expected to establish undergraduate, graduate and postgraduate teaching programs, and eventually, once the department was established, to develop a research program. A very pleasant memory about the development of these programs is the support lent by Dean Kellow, Dean Gonnella and Mr. Thomas Murray, the Business Administrator of the College. They always had time to listen, to evaluate and to offer constructive advice, regardless of the magnitude of the problem or their busy schedules.

The Undergraduate Family Medicine Curriculum

The first mandatory Family Medicine Junior Clerkship was started in the Fall of 1974. The curriculum, which was designed for this clerkship, emphasized the development of an ambulatory experience that would provide ready access for patients, allow continuity and comprehensiveness of care, and give attention to the psychosocial needs of the family. Simultaneously, a curriculum was designed for the senior year elective. Even in 1974 the Curriculum Committee was aware of the upcoming emphasis that would be placed on ambulatory care training. Jefferson’s curriculum was way ahead of the times!
Resident Robert Motley, M.D., '85 checks patient Robert Smith as Clinical Assistant Professor Richard C. Wender, M.D. and Mrs. Smith look on.
Among the existing Jefferson affiliations was the Wilmington Medical Center. There, under the direction of Dene T. Walters, M.D., was an excellent residency program. It was a logical choice to include Wilmington Medical Center as one of the first affiliate sites for the undergraduate clerkship. Simultaneously, the Chestnut Hill Hospital expressed a rekindled desire to establish a family practice residency program and to accept undergraduate students for the clerkship. Harry Kaplan, M.D. was named the first director of this program. Up until the present time, both of these institutions have made a valuable contribution to the undergraduate teaching. Still, the Department lacked an adequate number of spaces.

In late 1973, a discussion was begun with the Richard K. Mellon Foundation and representatives of the Latrobe Area Hospital in Latrobe, Pennsylvania, about the possibility of an affiliate program in family medicine. The Hospital was seeking to establish a medical school affiliation in order to attract an even better and more diverse medical staff; to improve the quality of patient care, secondary to the stimulus that an educational program would provide; and to serve as a training site for family physicians who were sorely needed in Latrobe and the surrounding rural communities. After an extensive study by the Mellon Foundation about the advisability and feasibility of such an affiliation and educational program, the Foundation gave the Latrobe Area Hospital a grant to build a clinical outpatient facility where the students could see ambulatory patients, and also to establish housing for both the undergraduate students and anticipated family practice residents. This was a great assist!

Once the Latrobe Area Hospital Affiliation was well underway, the College turned to face a societal concern for the better distribution of family physicians. In 1974, there were several counties in Pennsylvania with just two or three family physicians. Consequently, the Physician Shortage Area Program (PSAP) was established. Under this program the College would accept as many as twelve qualified students from either urban or rural physician shortage areas, with the understanding that these students would pursue the undergraduate family medicine curriculum at Jefferson, select a family practice residency program, and eventually return to a "shortage area." This program has been very successful. It was expanded in 1978, and at the present time it allows the College's Admissions Committee to preferentially admit up to twenty-four students per year—providing their academic credentials are similar to those of other student applicants. Many of the students who have gone through this program are now practicing in shortage areas. Its success has attracted a great deal of regional and national attention.

**The Residency Program**

Shortly after arriving at Jefferson in 1973, I submitted an application to the Residency Review Committee for a family practice residency to be established at the University Hospital. Much to my dismay, in September 1973, this application was not approved. On the same day that the Department was notified of this I made telephone arrangements with the educational representative, Robert Graham, M.D., at the American Academy of Family Physicians in Kansas City, Missouri for a consultative appointment. He agreed to see me that same night. After I arrived in Kansas City that evening, the two of us stayed up until the wee hours of the morning rewriting the application. The next day the application was retyped and resubmitted to the Residency Review Committee. In December 1973 provisional approval was finally gained, and the Department was able to begin the first family practice residency at Jefferson in July 1974.

Residency Review Committee approval was just the first hurdle to overcome in starting the program. The next major one was to obtain salaries for eighteen residents, six for each of three years. Weeks of meetings with administrators, committees and departmental chairmen followed. Understandably, no existing residency program wished to give up residency positions so that salaries could be obtained for the family practice residents; and similarly, there was only a fixed amount within the University budget for training house officers. To further compound the problem, many of the existing residency programs, with increased service demands, wanted to expand their own plans.

The solution to the problem came about rather unexpectedly. When Peter Herbut, M.D., the President of the University, asked me to give a progress report to the Board of Trustees on the state of the new department, I quickly realized that it would be embarrassing to the President to share my frustrations with the Board. Three days before the scheduled meeting I met...
with him to ask that I be excused from giving the report. When Dr. Herbut
discovered the reason for my hesitancy,
he found the necessary funds for the residency positions with a single phone
call. Three days later I was able to give
a glowing report to the Trustees.

The delay in the approval of the residency application and in obtaining
salaries for the residents hampered our initial recruitment of residents. It was
impossible to promise applicants either
a salary or an approved program prior
to the end of December 1973, just sev­
eral weeks before the deadline for the
National Intern and Resident Matching
Program. Much to our surprise, how­
ever, four out of six positions were
filled through the Match and the
remaining two were quickly filled after
the match results were announced. A
full complement of six residents were
enrolled to begin the first family prac­
tice residency program at Jefferson in
July 1974! These trusting pioneers and
the medical schools which they repre­
sented were: David Cheh, M.D., The
Medical College of Pennsylvania; Sand­
dra Harmon, M.D., Temple University;
Franklin C. Kelton, Jr., M.D., Jefferson
Medical College '74; Allan Kogan,
M.D., Baylor School of Medicine;
James Plumb, M.D., Jefferson Medical
College '74; and Margaret Fritz Stock­
well, M.D., The University of
Nebraska.

Facilities

Initially, the Department lacked two
requisites for both the undergraduate
and the graduate programs: clinical
space and an adequate patient popu­
lation. Fortunately, funds to develop the
overall program were available from
the Haas Community Fund and the
Department of Health, Education and
Welfare. The government funds were
to be used for funding preceptorship
activities and there was a stipulation
that they had to be used by July 1,
1973. The real priority, however, was
to establish an outpatient family prac­
tice center. Therefore, in early June
1973, I petitioned the government to allow these funds to be used to assist
with construction. They agreed, but
stipulated that they had to be design­
nated for specific construction prior to

July 1, 1973. The “squeeze” was on.

Working with the University’s archi­
tect, we designed a new Family Prac­
tice Center for the Edison Building at
Ninth and Sansom Streets. The blue­
prints were hand-delivered to Wash­ing­
ton, D.C., and were approved just
three days before the grant expired.
Despite our haste, this design proved to
be very practical and functional. The
Department occupied this Center until
1978, when we moved to the fourth
door of the new University Hospital.

Faculty Recruitment

Concomitantly, with the establish­
ment of the curriculum, the approval of
the residency program, and the build­
ing of a clinical facility, a search was
begun for qualified faculty. I had the
rare opportunity to recruit a brand new
full-time faculty, but at the same time
recognized that my choices would be
scrutinized carefully by the other
members of the faculty. I was aware of
the fact that it would be difficult to
recruit able faculty to teach primary
care, for there was not an abundance
of such individuals and the demand, with
all the new training programs in pri­
mary care, was high.

Edward H. McGehee, M.D., '45, a
friend and colleague of mine, was the
first potential candidate to be con­
tacted. Trained as an internist, with
additional training in hematology and
pathology, Dr. McGehee was a much
loved and respected “family physician”
practicing general internal medicine in
the Chestnut Hill section of Philadel­
phia. He was well known for making
house calls on his bicycle, working very
long hours, and always being available
to the students who crowded his pri­
ivate office. Dr. McGehee had chaired
the Department of Medicine at Chest­
nut Hill Hospital, and had served as
Physician to and Hematologist to the
Pennsylvania Hospital and the Ben­
jamin Franklin Clinic.

Dr. McGehee was very settled and
satisfied in his established practice.
Initially, he and his wife, Carolyn, were
dubious about the potential of joining
the Jefferson faculty. However, after
many meetings, and with some recruit­
ing help from Drs. Gonnella and Kel­
low, Dr. McGehee became “sold” on
the entire idea of training family physi­
cians, and in 1974 he returned to his
alma mater as Professor of Family
Medicine.
Dr. McGehee's coming to Jefferson gave me the idea of approaching another colleague and friend to both of us, William N. Mebane, III, M.D. Doctor Mebane practiced pediatrics in Chestnut Hill for many years and he too was active on the staff of the Chestnut Hill Hospital. In 1974 he was coaxed away from his very successful private group practice to become a Clinical Professor of Family Medicine. He remained on the Jefferson campus for two years; and in 1976 he moved to the affiliated family medicine program at Chestnut Hill Hospital, where he served as an Associate Director of the training program until 1985, when he became its Director.

The Chestnut Hill community did not take lightly to the loss of two of its most respected physicians to the new department at Jefferson. I received many concerned phone calls about the situation. Fortunately, most of the Chestnut Hill residents were understanding about the need for good role models in training future physicians. The number and intensity of the calls testified to the quality of the two faculty members that had agreed to come to Jefferson. In actuality, many of the callers followed both physicians to Jefferson as their patients. The loyalty of these initial patients and their enrollment in the Jefferson practice were extremely valuable in training the first students and residents.

**Outpatients**

The full-time faculty's private patient population was not in itself sufficient, however, to conduct an ambulatory care program. A much larger number of patients was required. In 1974 there was a fortuitous change in the Hospital's policy and organizational structure: the traditional outpatient clinic system which had been in place was disbanded in favor of a more traditional "private" system. With a larger number of adult, medical clinic patients to be provided for, the Hospital felt fortunate in having a new department so interested in ambulatory care and in need of such patients for teaching. Dean Kellow and the Vice-President for Health Services, Frank J. Sweeney, Jr., M.D., '51 felt that it would be highly appropriate for the Family Medicine department to take over the care of these patients. In 1974 the transfer was made.

At first, the clinic patients were skeptical that their needs could be taken care of in a single large, clinical facility. They were used to being referred to a number of subspecialty clinics, primarily focused on the traditional medical and surgical specialties. Usually, there was no appointment system and it was first come, first served; a process that necessitated long hours of waiting. It was rare that the patients would see the same physician over a prolonged period of time.

When family medicine became responsible for this patient population, every effort was made to assign a primary physician for each patient. Appointments were made, and in many instances, the necessity for multiple subspecialty type visits to other physicians or facilities was eliminated. This was a tremendous change for a large number of individuals. At first they were shocked and dubious. The initial appointment compliance rate was 20 percent. As time went on and professional relationships developed with the Family Medicine staff, the appointment compliance improved. Two years later, approximately 60 percent of the patients kept their appointments.

Initially, about 60 percent of the family medicine patient population came from the disbanded clinic system. This patient population was not able to afford the traditional professional fees and this meant that the Institution had to subsidize the clinical operation. This subsidy, necessary for the program and appreciated, was negotiated on an annual basis. This was always a trying time for me and the Hospital's administration. Primary care training is the most expensive kind of training, for it requires a great deal of continuous supervision and the rewards for service...
are considerably less than they are in the procedural type specialties.

**Inpatients**

The responsibility for the management of the inpatients generated from the Department's outpatient population aroused a great deal of discussion. From the very beginning the Chairman of the Department of Internal Medicine, Robert I. Wise, M.D., was genuinely concerned that family physicians might not possess the necessary knowledge and skill to care for adult patients in a hospital setting. He had numerous anecdotes to support his concern. Many members of the Department of Medicine believed that family practice in the United States should be similar to general practice in Great Britain, where inpatients were customarily referred to the hospital-based specialists. Members of the Family Medicine department, on the other hand, vigorously disagreed with such a concept and felt capable of handling general medicine type patients in the hospital setting. In addition, the accrediting organizations for family practice training insisted that the family physicians must have such responsibility. In fact, they encouraged family physicians to ask for obstetrical and surgical privileges, something which I did not and still do not think is appropriate for family physicians to request in a geographic setting such as Philadelphia.

Many meetings ensued to resolve this dilemma. Dean Kellow and Dr. Sweeney convened the leaders of each department in an effort to find a satisfactory solution. Finally, Warren D. Lambright, M.D., an associate of Dr. Sweeney in the Hospital's administrative offices, effected a solution: All inpatients would be admitted to the Hospital on the medical service. All qualified faculty in the Department of Family Medicine would receive secondary appointments in the Department of Internal medicine. The Chairman of the Department of Family medicine would be responsible for the quality of the family medicine patients' care and the professional conduct of his faculty. Should there be some flagrant discrepancy, the Chairman of the Department of Medicine would have the right to intervene if the care did not meet the usual standards. Dr. Wise felt comfortable with this arrangement, and incidentally, not once did I feel obligated to come to him to complain about inpatient care issues. A similar arrangement was established between Dr. Wise and myself for outpatient care. A seemingly insurmountable hurdle was passed. Ten years later, in 1984, Willis C. Maddrey, M.D., the subsequent Chairman of the Department of Medicine, suggested that the Department of Family Medicine have its own inpatient service, since it had long since demonstrated its ability to care adequately for such patients.

Thus, in two years, the new Department had a sound faculty, undergraduate and graduate programs, affiliate programs, an outpatient facility with an adequate patient population, and the privilege to admit and care for general
adult medical patients in the hospital. Without the Institution's real commitment to the program, not nearly as much could have been accomplished in such a short period of time.

Maturation of the Department

Undergraduate Programs

Once established, the new department grew quickly. By 1976, four additional full-time faculty had been recruited: Peter Amadio, Jr., M.D., '58; Su Hain, M.D.; Howard K. Rabinowitz, M.D.; and Elmer J. Taylor, M.D., '52. Their specialty representation, which especially suited a primary care training program, was in a proportion that has recently received favorable national attention. These physicians were trained in internal medicine, family medicine and pediatrics.

In addition to the family medicine faculty, the department has always enjoyed the cooperation of faculty members from the other departments in the College. Throughout the fifteen years that I have been at Jefferson, no faculty person has ever refused to cooperate; and in fact many have volunteered to teach in the program. This spirit of cooperation has led to a healthy integration of Family Medicine into the University setting.

With the increase in the number of faculty came an increase in the amount of undergraduate teaching responsibility. The department became involved in the freshman clinical correlation courses, and the Medicine and Society Course in the sophomore year, teaching epidemiology and exploring medicolegal and ethical aspects of health-care delivery issues.

Because of the demand from the seniors electing the family medicine track, the rural preceptorship program had to be expanded. With the help of federal funding, carefully selected family physician preceptors in rural offices from Vermont to North Carolina were chosen to serve as preceptors. Howard K. Rabinowitz, M.D. has been responsible for the supervision and organization of this program. It allows the students to see unselected problems in various types of communities, to live and participate in the community, and to have one on one teaching. The students are always amazed at the diversity of problems which they see, and they become increasingly impressed with the role that psychosocial factors play in keeping individuals well and restoring them to health. The preceptors have developed a real esprit de corps! Every year they return to Jefferson for a three day workshop to upgrade their medical knowledge, to introduce them to the potential senior preceptees and to discuss ways in which the program can be improved.

The Department also added two more affiliate programs to the three that were already in operation. The Bryn Mawr Hospital program, under the supervision of D. Stratton Woodruff, M.D., was added in 1975, and the Underwood Memorial program in Woodbury, NJ was added in 1983.

Residency Programs

The first residents to enter the program in 1974 performed admirably. They proved to be good ambassadors for the Department. It was not long before the residency program developed a creditable reputation both inside and outside of the institution. Residency applicants were quick to recognize the potential advantage of being able to train for family medicine in a medical school setting. The initial hurdle of attempting to fill the residency class was soon overcome, and after the first year of the program there has been a large pool of qualified applicants from Jefferson, and from medical schools all over the country. All of the graduates of the residency program have passed the certifying examination of the American Board of Family Practice. They are engaged in practices that range from hamlets to metropolitan cities in the United States. Several have gone outside of the country to practice. Ten of the past graduates and seven of the 18 current residents are Jefferson alumni.

In 1978, the residency program received full accreditation. One constant concern of this accrediting body is the belief that family physicians trained in the Northeast should be equipped to do obstetrics and surgery. After many discussions with the Residency Review Committee we reached a compromise. All of our residents receive a certain amount of obstetrical training as specified in the Residency Essentials for Family Practice and all of the residents experience a two month surgical rotation with emphasis on diagnosis, pre- and post-op care. For those who plan to practice obstetrics, a six month obstetrical fellowship is available at the completion of the three year residency.
The presence of the Family Medicine program at Jefferson, together with a national trend toward interest in primary care, has resulted in a significant increase in the number of Jefferson graduates going into family medicine residencies. In 1973, approximately three graduates per year elected to specialize in family medicine. At the present time approximately 16% of the Jefferson graduating classes enter the field—a number somewhat above the national average.

Four graduates of our program are currently full-time faculty members in the Department. They are: Christopher V. Chambers, M.D., Robert L. Perkel, M.D., Michael P. Rosenthal, M.D. and Richard C. Wender, M.D. In addition, four of our graduates serve as faculty in residency programs elsewhere. The Department has attempted to create a residency program which is optimally designed for all residents, regardless of their eventual practice type or location.

Postgraduate Programs

All diplomates in family practice are required to take at least 150 hours of approved continuing medical education courses every three years in order to qualify for the mandatory recertification examination that is given every seven years. This requirement makes it fitting for the Department to conduct annual continuing education courses. Some of these have been conducted at Jefferson, while many have been held elsewhere, frequently in conjunction with some other sponsoring body such as the University of Delaware, the Alumni Association or a medical society.

Research Programs

Other than clinical trials conducted by various members of the faculty, there was no concerted research focus in the department until 1982, when Donald J. Balaban, M.D., M.P.H. joined the department as Research Associate Professor of Family Medicine, and became the director of the Greenfield Research Center. Before coming to Jefferson Dr. Balaban was affiliated with the Leonard Davis Institute at the University of Pennsylvania, where he was involved in health care...
delivery research, especially the study of functional outcomes in chronic conditions. He brought with him an enthusiasm and expertise to conduct similar research at Jefferson, and was anxious to be involved in the faculty’s scholarly efforts. In addition to this role, along with Richard L. Brown, M.D. he has been responsible for the Department’s Faculty Fellowship program. The well-trained junior faculty and the Research Center’s presence lent an important academic stimulus to the Department. Research questions began to be raised, and methodologies were developed for pursuing the answers.

**Economic Influences**

In 1982, the advent of the Prospective Payment System (PPS) for hospitalization brought changes in the funding and delivery of care. It was now apparent that society was going to impose limits upon the costs of inpatient care. For the first time in American medicine, there were debates about the rationing of care and the effectiveness and efficiency of certain types of care. The private, corporate sector began to exert a strong influence upon the organizational structure of health care delivery, including the payment mechanism. Almost overnight, medicine came to assume much more of a business posture. While different types of capitation systems sprung up for the well and employed, government subsidies for the care of the poor and the elderly became limited. It was apparent that hospitalization, the most expensive part of health care, would be curtailed. The PPS was particularly threatening to most of the nation’s teaching institutions, for the majority of them are located in urban poor areas where much of the care has to be subsidized.

For the first time in 60 years, the outpatient setting and the concept of ambulatory care began to take on a new significance, while at the same time medical schools were turning out a surplus of physicians. Terms such as “competition” and “doctor-glut” were common language, and residents and students began to be concerned about finding a job after finishing residency training.

Jefferson was attuned to these trends, and in its long-range planning attempted to ensure that the institution would remain fiscally sound, while still fulfilling its mission of education, patient care and research. The Department, in cooperation with the hospital administration, participated in various types of capitation payment programs. Some of these were designed primarily for the working-well, but other such as HealthPass were created for the poor and the elderly. In 1986, satellite family practice centers were established in the Fairmount section of Philadelphia, and in 1988 a third satellite office was started in Chinatown. The purpose of the satellite offices was to be involved in the community, provide needed primary care, and serve as a source of patients for the educational programs.

In order to staff these satellites, the Department again invited several of its graduates to participate. David J. Anderson, M.D., completed his residency in 1987, is the staff physician for “Jeffcare,” an HMO type program that is a subsidy of Blue Cross. John W. Stringfield, M.D. and Judith Shimer Stringfield, M.D. met and trained together in our residency program. After graduation in 1983 they entered private practice in North Carolina, but returned to open the first Jefferson sponsored satellite in the Fairmount section of Philadelphia in August 1986. David E. Nicklin, M.D., who graduated in 1984, and Neil S. Skolnik, M.D., who graduated in 1987, staff the South Philadelphia family medicine practice on a part-time basis. Dr. Nicklin also has a private practice in West Philadelphia, and Dr. Skolnik pursues his writing interests and training when not practicing at the satellite. Clement C. Au, M.D., who was graduated from our program in 1985, returned to his native Hong Kong before rejoining the department to open the new practice in Chinatown, just north of the well-known Chinatown “arch.”

It is still too early to evaluate the impact of these centers. The training of students and residents in a capitation model requires skill, for intelligent use of resources and logical
Instructor Clement Au, M.D. with receptionist Thanh Tran in the newest satellite center.

Geriatrics Program Nurse Coordinator Suzanne Sherry with Dr. Perkel. Below right: Instructors John W. Stringfield, M.D. and Judith Stringfield, M.D. at the Fairmount center.

Merle Happ, receptionist in the busy Patient Office, with Dr. Amadio.
decision analyses are required in order for the practice to remain financially sound. This particular type of expertise will be even more important as the residency graduates become dependent upon these models for employment. The Department is continuing to do research on these programs so that there will be a factual and statistical basis for the management decisions which will be required.

Benfactors

There have been a number of individuals who have contributed most generously to the Department during the 13 years of its existence, and this history would be incomplete without mention of their special contributions.

The Alumni Association of Jefferson Medical College in 1973 voted to make an annual contribution of $50,000 to help sponsor the Alumni Professorship in Medicine. This honor, along with an honorary lifetime membership in the Alumni Association, are distinctions of which I am most proud.

One very loyal alumnus was Dale W. Garber, M.D., ’24, a respected general practitioner in Delaware County, Pennsylvania. I had the good fortune to meet Dr. Garber in 1976 on an alumni sponsored continuing medical education trip to the lowlands of Europe. He became very interested in the Department and, after several years of finding out more about the Department and how it functioned, decided to establish an endowed professorship in Family Medicine. The chair was awarded to Edward H. McGeehe, M.D., ’45 in 1984, when he became the first Ellen M. and Dale S. Garber Professor of Family Medicine. We all were proud that Dr. Garber left such a heritage to his College and to the new department of which he had become very fond.

In 1982, Mrs. Nellie T. Haac, who had been a patient in Jefferson Hospital repeatedly over a span of 50 years, left a generous sum to be used for departmental programs.

As the Department’s programs expanded, the office space on the first floor of the College building was no long adequate. The Pew Memorial Trust came to the rescue with a very generous grant for renovations to be made on the fourth floor of the Curtis building. The Department moved to these new offices in 1983.

In an increasingly restrictive financial climate, the Research Division had difficulty funding various research projects and stipends for fellows. Mr. Gustave Amsterdam, a member of Jefferson’s Board of Trustees and the Board of the Etelka J. Greenfield Foundation, became aware of this and, acting as an intermediary, coordinated a generous gift from the Foundation to the Research Division. In recognition of this gift, the Research Division was renamed the Etelka J. Greenfield Research Center of the Department of Family Medicine in 1985.

All of the individual gifts, plus the dedicated efforts of many individuals in an institution that has been most supportive of a new department, have allowed much to be accomplished in a short time. A solid foundation has been established and hopefully, in years to come a recapitulation will demonstrate that a great deal has been accomplished to further Jefferson’s and Family Medicine’s mission.

Left to right: Instructor Neil S. Skolnik, M.D., Residents William Thompson, M.D., ’87 and Janice Nevin, M.D., ’87, and Assistant Professor Richard C. Wender, M.D.