John D. Clough, MD

John D. Clough, MD, is a rheumatologist. He practiced with Cleveland Clinic's Department of Rheumatic and Immunologic Diseases from 1971 until his retirement in 2008, serving as chair from 1979 to 1991. Over the years, he has served Cleveland Clinic in several other capacities, including Chairman of the Division of Health Affairs from 1991 to 2004, Editor in Chief of the *Cleveland Clinic Journal of Medicine* from 1997 to 2005, and publisher of the Cleveland Clinic Press. He currently volunteers in the Cleveland Clinic Archives Department.

Cleveland Clinic—A century of progress

When Cleveland Clinic's founders-to-be (Drs. Frank E. Bunts, George W. Crile, William E. Lower, and John Phillips) returned home to Cleveland in 1919 after serving in World War I, the first 3 resumed their practices in the Osborn Building, near Playhouse Square in downtown Cleveland. They had already determined that they would form a group practice with some of their close colleagues, including Phillips, which would operate out of a new, specially designed building that would also support research and eventually education as well as clinical practice.

They leased a parcel of land at the corner of Euclid Avenue and East 93rd Street, formed a company with the help of Bunts's son-in-law, attorney Edward C. Daoust, to design and construct the building, and opened the new group practice in February 1921 with a professional staff of 15 members. A new hospital was added in 1924, a new research building was finished in 1928, and new outpatient facilities were opened in 1931 after a disastrous fire in 1929 killed Phillips and 123 others who happened to be in the original Clinic building. The Clinic survived that setback and thrived, growing exponentially into the 21st century.

It is somewhat sobering to realize that, as we approach the 100th anniversary of the founding of the Cleveland Clinic, I have been associated with the organization in one form or another for more than half of its history (55 years). Although I never met the founders (they were all gone by some 25 years before I got here), I did know Crile's son George Jr., called Barney, and other members of the Crile family.

So I have observed the Clinic's transformation from a relatively small regional organization into the massive international entity we are familiar with today. About 10 years before I arrived on the scene, the Clinic had significantly reformed its governance by establishing an elected physician board of governors, allowing the professional staff a greater voice in the direction of the organization, including decisions about growth. This cemented physician control of the Clinic and set it on a course of continued growth. (All of this is recounted in the several editions of the Clinic's history *To Act as a Unit*).[1,2]

In July 1965, when my wife Mary and I moved to Cleveland from Washington, DC, to begin our internships at Cleveland Clinic (she in pediatrics, I in internal medicine and rheumatology), the institution was very different from what it is now. It included 2 outpatient buildings, a small research building, and a single 484-bed hospital with a small 4-bed intensive care unit, 3 of which had to be pushed into the hallway if one of the occupants needed to be resuscitated. Believe it or not, there was also a small emergency room, marked by a small sign identifying it as the "Ambulance Entrance" on East 90th Street. There were 127 "full staff" physicians and surgeons, mostly specialists, all of whom knew each other, as did the small and compact house staff. The culture was characterized by cooperation and collegiality. The physicians—staff and house staff—interacted both professionally and socially. Interns and department heads would mingle in the hospital cafeteria with little sense of hierarchy.

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Although the Clinic had a prestigious cardiovascular research program headed by Irvine Page, discoverer of angiotensin and serotonin, who had arrived at the Clinic mid-career in 1945, it did not yet have a medical school. Yet, despite this apparent drawback, the few posi-

doi:10.3949/ccjm.88a.20185

tions in the medical, surgical, mental health, and pediatric training programs offered at the Clinic were highly sought after, because the Clinic was a hotbed of clinical and research activity with a strong emphasis on education.

Pioneered by F. Mason Sones, the use of coronary cineangiography to diagnose coronary artery occlusion was just gathering steam at that time. This led eventually to the establishment of coronary bypass graft surgery as the treatment of choice for prevention of heart attacks in patients with severe occlusions. From the point of view of the house staff, a majority of the medical admissions during the week were to the Sones-Shirey-Sheldon service.

Other, less well-known but innovative initiatives abounded. On the medical side, endocrinology pioneered a program called "diabetic recheck." On a regularly recurring basis, patients with diabetes returning for follow-up were treated to a meal (usually breakfast), a group educational event with opportunity for questions, and a physician appointment. This sounds like the "medical home" idea of recent times, but it was in full flower at the Clinic in the 1960s. The result was that the hospital had few medical emergencies due to diabetic acidosis, unlike the situation I had come from.

Cleveland Clinic has grown from a relatively small hospital with emphasis on medical research and education to a world-wide organization

Bruce Stewart and his colleagues in urology, nephrology, and immunopathology developed an aggressive approach to kidney allotransplantation, which was greatly aided by the development of tissue typing in the immunopathology laboratory of Bill Braun and later by the use of immunosuppressive drugs.

Barney Crile created a furor among cancer surgeons by advocating limited excision of malignant breast tumors in selected patients. For this inexcusable transgression, he was expelled from the Academy of Medicine of Cleveland and roundly castigated around the country. Eventually, he was shown to be correct.

And there was much more going on—the use of methotrexate by Art Scherbel and his colleagues to treat severe rheumatoid arthritis, the discovery by Virginia Donaldson and Dick Evans that absence of a C1-esterase inhibitor caused hereditary angioneurotic edema, and the exploration of guided radiation to treat brain tumors by Joe Hahn are just a few examples.

With all this activity, the reputation of Cleveland Clinic was spreading, the demand for services was increasing, and the organization was growing at an exponential rate. In the middle of the 1990s, several circumstances transformed the Clinic from a large, though regional, entity with a good reputation to a huge international organization. The rise of for-profit healthcare prodded the Clinic to link up with other Cleveland metropolitan hospitals. Changes in the health insurance industry spurred the growth of outpatient centers throughout the region. The Clinic's growing reputation in cardiology led to a national and international reputation. And longstanding relationships spurred growth in international medicine.

Today, Cleveland Clinic has grown from a relatively small hospital with emphasis on medical research and education to a world-wide organization with 18 hospitals (6,026 beds), more than 220 outpatient locations, more than 4,500 physicians also serving patients in southeast Florida, Nevada, Toronto, Abu Dhabi, and London, as well as a medical school in Cleveland in partnership with Case Western Reserve University.

Clearly things have changed a lot since 1965. The days of all the doctors having lunch together in the hospital cafeteria are over. Curbside consultations on the Skyway still happen, but when we are dealing with many institutes and departments, some of which contain more than 100 physicians, the opportunities for spontaneous interaction between doctors in different departments are much more limited. The use of electronic media to aid communication has helped this, but the quality of communication, even with video, is different from that of face-to-face. This is an issue that Clinic administration continues to face. Nonetheless, our ability to care for our patients is infinitely better today than it was 100 or 55 years ago, and no one in their right mind would want to return to those "good old days."

DISCLOSURES

The author reports no relevant financial relationships which, in the context of his contribution, could be perceived as a potential conflict of interest.

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