Adaptive Planning: The Work of Dr. John B. Grant in Three Settings

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I visited the Rockefeller Archive Center on November 3-7, 2003 to look at the diaries and papers of Dr. John B. Grant. Grant was affiliated with the Rockefeller Foundation for over forty years; his life and work therefore refract and reflect many of the prevailing public health concerns and ideologies during the first half of the 20th century. Because Grant considered his experiences in Pitt County, North Carolina as crucial to his development, I was particularly interested in examining the materials related to this tour of duty. I was also interested in reading about his work in China and Czechoslovakia. The former has been covered by other researchers, including John Bowers (*Western Medicine in a Chinese Palace*) and Mary Brown Bullock (*An American Transplant: the Rockefeller Foundation and Peking Union Medical College*); the latter was much briefer (and hence less documented) than anticipated. This report will therefore focus primarily on Grant's involvement In North Carolina.

North Carolina as a Training Site

A recent graduate of the University of Michigan School of Medicine, in 1916 John B. Grant was recruited to work for the foundation by none other than the foundation's director of the International Health Board, Wickliffe Rose. Although Grant indicated at the outset that he was interested in working in China, where he had been born while his parents worked as missionaries, Rose could not offer him anything there immediately. He did, however, offer Grant two things: a large vision of how disease-specific initiatives could expand into overall, organized, multi-purpose community efforts; and the opportunity to “start from scratch.” This meant taking part in whatever

project the foundation was working on at the time, which was the campaign against hookworm. This prospect was not particularly exciting: Grant had had practically no training in parasitology and had, in his words, "no real concept of what was or was not going on in hookworm." Nevertheless, he decided to get out into the field and "see what it was all about."[1] Rose told him that the best thing was therefore to "turn [him] over to the responsible authority and farm [him] out to one of the Southern states and let [him] learn a little bit about how to organize a hookworm campaign."[2] Then, if in a few months his supervisors felt he had gotten enough in-service training, he would be sent out on his own.

At that time, Rockefeller support had been instrumental in efforts to control hookworm in the South for six years. The Rockefeller Sanitary Commission for the Eradication of Hookworm had been particularly active in a group of southern states between 1909 and 1913. Although the work of the Commission, which later evolved into the International Health Board, targeted only one disease, its bylaws included "building up in each state a system of permanent agencies which would take care of the whole problem of public health."[3]

By 1917, Dr. Watson S. Rankin, Secretary of the North Carolina State Board of Health, had embarked on this latter task, which he felt was more important than the prior disease-specific efforts. Rankin was negotiating with the U.S. Public Health Service (USPHS) to establish a network of county health units, but also sought the support of the International Health Board. He felt that IHB support would not only provide him with more funds, but would also give greater legitimacy to the county plan of health work. Moreover, it would allow him to retain the services of Dr. B. E. Washburn, an IHB official, as state supervisor for the county units.[4] The last point was particularly important to Rankin. Indeed, although the USPHS was willing to assign him one of their best men as state supervisor, "without cost and with franking privileges,"[5] Rankin had such

confidence in Washburn that he preferred him even if it imposed some additional expenses on the state's office.

In April 1917 Rankin submitted his plan to the IHB. It envisioned the creation of county health units which would provide multiple services, the aim being organizing "on an efficient and permanent basis ... local work in general."[6] In addition to continuing the control of soil pollution that was the major activity in the campaign against hookworm, the units would be in charge of quarantine and disinfection, medical inspection of school children, infant hygiene work, and life extension work. The latter was modeled on the protocols of the Life Extension Institute, which sought early detection of treatable conditions by conducting periodic physical examinations among adults.[7] All these services would be phased in gradually, under the direction of the State Director for County Health Work. The loan of Dr. Washburn for eighteen months was requested for this position, Rankin stressing once again that there was no one to whom he could entrust this work with so much confidence as he would to Dr. Washburn. The scheme proposed organizing approximately fifteen counties every three years, thereby covering half the counties in North Carolina (50) in ten years.

Within a week, Rankin received word that his proposal would be recommended for funding by the IHB. The commitment was to support a total of ten units for three years, and to lend North Carolina the services of Dr. Washburn.[8] The IHB contribution was to be matched by the state, with additional funds allocated by the county. Washburn was therefore accountable to both the State Board of Health and to the IHB, but had relative autonomy to deploy staff and other resources and carry out the approved scheme in ten counties. In recruiting medical staff, however, he was dependent on the few recruitable physicians he found locally as well as those sent by the IHB for

field training in North Carolina.[9] It was therefore under the aegis of Washburn that John B. Grant found himself in Pitt County in early 1918.

The situation in the field was not the most amenable to the work he was assigned, but this only made the need for his services more acute. Bad weather had made many roads impassable, and the major work on soil pollution had to be postponed. In addition, Washburn felt that the health officers, while the best men available in the state at the time, were handicapped by their limited experience in public health work in general and in soil pollution in particular.[10] In addition, the war effort was siphoning resources from the field, and the turnover among the state health officers was unusually high. The only available doctors were either "old men or young men with some physical defect."[11]

Upon meeting Grant and another IHB recruit, a Dr. Miller, Rankin reported being favorably impressed with both.[12] Shortly after their arrival, however, the departure of the health officer in Pitt County left their unit without a director, and Washburn was considering suspending the work. In the meantime, Miller was called upon to assume the direction of the county health unit. Although Miller was energetic and seemed to know what to do, Washburn was concerned that he lacked "executive ability and did not know how to "handle folks -- especially the rural people."[13] Not only did he have a brusque manner; his "tone of voice, manner of dress, moustache, etc. all advertise him as anything but a native. And country people like native-born-folks to work with them."[14] Although Grant was far from native-born and had no sense of humor,[15] he found the people "delightful" and had no problems relating to the residents of Pitt County. As a result, less than a month after his arrival he found himself sharing the job of county health officer with Dr. Miller.[16]

Because Grant's assignment was quite short -- less than two months -- he had a very short span in which to learn, get on with the task, and "deliver." He acquitted himself remarkably well. A

month after his arrival, Washburn was reporting to the IHB that Grant had been doing some excellent work in the county, and had completed a sanitary and malaria survey of Greenville.[17] At the end of February, as Grant was getting ready to leave North Carolina, Washburn wrote the IHB giving his appraisal of the young physician:

> He has done very interesting and valuable work in Pitt County and is highly appreciated by the people. I believe he is the best man who has come to the State for training during the past year, being energetic, well trained, and tactful; and able to mix with and interest all classes of rural people. I feel that he will be successful in any field he may work.[18]

Having proved himself in the most rudimentary although essential of tasks (i.e, basic sanitation and the construction of privies, maternal and child health), John B. Grant was ready to represent the IHB elsewhere, and to take on the challenges of protecting the public's health in the rest of the world.

Grant in China

Having gone through on-the-job training, completed an MPH at Johns Hopkins School of Hygiene and Public Health, and carried out other brief assignments for the re-christened International Health Division of the Rockefeller Foundation, Grant in 1921 was assigned to join the staff of Peking Union Medical College (PUMC). These operational responsibilities required “a broad and deep perspective”[19] of China, which he acquired by delving into the library, befriending Chinese, and doing his own reconnaissance of the country. Over time, Grant was given (or, more likely, earned) remarkable latitude to develop and implement a training program that evolved into a comprehensive health scheme for parts of the country as a whole. After an initial orientation, he was charged with developing a Department of Hygiene and Public Health within PUMC. This provided the crucible for testing many of his emerging concepts.

China had no public health organization, so Grant started with a clean slate on which to implement his ideas. One of these was organizing an urban health center where medical and nursing students could practice what they were taught in the classroom. This field practice area, created in 1923, was followed by the Department assuming responsibility for developing health services in a rural county of 400,000 inhabitants. This provided PUMC an unparalleled opportunity for training and research.[20] Through his political alliances and well-placed students, Grant was subsequently able to exert leadership in the planning of health services in Shanghai and Canton, and later to assist in shaping the Ministry of Health under the National Government at Nanking. It is therefore not surprising that, in her history of PUMC, Mary Brown Bullock titled the chapter on Grant "Medical Bolshevik."[21] Indeed, he was not loath to shake up the prevailing order in pursuit of better collective health.

Post-war Czechoslovakia

After World War II, Grant became director of the European Regional Office of the Rockefeller Foundation's International Health Board. Based in Paris, his role was to keep abreast of developments in the countries that came under the purview of that office, with a view to finding opportunities where the IHD might assist in the development of public health. The IHD had been particularly interested in nursing and in awarding fellowships for the training of health personnel, but during the postwar period it expanded its concerns to include the establishment of local public health programs and the organization of medical care.

Grant had visited Czechoslovakia before the Communist putsch of 1948, and upon arrival in Paris had re-established communications with the then Minister of Health. He was scheduled to visit the country on the day of the putsch, and cancelled his trip, not expecting to be invited back.[22] But the new Minister of Health urged him to visit as soon as possible, and Grant went to

Czechoslovakia in July 1948. There he met with health leaders in Prague and Bratislava, including some who had been Rockefeller Fellows at Johns Hopkins.

In Czechoslovakia, Grant found that the country was initiating "a very real medical revolution."[23] A five-year plan for the reorganization of public health had been drafted and was in the process of being enacted. This envisioned a complete overhaul of most aspects of the production of health, from the training of personnel to the delivery and financing of care. The program included reforming the medical curriculum; establishing schools of public health, graduate nursing, and paramedical workers; and reorganizing all personal health services on a district basis. The entry points into the system of care were local health centers, each of which provided an array of primary health services to a population of approximately 50,000. Some centers would have beds, and all would be linked to hospitals. The Czechs therefore expected to create a regionalized scheme in which everyone would have an entry point and continuing source of care, and patients would be referred according to need.

Grant was impressed with the degree of detail included in the plan: staff-to-population ratios were clearly established, districts had been delineated, and curricula had been designed with the goal of creating the types and numbers of workers required by the new system. Grant concluded that "at least 15 years [would] be required to complete the revolution," and felt that its effectiveness would hinge on the production of leadership where it was lacking, chiefly in the areas of statistics, public health engineering, and public health administration. He gave them his candid appraisal of these weaknesses and of ways to address them. Grant also advised them against establishing a School of Public Health, because he did not think the country had the population to support one. In a meeting with Grant, the Minister of Health "stressed that whatever ideological differences there might be in economic and political fields, because public health possessed a common

universal ideology, he hoped collaboration would be an important bridge in bringing about international understanding."[24] Following his visit, Grant corresponded with the Czech officials about possible projects, but no decisions were reached, and letters went unanswered. Grant finally notified them that he would discontinue attempts to follow up, and that ended any negotiation.

In any event, Czechoslovakia did implement its plan and created a network of polyclinics that a decade later served as a model for the redesign of the Cuban health system under Castro, which had in turn spawned other similar initiatives in Nicaragua and other countries.

Lessons learned

The materials on John B. Grant allow the researcher to identify the lessons he learned from his experiences in North Carolina and elsewhere. I have therefore summarized some of these, primarily as exemplified in the county work and described by Grant in his writings and oral sources.

1. Sensitivity to the nuances of local conditions. One of the things that became evident to Grant in Pitt County was the need to maintain prevention and care separate. While Grant felt that this was a "negative lesson" because the distinction between the two is ultimately arbitrary and illogical,[25] classifying different services as one or the other kept the peace between the county-sponsored public health workers and private practitioners. The county medical society supported the local health unit as long as it did not infringe upon curative medicine. Grant considered this a "lesson in public relations" or on how to get on with people.[26] In addition, it suggested a second lesson:

2. Co-opting dissent, neutralizing the opposition: While the county doctors had no objection to environmental surveillance or to the mass treatment of children, they did not want clinical services delivered to individuals. Thus, people going to the health unit for medical consultation or to request a prescription would have to be refused. This respect for turf earned the county doctors the

cooperation of the private practitioners, who considered them colleagues. The relationships were such that, forty years later, Grant felt that, had he stayed in Pitt County, he would have eventually become president of the county medical society!

The relationship between the private and public sectors in North Carolina was not only harmonious but symbiotic. In the event of an epidemic or major outbreak, all had to pull together to identify and take care of cases, as occurred during the influenza pandemic. In addition, the county doctor stressed that his efforts, which took the burden of preventive medicine off the shoulders of his colleague in private practice, enabled the latter "to give his whole time to non-preventable diseases and at the same time enable[d] the people to have more money to pay for his earnest endeavors to save life."[27] Moreover, both the school health and the life extension programs uncovered much disease that led to referrals to private practitioners. County health officers met with doctors and dentists to inform them of the number and character of "defects" found among the children, and urged the practitioners to agree to a reduced rate for effective treatment. Similarly, life extension work, which targeted the "undiagnosed ill" as well as what would later be called the "worried well," was welcomed by private physicians, who thereby increased their patient loads. In the words of one doctor, life extension was "the greatest step in the right direction that this county has ever taken in the conservation of life and safeguarding of the public health:"

> I have repeatedly had patients call at my office for treatment who never thought that there was anything wrong with them until they had taken the free examination at your office. People who boasted that they were never sick and had not needed medical attention or medicine in years; people who were skating on thin ice and didn't know it.[28]

3. For public health efforts to be effective, they need to be local. Until the Sanitary Commission on Hookworm spurred the development of local health units, health initiatives in North Carolina (as in

most states) were largely regulatory and had no direct impact on health status. The campaign against hookworm and the inclusion of maternal and child and other services changed the approach to community health and began to have an effect on the morbidity and mortality of the population. In Grant's words, the chief thing he learned during his sojourn in Pitt County was that “it is all very well to have health officials at the state level, but unless you could get down to the local community level, you couldn't get results.”[29] Under the leadership of Dr. Watson S. Rankin, North Carolina entered the vanguard of public health. His plan to establish county health units “on the installment plan” had the desired demonstration effect: those counties not included in the initial efforts were soon requesting that similar units be developed in their jurisdictions, and began appropriating funds for that purpose. Between 1909 and 1918, Rankin developed the State Board of Health from an agency employing six people and having an annual budget of $10,000 to one employing eighty-three and having a budget twenty fold greater.[30]

The effectiveness of the county units was put to the test during the influenza pandemic of 1918. Although North Carolina was hit hard and the outbreak spread to all parts of the state, those counties that had local health units were better able to control the epidemic because the health officers there took steps to prevent public gatherings and instituted quarantine measures. In addition, they got the population organized, establishing Committees on Intelligence and Nursing, among others, to monitor the situation, triage patients, and provide priorities for treatment. Because the counties that were under Dr.Washburn's direction were better equipped to mobilize the population, they were better able to address the outbreak. This was recognized by the press and by public officials throughout the state. Washburn was therefore able to report to the IHB that the epidemic had brought “the health departments in closer touch with the people than anything else could have done” and that this in turn would bode well for future work.[31]

4. Times of turmoil can foster innovation. Grant felt that upheavals could stir new initiatives, and that waiting until a situation stabilized often meant foregoing a propitious moment for change. In Czechoslovakia, for example, as in other European countries, postwar reconstruction and the need to rethink societal needs promoted health reform. Immediately after a war, he stated, "one finds thinking stimulated, and individuals having aspirations of a 'brave new world,' so to speak. That spirit of adventure and exploration, ten years later, had generally died down, and the nations then adopted a rather supine, just-dead attitude."[32]

5. Plan for the whole, even if you can only do part. A recurring motif in much of Grant's writings and actions is the need to think comprehensively even if resources do not allow full implementation at once. In his words:

> To construct any part well and avoid mistakes in local effort, the whole design must be before the mind. Any effort, however small and localized, can confer benefit if designed in relation to the scheme as a whole.[33]

In North Carolina, this seems to have been a guiding principle in the work of both Rankin and Washburn. Despite staff turnover, bad weather, war conditions, and other setbacks, the comprehensive plan to create the county health units continued to unfold, the "whole design" serving to inspire political and broad popular support. Similarly, in China, Grant had an overarching scheme which he gradually implemented, later exporting it beyond the catchment area served by Peking Union Medical College. This lesson, which appears to be almost self-evident, continues to be useful at a time when "disjointed incrementalism" often seems to be the order of the day.

Notes

[1] Reminiscences of Dr. John B. Grant: Transcript of interviews conducted by Saul Benison, Oral History Research Office, Columbia University, Vol. 1, October 1961: 41.

[2] lbid: 42.

[3] Article 11, Bylaws of the Rockefeller Sanitary Commission, RSC Collection, cited in John Ettling, *The Germ of Laziness: Rockefeller Philanthropy and Public Health in the New South*. Cambridge: Harvard University Press, 1981: 110.

[4] W. S. Rankin to Dr. John A. Ferrell, March 30, 1917. RAC, Record Group 5, IHB/D Series 1, Correspondence, Series 1.2, Box 236, Folder 654.

[5] Ibid.

[6] W. S. Rankin to John A. Ferrell, April 2, 1917. RAC, Record Group 5, IHB/D, Series 1.2, Box 453, Folder 654.

[7] Although in 1912 Wickliffe Rose asserted that the work of the Sanitary Commission in the South had been carried out "without race distinction" (quoted in Ettling, p. 173-4), Rankin's description of the life extension work contemplated only the "examination of white adults of each county." Rankin to Farrell, April 2, 1917. Once the life extension work was operational, Rankin pointed out the political dividends to be obtained from that initiative. He thus wrote to Dr. Ferrell: "...you will understand how the life extension unit, in bringing from 1,000 to 2,000 of the more influential people of the county into the health officer's office for an examination, is going to serve as one of the very best entering wedges for the more difficult unit, the soil pollution unit." Letter of October 3, 1917. RAC, Record Group 5, IHB/D, series 1.2, Box 43, Folder F655.

[8] Telegram from John A. Ferrell to W. S. Rankin, April 9,1917. RAC, Record Group 5, IHB/D, Series 1.2, Box 43, Folder 654.

[9] B. E. Washburn, *As I Recall*. New York: Office of Publications, Rockefeller Foundation, 1060: 148.

[10] B. E. Washburn to Dr. Ferrell, January 17, 1918. RAC, Record Group 5, lHB/D, Series 1.2, Box 60, Folder 875.

[11] B. E. Washburn to Dr.Ferrell, December 21, 1917. RAC, Record Group 5, IHB/D, Series 1.2, Box 43, Folder 660.

[12] W. S. Rankin to Dr. Ferrell, January 18, 1918. RAC, Record Goup 5, lHB/D, Series 1.2, Box 60, Folder 871.

[13] B. E. Washburn to Dr. Ferrell, January 24, 1918. RAC, Record Group 5, IHB/D, Series 1.2, Box 60, Folder 875.

[14] Ibid.

[15] In his reminiscences, Grant attributed this to his missionary upbringing or to fact that he was just a “dour Scotsman.”

[16] B. E. Washburn to Dr. Ferrell, February 22, 1918. RAC, Record Group IHB/D 5, Series 1.2, Box 60, Folder 875.

[17] B. E. Washburn to Dr. Ferrell, February 14, 1918. RAC, Record Group 5, IHB/D, Series 1.2, Box 60, Folder 875.

[18] B. E. Washburn to Dr. Ferrell, February 27, 1918. RAC, Record Group 5, IHB/D, Series 1.2, Box 60, Folder 875.

[19] Reminiscences of Dr. John B. Grant, Vol. 6: 1.

[20] Conrad Seipp, “Introduction,” in Conrad Seipp, editor, *Health Care for the Community: Selected Papers of John B. Grant*. Baltimore: The Johns Hopkins University Press, 1981: xiv.

[21] Mary Brown Bullock, *An American Transplant: The Rockefeller Foundation and Peking Union Medical College.* Berkeley: University of California Press, 1981: 134-161. The chapter provides a very complete account of Grant's accomplishments and *modus operandi* in China.

[22] Reminiscences of John B. Grant: 44-5.

[23] John B. Grant, Diary notes of July 1-6, 1948: 114-118, accompanying the Oral History transcripts.

[24] Ibid: 118.

[25] This was a mistake which he made special efforts to avoid in China. See Bullock, p. 135.

[26] Reminiscences of Dr. John B. Grant: 46-47.

[27] Circular to physicians from the County Health Officer, Jackson County, North Carolina, April 16, 1918. RAC, Record Group 5, lHB/D, Series 1.2, Box 60, Folder 875.

[28] Thomas C. Johnson, MD to Dr. W.A. McPhaul, Lamberton, NC. RAC, Record Group 5, IHB/D, Series 1.2, Box 60, Folder 875.

[29] Reminiscences of John B. Grant: 49.

[30] W. S. Rankin to Dr. Wickliffe Rose, May 11, 1918. RAC, Record Group 5, IHB/D, Series 1.2, Box 60, Folder 872.

[31] B. E. Washburn to Dr. John A Ferrell, November 1, 1918. RAC, Record Group 5, IHB/D, Series 1.2.

[32] Reminiscences of John B. Grant: 820.

[33] John B. Grant, "Effective Utilization of Health Care Resources," in Seipp, editor, *Health Care for the Community* …: 76.