Interview with Bernard Turnock

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Interviewer: Mike Czaplicki

Czaplicki: Today is Tuesday, April 8th, 2014. I'm Mike Czaplicki, project historian with the Gov. Jim Thompson Oral History Project, and I'm on the UIC campus today at the office of Bernard Turnock, director of the Illinois Department of Public Health from 1985 to 1990. How are you this morning, Barney?

Turnock: I'm doing great, Mike, how are you?

Czaplicki: I'm good. Thanks for sitting down with us, we appreciate it.

Turnock: Happy to.

Czaplicki: We always begin these things at the beginning, and so I'll start off asking you when and where were you born?

Turnock: I was born in Cleveland, Ohio, in July of 1947.

Czaplicki: I take it you're still an Indians fan?

Turnock: Oh, no, no. My family home is in South Bend, Indiana, but my father, who was a salesman for IBM, happened to be working in Cleveland at the time. But shortly thereafter, he moved back to his hometown, South Bend, for most of the time during which I grew up.

Czaplicki: How did your family come to end up in South Bend?

Turnock: My dad was born and raised in South Bend, and there's lots of Turnocks around South Bend, Indiana. He met my mother, who was a nurse at the St. Joe Hospital there. They got married during the war, and after the war they settled down back in South Bend.

Czaplicki: Did your father serve in the war?

Turnock: He did, he was in the Navy.

Czaplicki: What background is Turnock?

Turnock: I think the name is probably Scotch-English, but my family has a long lineage of Irish heritage, and virtually all of the Turnock men for the last five generations have married an Irish woman. So we're probably 98 percent Irish.

Czaplicki: You continued the tradition?

Turnock: I did, my wife is Colleen Hogan.

Czaplicki: (laughter) Indeed. And what were your parents' names?

Turnock: My father's name was the same as mine, Bernard John, and my mom was Jane Alice Hanahan.

Czaplicki: What was your childhood like? How would you describe growing up in South Bend in the 1950s?

Turnock: It was fun. I was the second of five kids, and four of us were close in age, so it was a very busy, hectic childhood, with lots of activities going on in a small house, in a small community.

Czaplicki: Anything in particular that you would do for fun?

Turnock: Well, I'd get beat up by both of my brothers—and my sister when she got big enough. But most of the things we did were athletic in nature. My father was an avid golfer, and we started playing golf at an early age. Most of us became reasonably good golfers.

Czaplicki: Good skill to have, given the profession that you entered, I take it?

Turnock: Well, that's debatable.

Czaplicki: Where did you go to school?

Turnock: I lived in South Bend until I was in sixth grade, and I went to St. Matthews grade school on the south side of South Bend. When I was in sixth grade, my father, who worked for IBM, got transferred to, first, Poughkeepsie, New York, and then to Endicott, New York.

Czaplicki: Is that the headquarters?

Turnock: I think Endicott is where Thomas Watson Sr. started IBM, and they used to have some of their major manufacturing plants there. It was probably the largest single location for IBM for many years. I don't think that's still true.

Czaplicki: Did you attend parochial schools or public schools there?

Turnock: Oh no, always parochial schools through college.

Czaplicki: What was your dad's job like on the home life? Sounds like you moved around a bit, from Cleveland, to South Bend, to Poughkeepsie.

Turnock: My father started off after the war as a salesman with IBM, long before computers were invented. He was selling office machines, business machines, accounting machines, early data processing machines. He was a salesman, and a very, very good salesman, and as he became more proficient in sales, they began to use him more in marketing to help develop systems that would serve large customers. That's how he ascended the corporate ranks. And we did our tour of the IBM towns of Poughkeepsie and Endicott, and eventually—I think he told me one day he woke up and realized he wasn't going to be president of IBM, and that he wanted to be transferred back closer to where he grew up. So he was transferred back to Chicago, where he ran some big accounts, and within a few years he decided he'd just move back to South Bend and operate in a smaller arena.

Czaplicki: IBM had a pretty legendary corporate culture at that time.

Turnock: Absolutely, it was the most paternalistic, family-oriented—I mean, both Poughkeepsie and Endicott had IBM country clubs, and each of them had at least two eighteen-hole golf courses, and large swimming pools, and bowling alleys, and summer activities for all of the kids. It was a quite unusual experience for a big company.

Czaplicki: And these were things that the company paid for?

Turnock: Yes. I mean, there were very modest fees and dues associated with it, but virtually all employees at all levels participated there, and mixed there. You were elbow-to-elbow with the senior vice presidents and the people that were on the assembly lines putting the early monstrous computers together.

Czaplicki: Did you get a chance to work there at all when you were a kid, or what did you do for jobs?

Turnock: No, I never worked for IBM. My high school job, I wrote obituaries for the local newspaper, *The Binghamton Sun-Bulletin*. I had a Sunday job there where my primary duties were as an editorial assistant, and I got to demonstrate my writing skills by putting together obituaries.

Czaplicki: (laughs) Interesting. A bit of a morbid side, or is that just how you could cut your teeth in journalism?

Turnock: I always had an interest in writing, and journalism was one of the things that I was contemplating as a career early on. I was always intrigued by newspapers and how they put all of that together, so it was a lot of fun.

Czaplicki: Did you have a school newspaper as well?

Turnock: I was the editor of the school newspaper, and all of that good stuff, yeah.[1]

Czaplicki: Any teachers who were particularly strong influences on you?

Turnock: I mean, all of them were strong influences on me. In parochial school, they go out of their way to influence your behavior. (laughs) But there was probably one math teacher who taught all of the levels of math, from algebra on up to geometry, and trigonometry, and calculus. He was a fascinating character. This was in Endicott, where I went to high school, and his name was Max Deus. And if you're proficient in Latin, that's kind of short for *maximus deus*, the greatest god, and that's what his name meant in Latin. And he was just a very demanding, rigorous teacher, who probably had the greatest imprint on me because of my natural interest in math and science.

Czaplicki: Was there any particular religious order associated with that school?

Turnock: You know, there was, but I don't recall it.

Czaplicki: This is something I talked about with Dr. Mandeville, and he was very specific as to the flavors.[2]

Turnock: I remember the nuns had big bibs, but I can't really recall which order that was at the time.

Czaplicki: Was your family interested much in politics?

Turnock: Not at all. Not my family. My father and mother were never involved. I may have had some uncles in South Bend who dabbled in it, and were aldermen, or power brokers at one time, but not my dad.

Czaplicki: Did you get any insight into what their leanings or beliefs may have been?

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[1] Turnock attended Seton Catholic High School.

[2] Governor Thompson's budget director. Robert Mandeville, interview by Mike Czaplicki, December 12, 2013. Unless otherwise indicated, all interviews cited in the notes were conducted as part of the Illinois Statecraft Oral History Project, Abraham Lincoln Presidential Library, Springfield, IL.

Turnock: I think just about all of the Turnocks have been good solid Democrats all their lives.

Czaplicki: So what would dinner table conversation tend to be about?

Turnock: Since we had five kids, or four kids that were close in age, it was largely around kids' activities and schoolwork, and things of that nature.

Czaplicki: How about you, any interest in politics? You're editing the school paper, and there's often a correlation between those things.

Turnock: Well, I would say no, others might say yes. I was president of my class for most of the four years in high school, but I never considered myself a politician. It was a small school and they had little to pick from, and I was a good student, and I was a nice guy. So I got elected, but it wasn't an ambition, and I never had any ambition to go into politics. I've always enjoyed government and politics as a spectator sport; it's good entertainment. I think it's interesting, and some of it is very important. I'm not quite a student of it, but I do keep a close eye on what's going on. But I've never sought to get involved as a political person, or as an elected official.

Czaplicki: Would you put yourself forward for these offices, or were you drafted by your fellow students?

Turnock: I would like to think I was drafted. As I said, I don't recall ever having any great ambition to do these things, but if called upon to do a job, I like to do it, and like to do it well. I think I probably got involved with that more from my reputation: being a good student, someone who is reasonably well-liked by all of the other students as somebody who could do the job, willing to do the job, and acceptable to the majority of folks.

Czaplicki: Were you valedictorian of your class?

Turnock: Actually, I finished second.

Czaplicki: Did you get along with the valedictorian? (laughs)

Turnock: Oh, absolutely, absolutely.

Czaplicki: Any other activities in school, aside from the school paper and serving as class president?

Turnock: I played golf for four years, and ran cross—

Czaplicki: Oh, so you had a golf team?

Turnock: Oh, we had a golf team. Ran cross country for a couple of years, played basketball for four years. That was about it.

Czaplicki: So you'll observe politics as a spectator sport. Can you recall your first political memory?

Turnock: Political memory?

Czaplicki: Either a candidate, or an event.

Turnock: I certainly recall watching TV in the fifties, and when the national political conventions were on, I always found those very interesting. I certainly remember the one in which John Kennedy was advanced as a vice presidential candidate. I don't think he won.

Czaplicki: Fifty-six.

Turnock: Yeah, I remember seeing that on TV, and that's probably the first inkling of a political anything that I can recall.

Czaplicki: I think Kefauver got the nomination over JFK.

Turnock: I believe that's correct, yeah.

Czaplicki: Was Kennedy especially significant because of his religious background? Did that have an impact?

Turnock: Oh, for sure, absolutely. Being Irish Catholic, and he being the first Catholic candidate and president, and the terrible events that occurred with his family. Those are very, very, very memorable.

Czaplicki: What other events would you say had an impact on you as you were growing up in those years, fifties, early sixties? Anything stand out as especially vivid?

Turnock: I think we're really talking—I mean, by the sixties, I was in college. Certainly the exploration of space and the moon were big events, but…

Czaplicki: Sputnik?

Turnock: Yeah, yeah. Again, I came out of a science and math background, so these things were of more interest to me than most other kids my age.

Czaplicki: So as you finished up school and college was looming, where were you thinking about going?

Turnock: My dad had gone to Notre Dame, kind of as a neighbor. He lived only a few blocks away, and as he tells the story, he went there for two years before his father even found out he was going there. (Czaplicki laughs) His father was a plumber and had my dad and most of his brothers earmarked for the plumbing business. But my dad was, I think, the second of his siblings, and he had ten siblings. He was the second to go to college, and he did it by just walking on over, getting a job in the golf shop, and kind of running the golf shop there. He got out of college early because of the war, graduating six or eight months ahead of schedule, as they were doing to get students through college and into the war effort. So Notre Dame was always on the list, although my preference was not to go back to a town where so many people have my last name. I chose kind of a rival institution in some respects, emerging at that time as an academic as well as a destination college, Boston College. And that's where I went.

Czaplicki: What turned you on to BC in particular?

Turnock: At the time, I was living in upstate New York, and Boston wasn't all that far away. I really didn't know about colleges in the Midwest other than Notre Dame, so it was just the opportunity to go a big city, a nice place to go to college, from everything I had heard from all the people that attended any of the many, many colleges that are there. BC had a good reputation and offered a pre-med program, which I was interested in. It seemed like a no-brainer at the time.

Czaplicki: Did your older siblings go to college as well? Were you the first?

Turnock: I have an older brother, and he went to the University of Dayton. I have a younger brother and two younger sisters, and they went to various places.

Czaplicki: Of course, the US is just about at its peak involvement in Vietnam heading into that, shortly before you go off to college. What were your thoughts on the war at the time, and how did that impact your planning on what you're going to go off and do?

Turnock: The war didn't make a lot of sense to a lot of people, and I was one of them. So I don't think I was favorably disposed towards the war, nor towards participating in the war. Later on, I can't remember exactly when the draft took place, but I had a very high number.[3] My older brother had a very low number and was actually drafted, but he failed the physical because of high blood pressure. We kept an eye on that, but having a high number and being in college kept me out of the draft.

[3] Born in 1947, Turnock was part of the December 1, 1969, draft lottery for induction in 1970. The lottery assigned July 26 number 303, while the highest number called in 1970 was 195. Selective Service System, "The Vietnam Lotteries," https://www.sss.gov/About/History-And-Records/lotter1.

Czaplicki: Was this something you talked about at all with your parents? Your father being a veteran, what were his thoughts?

Turnock: My father came away from World War II with a very [strong] distaste for that kind of conflict. Although I don't think he ever was a passionate opposer of Vietnam, he did nothing to encourage any of his sons to participate in the armed forces at that time.

Czaplicki: What did you think of BC and Boston when you arrived? Was it everything you hoped for?

Turnock: Well, I'd never been to college, and I had limited exposure to colleges. It looked great, and it was great, and it was everything you could ask for. It was in a great location, a town that's very college-oriented and youth-oriented. Just a lot of fun, a lot of people, good academic program, and it was—those were good years.

Czaplicki: How did BC's campus compare to some of the other Boston campuses at the time? This was a very political era, and there was a lot of activism going on at various locations. Was BC swept up in that, or was it a different culture?

Turnock: It depends. BC probably was semi-active. I'm trying to think of who else. There's Northeastern and BU, they're kind of more urban campuses. Harvard was there, but that's a different world entirely.

Czaplicki: (laughs) Didn't interact much with them?

Turnock: I mean, they get a lot of attention. But certainly among all college-aged kids, it seemed like all college campuses, there was strong opposition to the war. That didn't permeate everything we did, but it was the environment in which we all lived.

Czaplicki: Did you get involved in any formal activism?

Turnock: No, I did not, no.

Czaplicki: How would you characterize the development of your intellectual or professional interests while you were at BC? You mentioned that you were interested because they had pre-med programs. Is this something that you'd follow through in a linear fashion? Did your interests change at all when you were in college?

Turnock: I think from the time I was in high school, I've always had dual interests. I've had a lot of interests, but I think the thing that always drove me was my strength in math and science. So, you know, I became more of an egghead scientist. As I mentioned before, I've always had an interest in government

and important decisions. And really, from almost the time I was in high school, I've always contemplated some sort of a career that would combine science, politics and government, and health. I was always tracked. I always thought I would find my way into a career in public health; that I would go to medical school to get the credentials and the credibility that go with having an MD degree, and use that to get engaged in public policy and public health issues at a governmental level at some point. That was pretty much my plan from before I went to college.

Czaplicki: Where do you suppose that desire for public service came from? There's a lot of talk in the fifties from people worried about your generation, that there's apathy, or there's big corruption scandals and maybe you won't want to go into government. But it sounds like you had a pretty strong call to service.

Turnock: I'm sure it's my upbringing. I don't think my parents raised us to be public servants, but they were very straightforward, honest, humble people who believed in the Golden Rule that you respect and treat others as yourself, and that we have an obligation to each other. My mother, as I said, was a nurse, and maybe some of it came from there. But I think both of my parents came out of similar value systems, whereby this was honorable work, and if you had the ability to get engaged in it at a level in which you could make an impact, go for it.

Czaplicki: So Kennedy's inaugural, his famous call, "Ask not what your country…"

Turnock: Oh, absolutely. Certainly resonated with a lot of young passionate people, but I don't think that was the cause, I think that was just a reinforcement.

Czaplicki: By the time you graduate, you're pretty sure public health is what you're after?

Turnock: Yes. I knew I wanted to go to medical school on the way to getting involved in public health, so I had to check out medical schools. By then, my parents had moved back to the Chicago area. We were living in Arlington Heights, and the University of Illinois was the least expensive medical school that anybody in that situation could ever ask for or dream of. You're paying 148 dollars a quarter.

Czaplicki: Wow!

Turnock: For tuition. So it was something that I could do without placing an incredible burden on my parents, who weren't really wealthy and had four other kids to take care of.

Czaplicki: Did you apply anywhere else, or was it U of I or bust?

Turnock: Oh, I did. I applied to Columbia, and I think the University of California-San Francisco, just to test the market out there.

Czaplicki: Why pediatrics? In terms of your specialty.

Turnock: Pediatrics is more about health and wellness than a lot of the other specialties in medicine. I mean, pediatric patients get well, you know? And they're naturally well. I think it's a more uplifting, hopeful, and positive environment. And kids are fun. It's as close to my interest in prevention and public health than any of the other specialties would have been. So that's why I gravitated towards that after medical school.

I actually had a plan for—I mean, I had planned to be—it sounds like I had plans all the time. (Czaplicki laughs) The plan at the time was to get dually certified in pediatrics and preventive medicine. There was a way to do that by taking two years of a pediatric residency after medical school, getting a masters of public health degree, and then completing a preventive medicine placement in a health department. You would then be eligible to get board certification in both pediatrics as a specialty and preventive medicine as a specialty. I embarked on that course, but along the way they changed the requirement for pediatrics to a third year, rather than the two that I had done. I opted not to do that third year, and just become certified in preventive medicine and public health.

Czaplicki: In terms of the "they" who's changing the requirements, is that a particular institution?

Turnock: There's a national board that sets the requirements for board certification and sub-specialty certifications, and the rules changed. It didn't greatly upset me.

Czaplicki: And no grandfather clause if you were already underway?

Turnock: No, no. It simply would've required another year, and at the time, I just wasn't looking to do another year of clinical pediatrics, because I was already kind of embarked on the public health route. I'd taken a public health residency with the New York City Health Department, and I didn't want to complicate things.

Czaplicki: Two questions here. When you got out of U of I, how did you end up in California, at Berkeley?

Turnock: After I got out of medical school, I applied for a pediatric residency, and I did one that involved the University of Illinois and the Illinois Masonic Hospital on the North Side. When I completed those two years, I applied for a fellowship that would get me an MPH degree in maternal and child health. And the leading program for that was at the University of California-Berkeley. I went there for a year under a federal fellowship that paid my tuition and living expenses. I was married at the time. We went out there, got the masters

in public health degree, and then to complete my Board certification requirements in preventive medicine, I found a residency program with the New York City Department of Health.

Czaplicki: As you alluded there, your medical residency wasn't just important professionally, it was also important personally. So you're saying that's where you met your wife?

Turnock: Yes. Well, I think I was actually in medical school when I met my wife. I was doing a clerkship at Illinois Masonic Hospital. She was a—I think they called them patient representatives at the time; they were people that were interested in making sure the hospital got paid. But she then took a job with the University of Chicago Hospital as a pediatric social worker. Yeah, I met her when I was a medical student, kind of in my first clerkship in my third year of medical school.

Czaplicki: And the newspaper mentioned that you proposed to her—I was thinking of this Irish connection—at the Shannon River Restaurant?

Turnock: That's probably true.

Czaplicki: (laughter) That ring a bell?

Turnock: I don't know where you're getting this information, but…

Czaplicki: Your wedding announcement in the Trib.[4]

Turnock: Oh my God, then it's probably true. Yeah, I think that's probably right. We've been known to visit some Irish establishments.

Czaplicki: So you went out to Berkeley then? It was mainly the reputation of the place because it was the leading school in that specialty?

Turnock: They had a good program in maternal and child health, and I was gravitating toward some sort of public health position in maternal and child health at the time. And it was an opportunity to visit the other coast, see what goes on out there, go to a great place.

Czaplicki: You had considered San Francisco earlier, right?

Turnock: San Francisco's attractive to everybody at every age, I think. But yeah, I hadn't been to the West Coast for any extensive time. And it was a great opportunity; it's a great place, great school. A lot easier than medical school. (laughs)

[4] *Chicago Tribune*, March 19, 1973.

Czaplicki: Did you and your wife consider staying out there? How much did you like California?

Turnock: That's a difficult question to answer. Did *I* consider staying out there? Yes. Did my wife consider staying out there? No. Did we decide not to stay out there? Yes. (laughter)

Czaplicki: But then you go all the way to the other coast and end up in New York City.

Turnock: We did, we did. Took a job with the New York City Health Department, and it would complete my requirements for board certification in preventive medicine and public health. It was a very unusual time and place. It was during the severe economic crisis in New York City under Mayor Beame. It looked like the city was going to go bankrupt.

Czaplicki: It nearly defaulted, yeah.

Turnock: Yeah, I didn't get paid for, I think, six months after I started. (laughs)

Czaplicki: Really?

Turnock: Oh, it was tight.

Czaplicki: Were you getting scrip? A voucher?

Turnock: No, I got—I mean, they were a true bureaucracy: they were in severe crisis, and I was the least of their problems, I think. We found a way to get by until all the back pay arrived. But it was a wonderful experience. New York City is an incredible place in size and scope. Makes Chicago look like a small town in many respects. I learned *a lot* about public health practice in one of the storied public health agencies in this country. The New York City Health Department is an incredible place. And despite all its problems, it has so many talented people, so many well-trained people, such depth, and skills, the skill positions in public health, that it was an amazing learning experience. I learned a lot from the people that I worked with, who were largely public health nurses because my role was often to travel around the city and inspect hospitals, and facilities that performed sterilizations and abortions.

I'd have to travel on my own dime. So I learned how to use the vast public transit system in New York City to get to places that were just so far from Manhattan, and so different from Manhattan, that you'd think you were in bombed out Warsaw after World War II. It was a very interesting experience for a couple of years. The city then passed a residency requirement, which meant that if I wanted to continue working there, I'd have to move into the city, because I wasn't living in the city.

Czaplicki: Oh, where were you?

Turnock: I was living in New Jersey, where my younger sister and her husband were living. We moved into a town, Cranford, New Jersey, so that I could commute. I could take the train, and the PATH, and get off at the base of the World Trade Center, and walk over to the Health Department offices. It was good, until we had to decide whether we wanted to stay out there or look elsewhere.

Czaplicki: And how did that feeling break down this time?

Turnock: Well, it breaks down the way it always does. My wife wanted to go back to Chicago and Illinois, and there was a job available at the Illinois Department of Public Health. It wasn't in an area that I had special expertise, it was emergency medical services, but they were looking for somebody with my qualifications. I knew the director. I'd met the director of the Illinois Department of Public Health, Dr. Peterson, earlier in the seventies, when he was the founding dean here at the School of Public Health, because I had come over here and talked to him about careers, and futures, and whether I might try to go to public health school here rather than in Berkeley.[5] So I knew him a little bit, and found him to be a very honorable man. I would be reporting directly to him, and I said let's do it. We moved to Springfield. It wasn't Chicago, where my wife wanted to be, but eventually we got to Chicago.

Czaplicki: I take it she was a Chicago native?

Turnock: She was born and raised, South Side, South Shore.

Czaplicki: What was the matching process like to get you to New York City in the first place? Was it the kind of thing where you picked several programs and prioritized them, and if they picked you, that's where you went? Or did you have some options?

Turnock: The kind of program I was looking for is difficult to find. Without getting into the nuances here, preventive medicine is one of the smaller medical specialties. You know, much smaller than surgery, and internal medicine, and pediatrics, and obstetrics. Less well-known. And preventive medicine has several sub-specialties, one of which is in public health administration. It also has sub-specialties in occupational health, and I think one in aerospace health, or they used to. I think several of the astronauts who had medical backgrounds came out of that. So it's very difficult to find a residency program that served the niche I was looking for. I can't recall specifically, but I doubt there were many others than New York City. And I don't know why New York City was offering one amidst all of their economic problems; they probably had

[5] Paul Q. Peterson served as Governor Thompson's first director of the Illinois Department of Public Health (IDPH) from 1977 to March 1979.

external funding to support their residency program at the time, and they could hire somebody. It was just a very fortunate match and opportunity. I don't think there were a lot of things to pick from. The other kinds of programs were probably more hospital-based in preventive medicine, rather than public health agency-based. It was just a fortuitous circumstance.

Czaplicki: Has the popularity of that specialty, or availability of programs, changed over time? I would expect more of that now, given the current focus on prevention. Or is that not the case?

Turnock: That's probably not the case. There are very few people, physicians, who are board certified in preventive medicine in the sub-specialty of public health. Most of the people who work in public health don't have any formal preparation or training for it. Including many of the physicians who hold very high positions. It's a small group that has not grown significantly, and while I think we like to believe that prevention in public health is a bigger part of our health system than it used to be, it's still a tiny, tiny piece of the health system. There's not a lot of people who aspire to that kind of training.

Czaplicki: Why do you suppose that is? Public health has a pretty old history in the US. A lot of the departments get founded fairly early, as far as regulatory agencies and things. So it surprises me that there's not a—is it the money?

Turnock: Part of it's the money, and I think part of it is our trend over time in which health agencies that employed a number of physicians in the past find that they don't want or need physicians to do the kinds of things that they need to do; they can replace those high-price people with people with less salary demands and skills, and just divide the work up differently. I think this explains part of it. There's not an increasing number of jobs that are looking for public health physicians these days. Certainly over the three or four decades I've been involved, I've not seen an increase. I would like to have seen an increase. And there's not an increased interest in students coming out of medical school to move into those positions, probably because the salary differentials are so great—the loan burdens that physicians come out of medical school with are so high—that they gravitate towards positions that pay more early. So it's been fairly static. I suspect there's even fewer today than there were thirty years ago. There's just not many.

Czaplicki: I understand your med school was cheap. How did you pay for the MPH at Berkeley? Was that a federal grant?

Turnock: It was a federal fellowship. They aspired to train people who would run MCH programs in states and large cities.[6] Someone like me would be very attractive to them: they would take me and train me, and I'd go out and get an important job in a state or the federal government and reflect well back on the program.

[6] Maternal and Child Health (MCH).

It was their way of creating a cadre of leaders in maternal and child health across the country. And one of the federal agencies, HRSA, the Health Resources and Services Administration, has supported a handful of these programs in various schools of public health over the last three or four decades. There's actually a program here now at UIC's School of Public Health. Places like North Carolina, Berkeley, UCLA, and Minnesota have traditionally been places where these federal grants would support this kind of leadership development.

Czaplicki: Were you there for the New York blackout? Or was that seventy-seven? I think it may have been after you left.

Turnock: Yeah, I don't recall being there for that, but I forget a lot.

Czaplicki: While you were in New York, you were primarily doing inspections?

Turnock: Yeah, I worked for the Bureau of Maternity Services and Family Planning, very in line with my maternal and child health training. I was the physician member of an inspection team that would visit various facilities that the New York City Health Department regulated. So hospital, maternity, and newborn services, including their high-risk services for moms, the neonatal intensive care units, and the system of referrals and ambulance transfers that move moms and infants to the more specialized facilities. We're involved in those kinds of regulations, and we would travel around to all of those hospitals.

This was a couple of years after *Roe v. Wade*, so there began to be the growth of medical services that provided terminations of pregnancy, abortions, and there were concerns about the proliferation of those providers, and abuses that can and actually did occur. There were licensing requirements placed on them, and we would investigate complaints of abuse, and attempt to deal with unsavory providers. We actually closed a number of facilities that provided those services.

Czaplicki: What would the nature of abuse be? What kind of things were…

Turnock: Performing abortions beyond a safe period, both for the mom or when the infant was—the fetus was viable. Abortions performed by untrained, unlicensed people; the lack of proper credentials for the people performing the abortions, the lack of referral arrangements. You know, should there be complications on-site. Things like that, serious stuff.

Czaplicki: Speaking of *Roe v. Wade*, what were your feelings on that decision?

Turnock: *Roe v. Wade*, I believe in it and support it. It certainly came into play later in my career when I was involved with another case on it before the US Supreme Court. But my personal belief is that it's a good decision and needs to be

maintained and upheld—kind of counter to my religious preparation and training.

Czaplicki: I'm sure we'll get into this later, but just to make a note, what was the Supreme Court case you were involved in?

Turnock: *Ragsdale v. Turnock*.

Czaplicki: *Ragsdale*, okay. I'll look into that before our next session, and I'll put it on the agenda.

Turnock: Oh, you'll find it of interest.

Czaplicki: I'm sure I will, so I appreciate that. How would you characterize New York City government versus what you later become familiar with in Chicago?

Turnock: To me, New York was such a vast place, I just never believed that anybody could run it, or that it could be run. I don't want to personalize it. It just seemed to me like it was just *monstrous* and out of control, and just too many people, too many problems. And certainly, government at the time wasn't perceived to be progressive, or aggressive, or to have a plan to bring it all together. Plus, I was so far down the totem pole in terms of the city government. (laughs) I had no clue what major policy decisions were on the table, so I thought it was unmanageable, and I thought I was contributing my part to making it unmanageable.

Czaplicki: But at the borough level, did you have the sort of fiefdoms that you often see in Chicago at the aldermanic level, the ward level? Or did clout operate the same?

Turnock: I didn't know, or I didn't observe that because I wasn't a resident there. So I wasn't living in one of those communities and being exposed to the local political infrastructure. That all seemed to be going on kind of peripheral to what I was doing, and I never really encountered that, or problems, or issues related to that, or city councilmen in New York trying to get involved in some decision that might be made about a facility. I never encountered any of that kind of political influence there. I was ignorant of it. I'm sure it was there.

Czaplicki: You said you saw that there was a job out in Illinois. Were you just looking at postings?

Turnock: I knew I couldn't live in New York City.

Czaplicki: Were you recruited for the position?

Turnock: I think I saw the posting for it, and I knew I had to get out of New York. And really, to be honest with you, I wasn't totally enamored of living on the East Coast. It's just a different culture, and I find people a little bit less appreciative of their fellow humans there.

Czaplicki: That's where I grew up, so I understand what you're saying. (laughs)

Turnock: The Midwest, to me, is a much more civil society. And going back to Illinois was something that was inevitable for me, because as I said, my wife was very—all of her family is there, and she grew up in Chicago, and has always wanted to stay in Chicago. So getting to Springfield was a step in that direction—get there, see what develops in the Chicago area, and at the right time, make a move. That was what we were thinking at the time.

Czaplicki: You were in Chicago, you were in Berkeley, you were in New York City, and now you're in Springfield. What'd you think of Springfield?

Turnock: I thought Springfield was fine. I mean, I grew up in places like South Bend, Indiana, and Poughkeepsie and Endicott in New York. And to me, Springfield was okay. It was a manageable size, and you could walk or ride your bike to work; you weren't spending several hours unnecessarily commuting somewhere. People were nice, it had a lot of the things in life that I was interested, it had the state government there, and it had a lot of people my age working in the state health department. So there was a lot of collegiality, a lot of informal, casual, good living—a slower lifestyle. It had a lot of things I liked.

Czaplicki: Yeah, what was social life like in Springfield?

Turnock: You play softball? You would fit in. You drink beer? You fit in. You play golf? You fit in. Everybody fits in; I think it's a very informal existence. And a lot of the state workers, across the agencies, are all engaged in these kinds of activities together.[7] And in the agency I was working in, the Illinois Department of Public Health, there just seemed to be a lot of people in their early 30s, as I was, and young and energetic, and work hard/play hard.

Czaplicki: What part of town were you living in?

Turnock: It was south and west of the Capitol. It was in one of the older neighborhoods, on Whittier Street.

Czaplicki: And did you have any kids by this time, or was it still just you and your wife?

Turnock: No, we had our first son Patrick when I was working for the New York City Health Department. He was born in '78.

[7] Robert Mandeville, interview by Mike Czaplicki, February 20, 2014, 14.

Czaplicki: As you're leaving, heading off to Illinois?

Turnock: He was very, very small when we moved, (laughs) so I think he was pretty new. Other than being born in a very expensive hospital on Fifth Avenue, he doesn't remember much of New York City.

Czaplicki: You said initially, you were hired not in your specialty, you were hired for EMS, right? Emergency medical services?

Turnock: Mm-hmm.

Czaplicki: So what was the nature of your duties in that division?

Turnock: I was the division director, and there was a staff of maybe twenty or so people who were involved in various activities that would relate to standards for trauma centers, poison centers, ambulance services, and paramedic programs. It was kind of semi-regulatory in that we credentialed or certified the EMTs, the emergency medical technicians, at the various levels and designated particular hospitals at various levels of trauma. Some would receive the most specialized kind of trauma, and others would receive more generalized kind of traumas. We reviewed hospital trauma capabilities, and there were some people who dealt with emergency communication systems, the special channels you've got to use for particular purposes, and licensing the ambulance services, and all kinds of neat stuff. As they say, every physician wants to be a fire chief, and every fire chief wants to be a physician. (laughter)

Czaplicki: I've never heard that.

Turnock: It's really an interesting program because it's a system. It kind of extends beyond the traditional hospital and doctor medical system out into the community, where you have ambulance providers who are sometimes voluntary, but some of them are free-floating or proprietary, and these pieces have to fit together for emergency services to be successful. So you have this pre-hospital phase, and the hospital phase, and the medical people. And as I said, ambulance attendants, and paramedics, and fire chiefs—it's just great.

Czaplicki: Just for definitional purposes, what makes a hospital a trauma center? And was this a new concept at the time, or had this been around?

Turnock: People will claim that Illinois invented it. Before I took the job, David Boyd, who is a trauma physician at Cook County Hospital, was a trauma specialist. And he got involved to set up a system that would approve and designate some facilities to receive trauma, so that ambulance transport, helicopter transport, and plane transport of particular kinds of injuries would be taken to specific places that had the whole array of critical care capabilities—

physicians, nurses, and all of the other stuff that's necessary.[8] So the system was setup about ten years earlier.

Part of it was also to provide jobs to Vietnam War veterans who were returning, who had specialized expertise in critical care on the battlefield. A number of these people who worked in the emergency medical services program were veterans. It was a program that had kind of been initially designed, and then Dave Boyd went on to the federal government where he headed up the EMS program at the national level. So then there began to be funds that were provided to states to help develop these capabilities, and the emergency medical services program in the state of Illinois was the recipient of one of those grants that funded many of the people in the department. And we kind of did things in a semi-regimented way to enforce these standards.

Czaplicki: Do you know much about Boyd's background? Was he a veteran himself?

Turnock: I believe he was. I don't know.

Czaplicki: I presume there must've been studies or data collecting to show that the outcomes are actually improving?

Turnock: It's kind of military in its genesis anyway. The military organizes stuff, you know? You have different levels, and everybody follows this command and control structure. So efforts to reform the trauma system are very much along those lines, it's kind of a top-down—here's the stuff that the more specialized capabilities can do; if you can't handle it, you refer it up. It's very systematic. It's viewed as a system, and it has these pieces that are inside government, outside government; inside the medical structure, outside the medical structure; and it involves all kinds of public safety personnel—police and fire, and however the ambulance services provide it. There's a lot of pieces that need to be put together to make that system work. So it's a real good working example of a system of healthcare.

Czaplicki: In terms of staffing, you mentioned it's something that vets are particularly well-suited for. Were you integrating job postings or hiring with Veterans Affairs, either at the state level or the VA nationally?

Turnock: There was. There was always a very close relationship with the state office of Veteran Affairs, or something like that; it's a small office, at least it was in those days. But actually, the person who ran it came out of this trauma program. The trauma program would have these regional trauma coordinators stationed across the state, and there'd be regional trauma nurses, and those

[8] Cook County Hospital created one of the nation's first trauma unit in 1966, and its doctors actively lobbied for a more extensive trauma system. Governor Richard Ogilvie took an interest in this activity and asked Boyd to develop a statewide plan, and on January 23, 1971, IDPH released the Illinois Trauma Center Plan. David R. Boyd, "Trauma Systems Origins in the United States," *Journal of Trauma Nursing* 17:3 (July-September 2010), 128.

would be the people that would provide the technical assistance locally to the communities, the community hospitals, and the community docs. The person who was running the VA program was actually one of those former regional trauma coordinators. And it just seemed to be one of those places where returning Vietnam vets were especially welcomed, and college degrees and other things didn't seem to matter.

Czaplicki: I'd like to back up a little bit and go from a broader perspective, just thinking about the Department of Public Health and its place vis-à-vis a lot of other agencies. Looking at budget books is one way I get a handle on these different agencies: what do you do, what are you up to, and—

Turnock: Money is the measure of a man. (laughs) Or of an agency.

Czaplicki: Right. And it's just interesting to me because in addition to the things that are really obvious medical services, I'm struck that the department has responsibilities for professional regulation, environmental protection, social welfare administration, compiling vital statistics, aiding law enforcement—whether it's through the state labs or breathalyzer certification—emergency management, a planning division, and then a whole range of inspection functions like food and dairy facilities, homes, and even migrant labor camps. So why such a hodgepodge of functions?

Turnock: I'm not sure I know the answer to that, Mike. I think that probably historians like you would have a better handle on that. The state health department was one of the earliest agencies founded.[9] And as laws were enacted by the General Assembly, they were delegated to specific agencies. So over time, anything that came up that was related to health was given to the Illinois Department of Public Health. But as time went on, some of these pieces got so big that they would be taken out and become separate agencies, like Mental Health, Environment, Public Aid, the Department of Children and Family Services, Aging, and other things. Discrete pieces would be taken out, and my interpretation of history here is that what was left, the bits and pieces that didn't fit anywhere or weren't big enough to comprise a separate agency, often got left with the mother agency, the state health department. So some of these things are difficult to understand where they fit in because they came to the health department at different times in history, under different circumstances, for different reasons. And because of little nuances that occurred thereafter, they never got relocated some place else, even though they might be more properly placed some place else. So there's a hodgepodge of activities, in addition to some of the core things of what public health agencies ought to be doing, that the state health department is responsible for. It's just one of those little facts of state government that happens in every state like this. They all evolve differently and decide to do things differently, and

[9] IDPH originally began operation as the Illinois State Board of Health on July 12, 1877. *Illinois Blue Book, 1977-1978*, 400.

have different priorities at different points in time, and things just end up looking different.

Czaplicki: Was there much talk about reorganization when you arrived there? Because I know this was the start of the Thompson administration, and they were interested in reorganizing other types of agencies.

Turnock: I don't recall major state reorganization. There's always been discussions of some sort of thorough systematic review of the statutory obligations of the state health department, to reconfigure them or codify them in some understandable fashion. But by and large, inertia takes over in things that existed somewhere in the past and are going to exist somewhere now and in the future; it's harder to change things than it is to leave things alone, and so things just kind of persist. I don't recall any major discussions about a truly major restructuring of the health department. It's always been a department from which others have been spawned. And I don't know if that exists now.

Czaplicki: A governmental nebula.

Turnock: Well, it is. There were some reorganizations after I left, later on in the '90s. A lot of the maternal and child health services and the WIC—Women, Infants, and Children—supplemental food program services were moved out of the state health department in the mid-1990s, something that a lot of us didn't think was a good idea at the time. That's the most significant restructuring that I can remember in my time period here, which goes back to the late '70s.

Czaplicki: You're a good person to ask this because you've written a whole book on the topic, in some ways. How would you define public health?

Turnock: There's lots of academic definitions of what public health is: ensuring conditions in which people can be healthy; an organized community response to perceived problems and priorities. So there's lots of abstract ways to look at it. I've always looked at it as the confluence of science and politics, science and social values: what do we know, and what do we choose to do with what we know? And I think that's really where public health operates. It doesn't operate in the rocket science category. It attempts to use the knowledge that we have about health and illness, and to see that that knowledge gets applied to have the greatest impact on population-wide health.

Czaplicki: It's a potentially expansive mission, as some of these functions attest. How did limits get placed on this mission in practice? Were legislative restrictions more important, or budgetary, executive?

Turnock: There's always a long list of needs, things that should be done. But we all live in a real world in which resources—not just financial resources, but human resources—and commitment, and will, and priorities dictate what will be

done, given the fact that our resources are limited. We're not going to do everything we need to do about everything that needs something to be done. So resources, broadly defined, set those boundaries. But some of those resources are economic, and some of those have to do with the underlying value structure—what's important, what's more important than something else. That's where the social value part of the equation blends into politics; different perceptions of what's important or valuable to different groups, and how you balance that at a larger population level.

Czaplicki: Thinking about fiscal resources and commitments, how strong was the department's bureaucratic capacity, its ability to go out there and secure funding or protect its domain?

Turnock: For a state health agency like the Illinois Department of Public Health, its major funding sources are two. One is the state dollars that it can acquire through legislative appropriation, or to a lesser extent, through setting fees on services that are offered. The other is through resources that are made available by external parties, especially the federal government, which generally makes resources available for specific categories of conditions. In effect, they're setting your priorities by telling you that we have some money here, you don't have to take it, but if you do take it, you can always spend it on this stuff in this way. State health agencies kind of balance what you're being told to do by virtue of somebody else's money, and what you can do as a reflection of what is perceived to be the needs within the state. Hopefully, that comes with some direction from the legislature, but it may not. So you're constantly trying to get resources from the General Assembly or from the federal government, and that often dictates what you will be doing.

Czaplicki: When it comes to some of these federal standards, or benchmarks, or capacity goals, it sounds like the states don't have a lot of input in defining those priorities?

Turnock: Well, I think that's the nature of operational federalism. That's the way we constituted this government; health is not a federal governmental responsibility. It's not mentioned at all in the Constitution of the United States. It's one of those duties or powers that are reserved for the states and the people, and public health has always been a state responsibility. But the federal government, where it wants to influence what states do, can only really do so through offering money that states are free to take or not take, as long as they want to play by the rules that the federal government sets. This is an exercise in civics. This is our federalist system at work, and to a large extent, why we don't have strong consistent national health policies. It's not one of those responsibilities that the federal government feels it has a constitutional basis to act on. Look at the Affordable Care Act here. (laughs) Look at Medicaid.

Czaplicki: I was wondering if this very small professional world that you talk about provided some sort of coordination, just through informal networks of people knowing each other, whether through conferences, whether through shared training, whether working in agencies, and as some people get kicked upstairs and some remain at the state level. It sounds like there isn't really a network like that, then, that the federal government is fairly autonomous in how it develops policies that it then asks the state to do.

Turnock: The people in the federal government all come from somewhere, they don't all come from DC. Many of them come up through states. But I think the inherent powers and authorities of the federal government when it comes to health, and specifically public health activities, is in fact limited. They are constrained by how they can get things done. And what has evolved over time is this carrot and stick kind of relationship, whereby the Congress, largely, will identify some important problem—tuberculosis, or lead poisoning, or HIV, or any of a thousand other things—and they will provide funding for that, which the Centers for Disease Control, or some other agency, will then extend to states and localities through their health departments. But you can't take that money that's intended for tuberculosis and spend it on lead or HIV.

So in effect, if you want to acquire resources in this state, you go after whatever is available, whether it's your priority or not, and you try to do a good job. But you also probably try to find a way to cross-subsidize things for which there's no clearly earmarked funding source. The more resources you have, the more seeming flexibility you have around the edges to do things that would provide a benefit to all kinds of programs, rather than to just a narrow tuberculosis program. I mean, it is a lot of gamesmanship that goes on here. The federal government, its influence is, in fact, limited. And as I said, that goes right back to the Constitution; that's the way the Founding Fathers set this country up, and if they wanted health to be one of those enumerated powers, with the power to declare war, and things of that nature, they would've included it there, but they didn't. And that leaves it to the states to find how to do it, and the federal government to try to figure out a way to be helpful.

Czaplicki: So an informal constitution isn't powerful enough? You know, changed thinking or something like FDR's Economic Bill of Rights, which did mention healthcare as a right. You think it needs to be codified, like we would need an amendment to actually get a national system?

Turnock: Probably. (laughs) Yeah, that's why virtually all of our national health programs are flawed. They have to be operated through the states, and that gives you fifty different varieties and very, very great differences across the states in the way that these responsibilities are carried out. That's one of our fatal flaws—maybe not fatal, but it's a serious flaw when it comes to health. It's a serious flaw when it comes to the Affordable Care Act and universal coverage. It's an impediment.

Czaplicki: How about relationships at the state level with the legislature? Did you find that the state legislature had enough knowledge to effectively oversee the Department of Public Health? The nature of what you do is fairly specialized. Was it reliant on taking your word for what you did, or did they have their own…

Turnock: Yes and no. I suspect you know the answer to this question before you ask it. As a group, no. As a mass, no. But there's always some legislators who have an interest in a particular issue area, and to the extent that they're able to influence their peers and their parties and the larger political process, they can be very, very successful. And they know *a lot* about what you're doing. For instance, when I was involved in emergency medical services, there was one young legislator from Jacksonville who had kind of taken on the role in the General Assembly as the person most interested and most knowledgeable in local emergency medical services, and all of this trauma and EMT stuff. He was a bear with it. That was Jim Reilly, who later became the deputy governor and the governor's chief of staff, and many, many other things beyond that. So after I came there, we began working on legislation that would help codify some of these things that the national program wanted to see. He was really the legislative leader that made this happen; that bill got enacted, and it virtually institutionalized the emergency medical services program and solidified all of these pieces that were important to these communities. But there's someone like that on almost all of these issues. Some of them aren't very effective within their own peer group of legislators, so things may not percolate up to where things get done in a big way or you feel that the whole General Assembly is supporting what you do, but some of them really are.

Czaplicki: And how about at the staff level? Did they hire medical experts?

Turnock: You mean the legislative staff?

Czaplicki: Yes.

Turnock: The legislative staff are generally, I've always found, quite good. They really spend a lot of time learning this issue; they become very comfortable with the people like me and the program staff; they know a lot about the ins and outs of what's going on, and they clearly get a lot of input from the other side, kind of the non-governmental side, on all of this. I've always found that the legislative staff are generally young, very bright, hardworking, and quite knowledgeable about the issues, and very valuable allies throughout the process.

Czaplicki: Would the department have its own legislative liaisons, or would you work through the governor's legislative liaisons?

Turnock: This may vary from time to time. In the time that I was with the Illinois Department of Public Health, there was always a legislative liaison. There would be at least one, maybe two or three people, who would work largely for somebody out of the governor's office in terms of coordinating the overall legislative agenda. But they would run the interference; they're the ones who would handle the day-to-day contacts with legislators and make sure legislators got matched up with the right persons or programs. Yeah, that was a regular activity in those days, and I'm sure it is now.

Czaplicki: Aside from Reilly, were there other significant legislators who would carry your bills for you or shepherd them through? Or did they just do it on a program by program basis?

Turnock: There's a lot of turnover there. For a good while, Denny Hastert was our point person for the budget, and Denny was very interested in public health activities. He went on to bigger and better things in here. There's also people on the opposite side. When I was director, some of the issues we had with AIDS and HIV, Penny Pullen was just the total antagonist of everything we ever wanted to accomplish. (laughs)

Czaplicki: So Illinois's equivalent of Jesse Helms?

Turnock: Probably even—well, very much along those lines. But she was very much behind a number of the very objectionable—to public health people anyway—legislative proposals, including the mandatory premarital licensing act that got implemented for a year and a half or so. But there's lots of others. A number of the legislators were very interested in rural public health issues, and I remember several field trips, might call them government junkets, but field trips to other states like North Carolina or Washington state, that involved very knowledgeable young reps like Tom Homer, Tom Rider, and Dave Phelps. So there's lots of opportunities to interact with the legislators.

Czaplicki: Any other strong nemeses stand out? Nemeses might be too strong a word.

Turnock: Later on when I became director, and because I'm not quite apolitical. Most public health people lean a little bit to the left; we're a little bit more liberal or progressive with a lot of these social issues than some others are. A number of the Republican leaders, including the Senate president, Pate Philip, always had me in their targets. I always vote Democratic in primaries, and they always had a way of knowing that at the time. And although I envisioned myself to be apolitical, when it comes to elections, I often vote Democratic. So they thought I was just an out-and-out socialist, you know? It wasn't personal, though, I will say that. I mean, it was difficult at the time, but in later life, when you get to know these people outside of that kind of setting and arena, it's business. It's just political business.

Czaplicki: Did you become friends with anybody from the legislature?

Turnock: I've known John Cullerton for a long time—he used to date my wife before I did. (Czaplicki laughs) I've known him because we used to hang around the same circles for a while. He's the only one that I think I've known for a long period of time. I've never really befriended legislators; it's kind of outside of my normal comfort zone.

Czaplicki: Thinking about all of these different functions that public health is exerting, which sometimes overlap with other agencies, was there much jurisdictional conflict with these other agencies? Did you get along better with some than with others? What kinds of issues would you struggle over?

Turnock: There's always the potential for conflict, and I think that's what a number of the governor's office staff were there to deal with and prevent. And there were some big egos in those days; I'm sure there are now. But many of our issues involve the other human service agencies, and especially Public Aid.

Czaplicki: That's what I was particularly interested in.

Turnock: They had a very influential and aggressive director, Greg Coler, for much of that time. And so we had a number of conflicts, often in the area of nursing home regulations, because the state health department licenses nursing homes but the Department of Public Aid certified nursing homes for participation in the Medicaid program, to receive Medicaid funds. We have some nurses doing licensing stuff, some nurses in the other department doing Medicaid certification stuff, and they have different views at times of what goes on in these nursing homes, and what should be done, what sanctions should be taken, and why the other guys aren't doing their job. And that seemed to go on pretty regularly because the Medicaid expenditures for nursing homes are a *significant* budget item.

Czaplicki: Another area of overlap, if I understand correctly, was Public Health controlled the WIC program and Public Health's planning office was responsible for setting Medicaid reimbursement rates. I think it was the planning office, could've been a different division—it eventually moves.

Turnock: Yeah.

Czaplicki: But when you're there in the late seventies.

Turnock: Yeah, there was an Office of Health Finance, that's correct. I think it was there the first time I worked with the state health department, in emergency medical services and maternal and child health. And when I came back as director, it was moving then.

Czaplicki: I was wondering how Public Aid felt about Public Health exercising these functions. I would imagine they thought they more properly belonged to them.

Turnock: The size of your budget dictates, to a large extent, your influence in Springfield. Nobody was bigger than the Department of Public Aid at the time. So their influence in the governor's office and with other agencies whose actions they may attempt to influence was *great*. And that relates to their size; they were very important, and everybody paid attention to them. And they had a very, very, very aggressive director.

Czaplicki: What do you mean by that? What made Coler so aggressive?

Turnock: Well, I don't want to speak—Greg was an incredibly bright, ambitious man, and I think could handle big enterprises. He was the original Chris Christie, his attitude and demeanor; he was forceful, almost to where he's bullying you, because that's the biggest boy in town.[10] That agency is the biggest one, and Public Health, for instance, is just *tiny*. I'm sure we were less than a tenth of the budget of the Department of Public Aid.[11] (laughs) So when Public Aid would want something from Public Health, or from Children and Family Services, or from Mental Health and Developmental Disabilities, or from Aging, they often got what they wanted, because they were deemed to be more important to the state governmental enterprise than these smaller players. And that's a reflection of the budget and the attention that they get.

Czaplicki: So Public Aid would be trying to add programs, or add departments and divisions?

Turnock: Yeah, I think they would've wanted to license the nursing homes, in addition to certifying them for Medicaid participation. And they would advance a very reasonable argument: Why do we have two armies of nurses invading these poor little nursing homes (laughs) so frequently? Why don't we just combine these forces, and of course we can't give up *our* responsibility to certify for Medicaid participation, so we'll do it!

Czaplicki: Unfortunately we can't talk to Greg Coler or to Art Quern, so it's useful to be able to talk to somebody who saw some of these interactions. How did he compare to Quern?

Turnock: I've met Art Quern, but I don't recall working with him.

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[10] Reference to New Jersey governor Chris Christie, whose belligerent style received national attention.

[11] Public Health averaged 2 percent of Public Aid's general fund appropriations during the Thompson administration. For example, IDPH received $109 million in fiscal year 1991, its highest nominal total between fiscal years 1977 and 1991, while IDPA received $4 billion. In fiscal year 1986, Turnock's first full fiscal year as director, IDPH received $69 million versus IDPA's $3 billion.

Czaplicki: You might've been in Chicago when he was running Public Aid. I'm trying to remember the exact sequence.

Turnock: Yeah, I don't know if Quern came after Coler or Jeff Miller.

Czaplicki: I think it was Coler, Quern, and Miller, but I'll check.[12]

Turnock: Okay.

Czaplicki: Did you have many battles with Public Aid in your earlier period when you were at Public Health? Or were these things that you would've been observing when you returned to the department?

Turnock: The first time I was there, after I did emergency medical services for a few years, I became the maternal and child health program director, which is a little bigger and seemingly more important in the state health department.

Czaplicki: That was around 1980, right?

Turnock: Yeah, '80 to '82. And that's where I began to encounter some of the other agencies, because we were directed by, I think, the Women's Caucus to develop a plan for teen pregnancy and adolescent support services. That's something that obviously would involve the other human service agencies, especially Public Aid and Children and Family Services. That was my first kind of serious entreaties with them, and the perception then was this would have to be some sort of a multi-agency program that had facets in at least these three major agencies. Trying to scope that out in a way that would satisfy everybody was difficult, because teen pregnancy was a hot issue at the time.

Czaplicki: How about other important interagency relationships? I know that you cooperate with IEMA to work on the state emergency services plan. How did that relationship develop, and how was the labor divided?[13]

Turnock: There wasn't the kind of overall planning and coordination for emergency events then as there is now, in the last decade, with all of these serious threats, risks, and environmental disasters. The relationship with IEMA was, they were always in charge of emergency management. When there were emergency events, there were some that had public health implications, and we had people on-call and ready to assist them at the state level. All of these things happen at the local level, so you've got local health departments involved. It seemed to be a fairly straightforward, well understood

[12] Quern was Governor Thompson's first director of public aid. He moved to the governor's executive staff in 1980 and was succeeded by Jeff Miller. Coler replaced Miller in 1984 after the latter became Governor Thompson's director of planning. Quern died in a 1996 plane crash; Coler passed away in 2010.
[13] Illinois Emergency Management Agency (IEMA).

relationship. There didn't seem to be a lot of territorial conflict. They were the Emergency Management Agency, and we played a secondary role, depending on what the emergency entailed.

Similarly, with the Environmental Protection Agency, they were always less focused, as they should be, on the environmental health aspects and more on regulating the risks and potential risks within the environment. The environmental health staff at the state health department always worked very well with the state Environmental Protection Agency, and there were a fair number of people who would switch from one agency to the other. The regulatory activities that took place in the state health department were fairly well specified in terms of water and sewage, mobile homes, food inspections, and stuff like that. And the EPA would be out there regulating the air, the water, and the land, in fairly clear cut ways. I don't recall much conflict with them either.

Turnock: We did have a conflict at one time with the Department of Agriculture.

Czaplicki: That was another one I was wondering about because you're responsible for inspecting milk production and other dairy facilities.

Turnock: Yeah, this was around eggs. When Larry Werries was the director of agriculture—hard to remember the details, but… He went on to become US secretary of agriculture.[14]

Czaplicki: Just like John Block.

Turnock: There was a salmonella outbreak traceable to some eggs that were produced somewhere in the middle of Illinois. I can't recall the exact location. We took some action against that, and he, allegedly at least, in his press release, was concerned that we were defaming Illinois hens, giving them a bad name. This was bad for agribusiness. (laughter)

Czaplicki: Defending the honor of our hens?

Turnock: Yeah.

Czaplicki: Did you catch heat directly for this, or was this just something you heard about?

Turnock: Allegedly, he was going to take it to the governor, but no one ever talked to me about it.

Czaplicki: I'll be interested in the other outbreak, of course, that's going to get you back into the department, but we can talk about that next time. I think we have time

[14] Werries was director of the Illinois department from 1981 to 1989. He then moved to the United States Department of Agriculture during the Bush administration, serving as director of intergovernmental affairs.

for one more question. In terms of the state emergency plan, what would your contribution be? Would it be primarily informational, informing IEMA of what various capacities and types of centers existed, or would you have a role in communication and coordination?

Turnock: It'd be more operational. Again, depending on what the disaster was, but a lot of them have some sort of health implication. They all take place in some community, and the resources in communities vary but there's generally a health department. So when it comes to providing some sort of temporary support for displaced populations—maybe there's a flood and nursing home residents have to be moved, or homes get soaked and you're concerned about the effects of mold, or there's dangers with tetanus after some sort of tornado or something—they're there to provide technical assistance and often contribute to providing support services during rescues. It really depends on what the emergency is. It'd be different for a radiation emergency than for a tornado, or for a flood.

Czaplicki: Right. And that's another agency that I think spins off out of you, because initially, Public Health was responsible for nuclear safety.

Turnock: It did, yeah.

Czaplicki: Then a whole new department?

Turnock: Yeah, that's one of those specialized areas that actually came right out of our environmental health unit.

Czaplicki: Well, didn't get quite as far as we planned, but pretty close to the end there, so why don't we break today. And then in a future session, we'll pick up and get more into the details of what you're actually up to.

Turnock: Okay.

Czaplicki: Thanks.

(End of interview 1)

Interview with Bernard Turnock

IST-A-L-2014-013.02

Interview # 2: April 16, 2014

Interviewer: Mike Czaplicki

Czaplicki: Today is Wednesday, April 16, 2014. This is Mike Czaplicki, project historian on the Gov. Jim Thompson Oral History Project, and I'm back with Barney Turnock to continue our interview from last week about public health in Illinois during Governor Thompson's administration. How are you today, Barney?

Turnock: I'm doing fine, Mike, and you?

Czaplicki: I'm doing well, thank you. I want to talk some today about your time in Chicago, after you left your first stint at the state Department of Public Health. But before we get there, there were a couple major events I wanted to ask you about in the years before you left. The first event would be May of 1979, about a year after you're at the Department of Public Health. Illinois witnessed a major disaster, which in today's terms we might call a mass casualty event, when American Airlines Flight 191 crashed shortly after takeoff from O'Hare Airport, killing 273 people. Did the Department of Public Health have any role in responding to that disaster?

Turnock: I don't think the state health department had a direct role in that. Clearly, the Emergency Management Agency (IEMA) and the Chicago Department of Health played significant roles, as well as the hospitals that were in that general vicinity. I think we were indirectly involved because of our relationship with the Chicago Department of Health, with the EMS system, and with the hospitals that were involved, but we weren't involved as direct responders.

Czaplicki: How about the F4 tornado that struck Carterville and Marion in 1982. Is that something that Public Health had mobilized for? Or again, is that more of an IEMA mission?

Turnock: In instances like tornadoes, the emergency management agencies are the prime organizations that structure the responses. Local health departments, in those days, played secondary roles, often helping coordinate support services for victims: food, occasionally being involved with testing facilities for people to move back into and the water supplies, and providing tetanus shots. In most instances, the local health department is the direct provider of those kinds of health and public health services as part of the response organized by the emergency management people.

Czaplicki: Are events like that important in retrospect? Do you study the response to make assessments of capacity for hospitals?

Turnock: That's an evolving area that clearly has gotten much more sophisticated in the last ten or fifteen years. If we look back to the seventies or eighties, when we did have a lot of natural disasters, the responses were generally focused on the immediate needs of the populations, and less so on using those as learning experiences and having formal after-action plans and exit conferences to better plan how to respond in the future. We've come a long way in the thirty years, but I don't recall those kind of components being present in the 1970s and eighties.

Czaplicki: We discussed trauma centers last time, and your work establishing those in the state. Were there any other activities that you were responsible for that you think would be worthwhile to talk about?

Turnock: After I did a couple of years in the emergency medical services division, I became director of the state maternal and child health program in another division; I think it was called the Division of Family Health at the time. There's a national federal program for maternal and child health services, and we administered that grant here in Illinois. At the time, services for teens who were pregnant or parents was a particularly hot item, and I think especially the Women's Caucus in the General Assembly had that as one of their priorities. So we were involved with the Women's Caucus, as well as with some of our sister agencies like Public Aid and Children and Family Services, in developing the framework for a statewide plan that was eventually implemented a few years later.

Czaplicki: Was this Parents Too Soon?[15]

Turnock: Parents Too Soon, and the Ounce of Prevention Fund and Irving Harris's philanthropic contributions began to greatly expand programs for pregnant teens and teen parents.

Czaplicki: Why was that a hot issue, as you call it, at the time? Were rates soaring? Was it just something that people decided its time had come to address?

[15] See Jeffrey Miller, interview by Mike Czaplicki, June 15, 2015, and July 7, 2015.

Turnock: Well, I don't recall any precipitating events, and in fact, I think the history of teen pregnancy has shown over the decades that it's been steadily declining. But it was an issue that the Women's Caucus had picked up on; they felt it was getting less attention than it should, and they made it one of their priorities and pushed the state agencies and their fellow legislators to take it seriously. When they do that, the state agencies attempt to respond.

Czaplicki: How do they do that? Is it informal buttonholing, or is it formal resolutions directing the department to take certain actions?

Turnock: In those days, the Women's Caucus would hold their own hearings and bring the state agencies and the state agency staff into those hearings, try to get information, and use that as the basis for making broad recommendations back to the governor's office and the state agencies. Those were things that agency staff definitely needed to pay attention to in order to maintain good relations with the elected General Assembly members.

Czaplicki: Did any particular legislators within the caucus stand out in your mind as a prime mover of this?

Turnock: Barbara Flynn Currie was actually the prime mover there, and was the chairperson of the Women's Caucus at the time. I could be wrong, there may have been several people who co-chaired it, but I remember attending a number of sessions in which she played the lead role.

Czaplicki: Why the gap between these initial efforts and when Parents Too Soon got implemented? Were the programs already on the books but relabeled?

Turnock: I think it had more to do with the availability of funding to do those kinds of things. I don't recall the specifics, but the early eighties were an economically difficult time for state government.

Czaplicki: Yeah, we have our budget chart here.

Turnock: I think it was the opportunity. But what we were able to do was develop a plan that subsequently became the framework for Parents Too Soon, which was one of the initial cross-departmental programs where all three agencies—Public Aid, Children and Family Services, and Public Health—were the co-conspirators directing the program and carrying out the activities that would be distributed among those agencies. It was one of those efforts that extended beyond a single department, and that always makes it more complicated.

Czaplicki: And you said it was one of the first efforts to do that.

Turnock: It's one of the first ones that I recall in the health and human service areas, where usually, programs are siloed into a particular department and that department owns the problem and the solution. And I think the recognition that came out of the Women's Caucus was that this problem required interventions across a variety of state agencies, so it needed to be an interdepartmental type program. Subsequently, that's very much what happened.

Czaplicki: Were you the point person for Public Health in putting together this plan?

Turnock: Yeah, I was the director of the maternal and child health program in the division, so we were the program unit within Public Health that was central to this. There were units within Children and Family Services and Public Aid as well. But I think teen pregnancy was viewed in terms of its health implications more than anything else at the time, rather than its social, educational, and other important facets. So we were more or less the lead unit for putting this plan together.

Czaplicki: Did you draw on the experience of other states, or were there other programs that you looked at when you were deciding what should go into this mix?

Turnock: Very much so. It's a problem that's probably more serious in some other parts of the country, and there were states that had begun to move on it, especially some of the states on the East Coast—New York State especially, and some others. We certainly drew upon those experiences.

Czaplicki: Ultimately, when it does get funded, where is most of the money coming from? Are private monies playing a big role at this point in time?

Turnock: A lot of it came from the Department of Public Aid, which is a huge funder through Medicaid and a variety of other programs. Some of it came from Public Health, some of it came from the funding sources for Children and Family Services. There was significant interest in some of the private funders, again, especially Irving Harris and his foundation. It was kind of a public/private partnership that parlayed health and social welfare resources and private dollars, and very quickly developed a large scale program that got a lot of attention at the time.

Czaplicki: Yeah, I saw frequent references to it, and obviously something the Thompson administration was very proud of. When you're cobbling together these different functions, was this something the agencies saw eye-to-eye on, or did the tendency to silo things make it difficult initially to get everybody working together?

Turnock: No, this is very much of an endeavor that everybody sees there's an important role that they can play. I think people at the program level, like I was at the

time, aren't too concerned about the higher level—who's in charge, and who makes decisions, and who gets the money from whom. So planning the program was a very positive experience among program staff who really saw an opportunity to expand what they were doing within their agencies, as well as tap into expertise and resources that were in other agencies. It was actually one of the more positive experiences in my life in government.

Czaplicki: As you developed these plans, was the governor's office involved much in the process, or were those legislators involved in the process, or was it something where you put it together then reported?

Turnock: There was a large interagency task force that did most of the work. The governor's office was always involved in this. And certainly when there's more than one agency involved, they like to make sure that agencies don't get at cross-purposes to each other. But the plan was put together just before I left state government, and really, it didn't get implemented until about the time I came back several years later.

Czaplicki: I think it officially starts in '84.

Turnock: As I said, we developed the plan, and then the economic opportunities appeared a few years later; so a plan was already developed, and they took it off the shelf and put it to work. It just didn't get implemented at the time it was planned. It sat around for a while until the skies brightened a bit, but it was ready to be implemented a few years later, and was.

Czaplicki: That seems to be a common theme in policy history. Oftentimes, programs are developed and sit on a shelf, as you put it. Were there other programs like that that you can recall at any point in your time in state government?

Turnock: I've always been involved in plans. One of my personal philosophies is to leave something behind that kind of institutionalizes things. We did that in emergency medical services with a state EMS plan that got a lot of attention at the time, and that drove our program efforts. And in the maternal and child health position that I held, the teen pregnancy plan. Then down the road, there were others. Institutionalizing things is an imperative, rather than doing things and then not having something live on after you've moved on to something else.

Czaplicki: I wonder if you could be a little bit more specific about what you mean by institutionalizing. Is it enough to have a plan, or do you already need some seed funding?

Turnock: A plan precedes a program, so good planning often results in good programs down the road. Institutionalizing is having a program that has its own constituency and stakeholders and successes and sustainability characteristics,

and those are the things that live on after people move from one position to another. So building a program is more than just putting it in place, it's having adequate preparation ahead of time to make it work and to make it sustainable.

Czaplicki: I did note that in 1987, Parents Too Soon won a pretty major award from the Kennedy School of Government, the Innovations In American Government Award. Whose idea was it to apply for that? Was that something the administration asked you to do, or did you do this on your own?

Turnock: I don't recall doing it on my—it's probably something the governor's office did. The three state agencies were heavily involved in it, and I think there's always an interest in drawing attention to your more successful programs in state government. And this, I think, was one of them. Got a nice letter from President Reagan, and we won the award. But the award doesn't come with anything other than the external validation and recognition that this program makes sense.

Czaplicki: That's what I was going to ask you. So it's mainly recognition and morale? It doesn't yield greater funding, or people don't start beating a path to work in Illinois state government because of these innovative programs?

Turnock: I mean, it validates the program to the people who work in it, and I think that creates additional value for the program, as it's perceived on the outside. I think it encourages greater participation by the many community agencies, you know, the CBOs that actually provided the frontline services for these programs. The state agencies aren't direct service providers by and large, and so we all work through a network of community-based organizations. The state health department [works] largely through local health departments, but through other agencies as well. And Public Aid and Children and Family Services have their own networks of community-based agencies. So I think it encourages those organizations to become involved, or to stay involved in the program, and it has a value there for the program. It has some public relations value, but I think it has some program sustainability and visibility characteristics that are important.

Czaplicki: Public Health's budget is fairly small relative to many other agencies. The community health organizations are incredibly important, it seems, to carrying out your work on a daily basis. Was that something that most communities saw a need for, or was it a struggle to get communities to set up public health organizations?

Turnock: In terms of public health organizations, there are statutes that determine how these are setup in various—largely counties, but they can be setup in municipalities and other kinds of districts, or in multi-jurisdictional arrangements. But those agencies themselves, depending upon the communities in which they reside, have other local agencies that relate to

them and provide a variety of services that the local health department may not provide. So this network kind of ebbs and flows depending upon what issues you're dealing with. Different organizations might be involved in teen pregnancy and parent support services, and other agencies might be involved in AIDS and HIV services. It kind of varies from problem to problem. And since the problems are perceived differently in different communities, different priorities, you have a different mix and match of players and partners in these networks. It's just constantly evolving as communities identify problems that rise to the top of their job chart, things they want to do something about now, and in those days, teen pregnancy was a hot issue.

Czaplicki: Would it be more accurate, then, to talk about multiple public health networks depending on an issue, rather than a single state public health network?

Turnock: Well, you can talk about both. From one perspective, you can look at it as a unified system in terms of the state and the local health departments and the local partners being part of a system itself, which is hopefully unified and working towards common goals. But if you look at it from the ground up, at the community level, you might see different mixes and matches of who's doing what in Will County, versus Lake County, versus Knox County, versus Jackson County. From the ground level, it looks a bit chaotic, but at another level, you would hope that there's kind of a unified structure in this, in which they relate to each other and define understandable productive ways, and that that persists over time.

Czaplicki: Were there any areas of the state that just fundamentally resisted the public health mission? I think of fifties and sixties battles over water fluoridation and things like that. Have those questions been settled, or were there still…

Turnock: Not completely. Illinois doesn't require all jurisdictions to be covered by a local health department, so to some extent it's voluntary, not mandated. And in the seventies and eighties, there were probably twenty or thirty counties that didn't have local health department services, because they hadn't established a local board of health, or their county board hadn't established a health department. So one of the goals of the state health department has always been to foster and encourage local jurisdictions to develop a local health department. There's been a steady development of new local health departments in Illinois over the last thirty or forty years, and it's really only a couple of areas, a very, very tiny percent of the population in Illinois today, that are not covered by a local health department. But there's been a conscious effort over recent decades to expand that network, make sure that there was a local partner in terms of a local health department, by the state health department and the other state agencies, because a lot of other state agencies operate their programs through local health departments—Children and Family Services, Aging, just to mention a few. They're vital cogs in the

wheel, and promoting them was always a priority of the state health department.

Czaplicki: As you mentioned, right around the time this program's getting set up, you leave; in 1982 you head off to take a position in Chicago at the city health department. How did that come about? I know you mentioned that you had always been looking for a Chicago opportunity for personal reasons, but was there anything more to it?

Turnock: A good job opened up, really, the number two job at the Chicago Department of Health. It was called the Chicago Department of Health at that time; it's now called the Department of Public Health. But the number two position really was kind of the lead public health person for the agency. The commissioner at the time was not a public health person, he didn't come out of a public health background, and he had always tried to rely upon some senior public health–trained physician to play a lead role with the public health programs, the regulatory programs, and the clinical service programs that the department offered. The position became open, and in terms of my interest and my wife's interest to move back to Chicago, we saw this as a good opportunity. I obtained that job and moved to Chicago.

Czaplicki: Did you already have a prior relationship from your work at the state level, and did that help you get that job?

Turnock: Well, sure. Certainly, being both emergency medical services director and maternal and child health director, you interact with health departments, and the Chicago Department of Health is the biggest health department and the most influential health department in the state. We had many, many contacts with the Chicago Department of Health and the commissioner. I had actually known the commissioner from my days of training in pediatrics, because he was an endocrinologist at Illinois Masonic Hospital, where I did some of my medical training and my pediatric residency. So I had known him somewhat.

Czaplicki: What was his name?

Turnock: Hugo Muriel.

Czaplicki: Muriel?

Turnock: M-u-r-i-e-l, yeah.

Czaplicki: In terms of relative size, Chicago Department of Health, state public health department, is Chicago bigger, or is Illinois?

Turnock: It depends upon how you count and what you count. In terms of budget, the state health department was considerably larger; in terms of staff, the Chicago

Department of Health was probably twice as big as the Illinois Department of Public Health. Very much consistent with their different missions, the state health department playing a significant role in funding other parties to carry out services, and the Chicago Department of Health being a frontline provider of many services, including lots of clinical services to Chicago residents.

Czaplicki: So how did your duties change when you moved over? Were you out in the field more?

Turnock: I certainly was out in the field—well, depends on which field. But my job in Chicago certainly got me out into all of the clinics at the time, because this was the beginning of many discussions about what role the Chicago Department of Health should play in providing direct clinical services. You know, whether they should be in that business, whether they should turn that business over to somebody else, whether they should merge with Cook County Hospital and its ambulatory services. There were lots of services that required attention. There's also a network of mental health clinics, I think it was nineteen or so mental health clinics, that the Chicago Department of Health operated at the time. Yeah, you got out in the field a lot, but the main job was largely a senior level management position down at the Daley Center, where the health department was at the time.

Czaplicki: One major issue that emerged and received national attention was the cyanide scare, when several people died from ingesting cyanide laced capsules of Tylenol. That really became a law enforcement operation under Ty Fahner's direction, involving every level of government law enforcement, but I imagine the health department had a role to play in that as well.[16]

Turnock: Very much so. And that occurred just a few weeks after I joined the Chicago Department of Health.

Czaplicki: That's something to walk into.

Turnock: Yeah, my time at the Chicago Department of Health was book ended around some major, major media crises in terms of public health. And there was a significant public health role with the Tylenide tampering cases, because—

Czaplicki: Is that what you call it, Tylenide?

Turnock: Tylenol. (laughter)

Czaplicki: Oh, okay. I didn't know if that was a term from the time.

[16] Tyrone Fahner, interview by Mike Czaplicki, May 5, 2015; James Thompson, interview by Mark DePue, March 30, 2015.

Turnock: No, I guess I'm combining the cyanide and the Tylenol. There was a significant role from the very beginning, because part of it was a public education awareness campaign that attempted to get that product out of people's homes and out of their medicine cabinets, to alert the public that they might well have purchased something that could have been contaminated before they bought it. We also played a role, in the Chicago Department of Health, with testing those products to try to determine to what extent there were additional tamperings that took place. We would collect the Tylenol that people were taking out of their medicine cabinets and homes, and test them at the city public health laboratory. And that's a kind of activity that attracts *a lot* of attention.

Czaplicki: Were you asking for people to turn their medicine over?

Turnock: That's correct, yes. There was a massive amount of testing of those returned products. Subsequently, we were involved—through the Chicago Board of Health, which establishes regulations—with creating regulations related to tamper-proof and tamper-resistant packaging. As you suggested, we weren't the lead agency in this activity, this virtually terrorist event. I mean, this is the first one I was ever involved with. But we played a secondary role in terms of the health, the public education and awareness, and then the eventual prevention and mitigation activities that followed. We were heavily involved, and I was the point person for the Chicago Department of Health in all of this. I had many meetings with the mayor, Jane Byrne, and got to know her.

Czaplicki: What was the atmosphere like, attacking this problem, among the agencies, among the mayor and her staff, and yourself?

Turnock: It was largely tense. I mean, no one knew what really happened, or how extensive it was, or where this would turn up next. And if someone did it with Tylenol capsules, they could do it with a hundred other capsules. You're always dealing with uncertainty and apprehension and fear. There was just a lot of activity until these tamperings subsided and there were no more, and it turned largely into a criminal, law enforcement investigation. And we went about our business of trying to learn from that as to what might happen, what we might be able to prevent in the future. Unfortunately, these things spawn copycat stuff that would occur. From week to week there'd be scares about this, that, or the other thing, and white powder that somebody found on the floor somewhere; they have to close the building down and get the police to transmit it to the laboratory to test it, [only to] find that it's sugar or some—

Czaplicki: Was that happening then too, or are you just referring to the 2001 anthrax events?

Turnock: Oh no, very much the same, very much the same; it very much mimicked what happened with anthrax many, many years later. All of these events,

where something gets this kind of attention, spawn copycat kinds of activities. And I think the timing of this was, really, just before Halloween that year, which just cast a whole different perspective on Halloween. Neighborhoods and communities were cancelling the trick-or-treating that the kids would do. I mean, there was a very high level of anxiety and fear and apprehension, and it lasted, probably, six months.

Czaplicki: And in ’86, there was another cyanide threat to Morton’s Salt, allegedly.

Turnock: Mm-hmm.

Czaplicki: Did anything turn up there?

Turnock: No, I don’t believe so.

Czaplicki: As part of your testing, were you also going out and doing spot checks within drugstores and grocery stores, or was that something you left to those firms to handle?

Turnock: Obviously, the drugstores pulled all of that product off of their shelves, so we would test that too.

Czaplicki: So they weren’t even selling it, they just yanked it off?

Turnock: Oh, no, no. There was nobody selling it, and hopefully nobody using it until the smoke cleared here. Johnson & Johnson was very forthright in the recall. They didn’t know that it was limited to Cook County, and primarily suburban Cook County; I think there was only one incident within the city. It was largely in the suburban collar vicinity. But Johnson & Johnson was immediate in terms of their actions in recalling it. We wanted some of it to test, to see to what extent this threat persisted beyond the seven or eight deaths that occurred.

Czaplicki: Does the FDA also do their own tests, or are they happy to get your data from those you conduct?

Turnock: I don’t recall specifically. I’m sure they did some, but we were very much the focal point for the testing, which drew, again, a lot of attention. Then the media would come in and criticize the way you’re testing, or [claim] you’re putting the testers at risk. Whenever you get involved in something like that and it goes on for a few days, the media tries to find a new angle and you become the antagonist rather than the protagonist.

Czaplicki: What was the substance of that criticism? Was it primarily putting testers at risk?

Turnock: Things like that, yeah, and the disposal of the contents. These are natural things, I think, when these stories last for more than a few days and there's a need for a new angle. As I said, it was a very tense time, and lots of activity. And when you get the police involved, it just raises everybody's level of concern about what's going on. They operate quite differently, and information is often hard to come by as to what's going on. It was a very, very memorable fall in 1982, right?

Czaplicki: Yeah. Could you say more about how the cultures were different? A law enforcement operation versus a public health driven operation. Did they have overall authority in what information you could reveal?

Turnock: This was a crime. There were deaths, and I think everybody would acknowledge that this is an instance, like terrorism today, where law enforcement ought to be the lead agency. You know, in those days—again, that was twenty years before 9/11 and the anthrax mailings—the relationships, the planning for these kinds of things hadn't really existed. So when you throw the cultures together without a clear plan as to who's in charge, what the command structure is, and the clear roles that the various players have, you have the opportunity for confusion and misunderstandings.

But in the last several decades that's changed, especially since the events of 9/11 and the anthrax. Now the planning for these things does take place beforehand, and people in the various roles are trained in how to work with each other and understand what the other unit is doing, and what kinds of practices and principles and statutes they're following to carry out their jobs. And they could be quite different from the things you think you need to do your job. So we made a lot of progress there. But in 1982, this is really the first major tampering resulting in death; it got such incredible media attention, involving such a huge corporation and a product that just about everybody has, it just took on dimensions that exacerbated the prior weaknesses in planning.

Czaplicki: Anything in that investigation that frustrated you?

Turnock: Being the point person for the Chicago Department of Health, I was very, I'll say, offended or upset with the media handling of the testing that we were doing. I didn't think that was fair. I think I understood what was going on, but I just didn't like to see the laboratory staff, who were working eighteen-hour shifts, take that kind of criticism from the media when they were clearly doing a public service the best way we knew how at the time.

Czaplicki: We maybe tend to use the word hero too easily, but any unsung heroes from this investigation? Anybody working under you at the agency, or testers, that stood out?

Turnock: Clearly, the laboratory staff. I think the laboratory director was Hyman Orbach. They did a great job. These were crisis conditions, and under the microscope of the media and the public, and fears and expectations were high. That's a tough job, and they did well.

Czaplicki: Was this something your training had prepared you for at all? Back when you were in your education programs in public health, was it…

Turnock: To some extent, the public health training, and my work in emergency medical services, and just my involvement with local health departments. Crises occur; they take all kinds of forms, you never can predict what's going to happen, and you're not always totally prepared to deal with them. So a large degree of uncertainty about what can happen. Things can happen that we never thought can happen, and they do. Yeah, that's part of the business, I think, especially being a frontline agency, where you have to respond, you have to do something, and you have to make this part of a concerted plan.

Mayor Jane Byrne very much impressed me at the time in terms of her ability to see the big picture and not view this as purely a law enforcement issue, or a relationship with Johnson & Johnson issue, or a health communication issue. She saw how all of these pieces needed to be put together, and she was very forceful in getting the people that she managed—police, fire, health department, consumer affairs, legislative people, and everybody else—on the same page. And she was in charge.

Czaplicki: You've addressed this a bit in various ways, but aside from the technical capacity in responding, it seems that the Department of Public Health has a very important symbolic function too—just reassuring the public that something's being done. I'm struck when I'm looking at the press coverage, all of these photos of testers, the dominant image is people in lab coats working with fancy equipment. Was that a function you were conscious of at that time, and is that something you tried to cultivate, whether through press contacts, or giving access to photo ops for the lab, and things like that? Is that part of the response?

Turnock: Well, yes. I mean, it's very much part of the response. Public health agencies should be credible spokespersons relative to the health issues associated with any big event or crisis. That's very important. Did I know it then? Not nearly as much as I know it now. (laughs) But events like that certainly train you in terms of media relationships, crisis communications, what you should be saying regardless of what question you're asked, and things of that nature. It also was my first real experience in Chicago with Chicago media. I became very conscious after that of trying to cultivate the media by being very accessible to them on far less important things, so that when the next crisis occurs, they're not going to necessarily come after you, but they'll come to you to help shape how they're going to report and respond to these things. I found the Tylenol incident very instructive along that line. So I did spend my

time in Chicago trying to make sure that if they had an issue that related to public health, they knew they could contact me and I'd take the time to talk to them on-air or off the record about things that would help them do their jobs better.

Czaplicki: Were there any outlets or particular reporters that you had fairly good relationships with? Or warm relationships?

Turnock: I like to think I had them with all of them. (laughs) No, I don't think you can play favorites in Chicago when you have the three networks and WGN and others. You try to be fair to all, but each of them has one or more reporters they assign to health issues, who you become more familiar with and comfortable with. There were a fair number of those. Barry Kaufman, for years, was the health reporter at NBC; Maryann Childress was someone who was always very interested in health issues. You have to cultivate relationships with the investigative reporters—Pam Zeckman was very prominent, has been very prominent forever. It's more of a universal approach than one that's targeted towards having a specific friend; there's just too many of them.

Czaplicki: Yeah, I guess I meant more if there were reporters that stood out to you as being particularly interested in seeing your mission, or maybe got it better than others did.

Turnock: Health issues kind of come in two different forms. One is the kind of everyday useful information about some interesting little problem that occurs, where they need background and context, and maybe referral to somebody who's especially knowledgeable in that area. The other is these big incidents where health is part of some sort of a larger crisis. And the health reporters that come, as I said, are kind of common. Each outlet will have two or three that you generally deal with because they get assigned those kinds of minor issues. When the big stuff hits the fan, it's all of them, and it's often reporters who you've never dealt with before, because there'll be two or three reporters from the same outlet assigned to the same big story. So you have more difficulty in those circumstances.

Czaplicki: Is there a way that crises help the public health mission in terms of public appreciation for the department? I don't think it's a department people tend to think about very much, and as we've talked about, the budget is relatively small. How important are crises?

Turnock: Unfortunately, they're very, very important. Public health is largely a background operation; it's invisible, as we say. It works best when it prevents things from happening, and you know, you don't get thousands of people who didn't get measles going down and circling the Capitol about public health funding. So there's some inherent obstacles built in to its overall purpose and

mission; therefore, it does tend to be under the radar and not fully understood or appreciated. But then when something bad happens, when some big event happens, some crisis occurs, it's brought to the forefront and becomes a suspect for whatever failings it might have contributed to the crisis. But that helps, that draws attention to what public health does on a regular basis. And as I've seen over the years, it often provides the unique opportunities for that increased attention, visibility, and expectations from the media, or the public, or political leaders; it results in additional resources, and it helps move things along. Crises are not predictable, not necessarily avoidable, but they do have a silver lining on occasion. We've seen that in Illinois and in many other places, where when it appears that the system fails, more attention and more resources are given to the system to do better.

Czaplicki: Are those changes in resources durable, or do they fade when the panic over the crisis fades?

Turnock: Often, what happens is that as no new problems occur, we lapse back into this undervaluing and underappreciating and underrecognizing what public health does until the next crisis. But some of those things do endure; they help build capacity and expand the system, build new programs that take on a life of their own, and those persist. But as those things fall out of the public's eye, then the level of understanding, appreciation, and external support for the public health activities declines somewhat. So you could say we go from crisis to crisis. That's a bit of an overstatement, but it's at least partly true.

Czaplicki: The next year, July 1983, Mayor Harold Washington, the new mayor of Chicago, taps you to be his acting commissioner of health. And in doing so he says, "I think you can look for changes in every department where red flags have popped up lately," and he included the Department of Health as one such department. This criticism was echoed by his transition team, which issued a report that was fairly scathing of the department under Mayor Jane Byrne. Dr. Quentin Young was the chairman of the transition taskforce, and he said the department, "Abandoned the commitment that was a long tradition of the city to public health. It became, perhaps, the preeminent example of patronage politics." So I was curious what your feelings were about that line of criticism, particularly since you just had pretty high words of praise for Mayor Byrne. To what extent was the transition report an accurate document, to what extent was it a political document, and did you have any role in shaping that report or drafting it?[17]

Turnock: I would need to provide some context for the transition report, and some context here in terms of city government in Chicago. I don't think it's news to anyone that for decades and decades, jobs in city government were influenced

[17] Washington quote is in David Axelrod, "Sewer Boss May Be Out, City Spokesman Hints," *Chicago Tribune*, July 7, 1983; Young's is in Tim Franklin, "Study Calls City Health Services 'in Disarray,'" *Chicago Tribune*, July 22, 1983.

by who you knew. And patronage positions are abundant in many, many agencies. The Chicago Department of Health wasn't the largest city agency, but it's probably fourth or fifth behind police, fire, and streets and sanitation. So it's one of the bigger ones. And they had two thousand positions, probably more than that, during many of those years. It was ripe for people to get their positions there through political influence, and no doubt, there were a significant number of patronage hires in the Chicago Department of Health when Harold Washington became mayor. That's not an indictment of Mayor Byrne. I mean, she grew up and lived in that system, as did her predecessors, and certainly the original Mayor Daley. This should not be news to anyone, and I don't think it was news in 1983 when Harold Washington became mayor and the transition team identified the Chicago Department of Health as a significant location of patronage hires. That's no doubt true.

Czaplicki: But what about the linkage that, Okay, we know all the departments do it, however, it's corrupted the public health mission. Right? That seemed to really be the thrust of the critique: it wasn't merely the existence of these workers, but…

Turnock: Well, I know Quentin Young. I've known him since I was medical student and went to medical school with his daughter. He's a mentor and a heavy influence on me, and many other public health people. He's a strong, active advocate for public health and sound public policy. And I think the transition report reflects his desire to make the Chicago Department of Health more effective in carrying out its role, identifying some of the issues that might constrain it, in terms of it being a haven for patronage hires who might not be effective in carrying out their duties. All of that, I think, is fair. I do think it's a little unfair to generalize beyond that and in a blanket fashion criticize all of the employees of the Chicago Department of Health, because there were a good number of solid, well-trained, committed, hard-working people. You can't paint everybody with the same brush, and you can't necessarily pin all of the shortcomings of an agency on patronage hires.

But in general, those statements are true, and certainly Mayor Washington came into office as a reformer and wanting to turn around agencies. The Chicago Department of Health is a very important agency in terms of providing services on the South and West Sides to disadvantaged populations—those without health insurance, who can't be served by physicians and hospitals that only accept insurance card-bearing clients. So Mayor Washington did look to the health department as an area that could, in fact, be improved. And the economic environment wasn't good at the time. There were significant budget issues, and there was a need to cut back. That's virtually the first thing that he did with the health department, and with a number of the other city agencies.

Czaplicki: So when he said red flags, were there any notable issues in how the Department of Health was conducting its mission that did need to be

reformed, especially from what you had seen, having already spent a year there?

Turnock: The Chicago Department of Health is a huge operation. The bulk of its employees provide direct health services through neighborhood health centers, maternal and child health clinics, and the mental health clinics. It had assumed this role out of an attempt to meet unmet need in these communities, but it operated somewhat independently of the other healthcare providers and didn't really function well within a system. So greater coordination with the community hospitals, or with Cook County Hospital, Fantus Clinic, and some of the ambulatory sites that the county operates, have always been opportunities to enhance or improve services to the disadvantaged populations in Chicago. Is that a red flag? That's been a red flag forever. It's a red flag today. Yes, that's an area in which things could be done better.

But the Chicago Board of Health itself has a long history of credibility and progressive actions going back to the early 1900s. And Chicago for a long time, in the first two-thirds or three-fourths of the last century, was viewed as a very dynamic, progressive, urban health department, much like New York City's Health Department is viewed. So some of these criticisms have a little political tinge to them; some of them relate to larger health systems planning that really didn't take place because the city and the county and the hospitals have their own separate agendas that they like to act upon, rather than constructing a common agenda. These are criticisms and ways that things could be improved. And Dr. Young and the transition team, in a very progressive fashion, outlined some of these things.

Czaplicki: Did you have any role in drafting the report, or were you interviewed for it? How did that process work?

Turnock: No, they definitely interviewed me, but I was part of the establishment, the administration. As I said, I knew Dr. Young and actually had been on the board of his organization, the Health and Medicine Policy Research Group, for probably two decades out of the last three or four. He certainly interviewed me and many other people. And he was actually nominated by Mayor Washington to be president of the Board of Health, and that didn't materialize.

Czaplicki: What happened there?

Turnock: I think it ran into some political difficulties with the City Council.

Czaplicki: As part of the Council Wars?

Turnock: I believe so.

Czaplicki: So not necessarily a strong objection to Young as Young, but more stick it to Harold Washington?

Turnock: There's some semblance of both. Dr. Young is very progressive, viewed as a very liberal proponent of public health and public policy, and very outspoken. Very much involved in civil rights activity—marched on several occasions with Martin Luther King and organized the Physicians for Social Responsibility—and I think is viewed by some of the City Council members as a *very* liberal, left-leaning individual. If the mayor wanted him, they would find a reason to object.

Czaplicki: Would this be Vrdolyak and Burke, people like that, or was someone else handling public health for the council?[18]

Turnock: I don't recall the individual leaders, but I think it was an effort to prevent Mayor Washington from advancing that kind of an agenda through the Board of Health. Since the president of the Board of Health had to have City Council confirmation, they made it difficult, and eventually the mayor, I think, withdrew that nomination.

Czaplicki: Who ended up getting it?

Turnock: That's another test of my memory. It may have been Jorge Prieto, who was a very well-respected Hispanic family physician operating out of the county system.

Czaplicki: The transition report, then, was it primarily a political document, or did it actually lay out concrete policy recommendations for reform as a programmatic guide?

Turnock: I'm not sure of the details of it, but I'm sure it would've called for collaboration or merger with the county to create a more systematic, governmentally-based approach to care; to coordinate the daytime clinical services of the Chicago Department of Health with the Cook County Hospital, and at that time, Provident Hospital, which was part of the county system, and no doubt other hospitals. I think those were some of the more general programmatic proposals in there. I don't know what it had to say about patronage stuff, but in fact, as soon as the mayor took office there were a number of firings. I think there were 150 or so in the health department.

Czaplicki: Yeah, 151 cuts in public health staff out of a total layoff of 734, so 20 percent of the total layoffs in 1983 to help balance that budget. How much of that was true austerity, and how much of it was, Well, this is a great excuse to get rid of some of these people?

[18] Edward Vrdolyak (10th Ward) and Edward Burke (14th Ward) led the regular Democratic majority in the council, rejecting Washington's appointees and blocking most of his legislative proposals. This stalemate, which ended in 1986 after a court-ordered remap and special election in several wards, is popularly known as the Council Wars.

Turnock: I'm not sure to what extent either of those filtered into it. They were given the direction to reduce the size of the staff and to do an assessment of where those cuts could be most successfully done, in terms of minimum damage to the department's programs and services. That task fell to me as the acting commissioner, and I actually personally met with everybody that was let go. One of the most difficult experiences of my life, because everybody lives on the precipice, and losing a job is a huge thing, a huge event in their lives. I felt personally responsible, since I was authorizing these cuts, to meet with everybody who was cut, to explain as best I could what was going on and why this had occurred, and to wish them well.

Czaplicki: How long did that process take?

Turnock: Several weeks. Then, as you would imagine, a number of these employees felt that these cuts were based upon political influence, and in view of the previous Shakman decision, several of the employees sued. Part of my tenure as acting commissioner was spent before Judge Bua, defending cuts against the charges that they were politically motivated. You could argue that if there were patronage hires who did nothing, or who did little, and then they were terminated because they were patronage hires who did little, that some of these employees would charge that that was politically motivated. And we would argue that it's because they did little.[19]

Czaplicki: So that's not something your legal counsel could just handle, you yourself had to go to court and justify the firings?

Turnock: That is correct. I mean, it was a handful who initiated the proceedings, so yes, there were several—I probably spent, I don't know, more than a few weeks in front of Judge Bua in those cases. We won them all. But it was a learning experience, explaining to these individuals—and again, not all of them were by any means patronage or influence hirings. Some were positions and programs that were less needed; they might duplicate things that were available elsewhere in the community, or we could reduce costs by shifting responsibilities from units or hiring more full-time people and letting go part-time—it's just all kinds of strategies in there to meet the budget targets that the mayor had established, based upon the economic conditions at the time. But it was heavily involved in carrying out the reduction in force.

Czaplicki: Those were such deep cuts, I'm going to assume that there's only so much duplication and things that you can find. So it sounds like some programs, probably, took a hit as well. Were there any in particular that bore the brunt?

Turnock: Well…

[19] Nicholas J. Bua was the federal judge who extended the Shakman decree to bar political affiliation as a basis for hiring qualified public employees.

Czaplicki: Or did you just go across the board at that point?

Turnock: No, they're largely targeted. The health department operated an extensive network of what they called neighborhood health centers and smaller clinics. So to some extent, we could save money by consolidating some of the smaller clinic operations into the larger neighborhood health centers. I think that was one of the primary focuses. There were several mental health clinics that we felt were less necessary or needed in the communities than in others, so those might be closed. I don't know if that's the point where we gave up the—it may have been when we opted to discontinue providing our own laboratory services and enter into an agreement with the state health department to provide us with the public health lab services, and to use hospitals and others for the clinical lab services. There were just lots of bits and pieces. A big complex agency, and 150 positions against the backdrop of—I don't know what it was at the time, it was over 2,000. It's large, but it's not huge in comparison to the number of employees. It's not, like, 50 percent of the staff, it's probably not even 10 percent of the staff, but it's a significant…

Czaplicki: Seven or eight?

Turnock: Yeah.

Czaplicki: The city was also running its own network of mental health clinics in addition to the state Mental Health and Developmental Disabilities institutions? Or were they integrated as part of the state program?

Turnock: A little bit of both. The funding for the city mental health clinics would come partly from the state's Department of Mental Health and Developmental Disabilities. But it would also get some city money. It would be a combination. Plus, the city health services can charge people who are able to pay or have insurance, and there's a sliding fee scale. So there's a variety of funding sources, but it was a combination.

Czaplicki: You got sued by a handful of employees. How about the broader communities that were losing their neighborhood health clinics, or the press; did you receive a lot of heat for these actions?

Turnock: I don't recall there being a lot of media attention to this. These were reductions going on in a new administration that media and maybe the civic community would find desirable, healthy. Certainly, the communities in which there had been a facility that was closed or consolidated with another would be upset, and they would express concerns about it, sometimes directly to me and the health department, or the Board of Health, or their alderman. So these things would often come up in hearings at the City Council level, where an alderman whose district was affected would kind of go after—you know,

go into this and try to get a better understanding of what decisions were made, and why their unit was cut and one in a neighboring aldermanic district wasn't. Yeah.

Czaplicki: So no pickets of your office or anything like that?

Turnock: No, I don't recall any of that. And again, behind this was a mayor who largely represented communities in which these services were being reduced. I'm sure he took a lot of this heat, but he's much better able to deal with those kinds of things than his agency heads. It's not his agency heads that are necessarily doing this, they're doing it at his behest.

Czaplicki: Did you get a chance to have many conversations with Mayor Washington about public health?

Turnock: I did.

Czaplicki: And its place in his list of priorities, and its role in the city?

Turnock: Yes, during the time period in which I was the acting commissioner, I met periodically with Mayor Washington. He was very much interested in health issues. I think he saw that as very important to the congressional district that he came from and the communities that he was most concerned about, and it probably represented his major power base, politically. So he was always very concerned about health issues, but very rational, very reasonable, very bright. Very bright.

Czaplicki: Yeah, how was he personally, just dealing with him?

Turnock: He has a very infectious personality—or he had a very infectious personality. He was always uplifting to be around, you know? I never saw him in a mad, angry, depressed—I mean, he was a positive individual.

Czaplicki: Since we're talking executives that you worked under, how about Mayor Byrne, what was she like?

Turnock: Mayor Byrne was a very serious person. Despite her diminutive stature—she was very short and slim—she's one of the most intimidating people I've ever encountered. She's just strong, willful, clear, direct—she was the boss.

Czaplicki: Did she have the same appreciation for public health that Mayor Washington had? Or did the nature of their constituency give it a different priority?

Turnock: That's very difficult for me to say. I didn't have that many contacts with her, because our terms kind of overlapped by a few months, really. I came in the fall of '82, and she lost in the winter of '83, in the primary. So I didn't have a

lot of contacts with her about public health, but from what I had seen from the state level when I dealt with the Chicago Department of Health, it wasn't one of her major priority areas. She was much more into public safety kinds of stuff and seeing that Streets and San did their job, the snow got removed; she was into public services being provided, and keeping the citizens pleased with the level of service they got from city government. In the grand scheme of things, not a lot of Chicagoans get services from the Chicago Department of Health. Some do, but it's disproportionately in the poorer communities. But it's not three million people that get services like streets and san, and police and fire, and those seemed to be her major interest areas.

Czaplicki: There's often a racial disparity as well, correct?

Turnock: Yes, very much.

Czaplicki: How about Jim Thompson? I mean, not a mayor, but a governor. What was he like, and where would you say public health fell on this agenda?

Turnock: In many respects, Jim Thompson had the best of all of these characteristics. I mean, in comparison to Jane Byrne, he was a giant. Imposing and impressive, and just by virtue of his physical stature, I think he could be intimidating. But he had a very engaging personality—again, very, very smart. I think his father was a physician, so he had a lot more native knowledge about health and the health system, and the docs, and the hospitals, and how these pieces fit together. And social policy-wise, he was at least a moderate, probably more progressive than many moderates. He often sought to expand programs in health or in the human services areas, and these seemed to be significant priorities for him. He kind of combined the best features of a lot of the other chief executives. He's bright, engaging, but can be imposing. Clearly in charge. And he had a little bit of a different management style; he kind of let agency heads have a lot of autonomy under his general direction. He would hire good people to interface with the agencies and keep track of them, so he knew what was going on. But he didn't run things on a day-to-day basis. I mean, Mayor Byrne's fingers were heavily into the agencies, and I think Mayor Washington as well; I think he was perhaps suspicious of what was left in the agencies after he replaced the top people, whether the rest of the organizations would move in the directions that he wanted.

Czaplicki: How would that manifest itself? Just more frequent meetings, or would his chief of staff come around?

Turnock: Mayor Washington?

Czaplicki: Washington.

Turnock: He didn't come around, you know? He had a very influential chief of staff that spoke clearly for him and very much protected his interests. And there were lots of meetings generated by the chief of staff; he was very active.

Czaplicki: Who was his chief of staff?

Turnock: Bill Ware.

Czaplicki: So if part of the role of public health director, public health in general, is to educate the public, how important is it for you to educate the chief executive in whose administration you serve? Is that an important function?

Turnock: Certainly. You feel the obligation to provide whatever information or evidence you think underlies positions that you might want to take. But public health, like all of public policy, is a little blend of art and science. And public health, especially, is at the interface of science and social values. You know, what's important to people to do, and sometimes, those underlying values will supersede whatever science or evidence or empirical data you might want to throw out as convincing enough to take one position or another. So yes, it is, but it's not as if there's clearly objective truths that someone has to see to understand the right course of action. But for many of the issues we deal with in public health, there's all kinds of ways to get to where you want to be. Not everything that is convincing to you in terms of evidence will be convincing to the person across the table from you, because they look at the world differently.

Czaplicki: We can come back to that a bit later. I'm curious about your role as acting director, and what you were thinking at the time. Did you hope, perhaps, you'd lead the department, become a permanent director? Was it clear you were a placeholder? What were the discussions about, and what did you want out of this?

Turnock: At the time, I thought I was too young, to be honest with you, and I didn't have enough experience to be the permanent commissioner, although I was a consideration. I think Mayor Washington's chief of staff told me at one point that I wasn't what they were looking for. And I appreciated that frankness. (laughs)

Czaplicki: Did he explain what he meant by that? Because there's a few different ways you could take that.

Turnock: Well, he did, yes. He said I was the wrong color. And I understood and appreciated that.

Czaplicki: Did you help with the search, then, for a permanent director?

Turnock: No, I actually read about the appointment of the permanent commissioner in the *Chicago Tribune* one Saturday morning. (laughter)

Czaplicki: Surprise! So what went through your mind when you read that?

Turnock: First you feel like you're totally out of the loop in regards to—common courtesy would dictate that somebody would tell you that this was taking place and it'd be announced in the newspaper, but that didn't occur. I felt not numbed by it, but just kind of turned off. It didn't reflect well on the people I was working for at the time, and I thought that was disappointing. I had higher expectations.

Czaplicki: So careful what you wish for, right? Because earlier, I think you said one of the appeals of the public health field is you wanted to blend politics with…

Turnock: Exactly. I could certainly understand where the city's first African American mayor would want to have the city's first African American health commissioner. I think it's entirely appropriate, given both the political climate and the scope of services, and the recipients of the services. I think that would make a lot of sense. So I totally understood that this was a possibility, or even a likelihood. That part didn't bother me at all; just the way that it came down seemed too impersonal and discourteous, disrespectful.

Czaplicki: Yeah, you just explained that when you let those people go, you talked to every one of them. So a difference in style there. Did Bill Ware make that comment to you before you read about this in the paper, or was this a conversation after?

Turnock: Oh yeah, it was before. He was kind enough to let me know that it wasn't going to happen.

Czaplicki: Of course, the gentleman who is hired is Dr. Lonnie Edwards. So where did Dr. Edwards come from? What was his background?

Turnock: Lonnie was an elder, probably twice as old as I was at the time, and he had been a long-time physician administrator in the Cook County system. I think he was the administrator at Fantus Clinic, which is a large ambulatory center attached to the old Cook County Hospital. He wasn't well known in public health circles, but I think he was known well within the county system. Lonnie was just a fine, fine man, a real gentleman, a real thoughtful, caring individual. At the time, I had the choice: I could go somewhere else, I could still get public health jobs, or I could stay and help him, because he asked me to stay on as the deputy commissioner and doing most of the stuff I had done before. And I opted to do that.

Czaplicki: Was it hard to go back to being deputy after you had been the chief?

Turnock: No, no. Any of these jobs has so much attached to it that you just get lost in what you're doing, you get focused on what the job entails, and you don't have to do everybody else's job, you don't have to be the boss. I don't think I've succumbed to that temptation. I don't need to be the boss all the time.

Czaplicki: Given the nature of the services that Chicago's Health Department provided, much of the clinical work and things like that, did you have strong feelings about whether or not someone with a public health degree should be leading that agency?

Turnock: Well, Dr. Edwards had a masters in public administration and many, many years in the Cook County system, and to me that's totally equivalent. I would never argue about the man's credentials. He had all of the qualifications to have that job and to do that job.

Czaplicki: Of course, County is serving a lot of the same population.

Turnock: Absolutely, a big operation. County Hospital isn't a public health agency, but it's close; it's a provider of health services and public health services to a significant part of the population, especially in Chicago. He was more than well qualified.

Czaplicki: Did you have many discussions with Edwards about the department's needs?

Turnock: Yes. We were all wrestling with trying to make things fit within the scope of the resources that we had. Yeah, we had many discussions, largely around the clinical services. I think that's where he was more experienced and skilled. With his connections with the county system, I think we envisioned that there were new opportunities here to work more closely with County Hospital and Fantus Clinic, and its other clinics—and there's a number of community health centers across Chicago that are kind of independent—to build some sort of a more systematic approach or understandable network of safety net providers. We certainly worked in those directions.

Czaplicki: Did that vision work out? Did those connections help enhance the…

Turnock: Absolutely. I think we had stronger cooperation from the county than we ever had. He was well respected within the county system; he wasn't the leader within the county system before, but they knew him as an honest, caring professional. So that worked well. We began to develop linkages between the city clinics, neighborhood health centers, and neighboring hospitals, because a fragmentation occurs when patients go to the city clinics during the day for the services, and then at five o'clock those services aren't available or the physicians that serve them there aren't available on weekends. [We pursued] some sort of arrangement whereby the providers at the city clinics would

begin to work with and through the hospitals, and the hospital staff would be linked in with our clinics. Referrals would go better, and people would have a place to go at nights and weekends. A lot of that activity took place. I think it was called the Partnerships in Health Program.

Czaplicki: Did your time in Chicago give you a different appreciation, a different sense of the role of the state Department of Public Health? Because now you're at one of the community agencies that's working for the state, whereas before, you had been on the other side.

Turnock: I'd like to think that I've always had a strong appreciation of what the local health departments do. My first job was with the New York City Health Department, and although it wasn't in a direct service line, I clearly had a view of what a large urban local health department does. When I was training for my MPH, I was working part-time at the Contra Costa County Health Department in California. I actually had experiences in three different local health departments, and over the years I've developed a sense of what they do, a great appreciation for what they do. Greater appreciation for the people that work there, and I can certainly attest that it's more exciting, it's more being on the firing line, being on the front lines of where real needs are and where real people live. To me, it's a much more interesting and exciting job in public health working in local health departments. And the higher up you go in state and federal government, the further removed you get from real people, real problems, real solutions. (laughs)

Czaplicki: That's helpful, but did working at the local level change your understanding in any way of what the state was doing, and the importance of the state role?

Turnock: I doubt it. I think I knew from my time with the state health department pretty much how they viewed the world and what their role was with local health departments. Seeing it on the other side, I think you get the same picture, other than now you're the stepchild, rather than the parent. (laughter) It's not quite a master/servant relationship, but it's somewhat like that. So you do get an appreciation, maybe, for what the state could do better to support local health departments, absolutely.

Czaplicki: I was interested in this because you were about to return to the state, so I was wondering what you were taking with you. Of course, in the very end of March, start of April 1985, there's another public health crisis. I'm not sure if this is the one you're referring to when you said you were bracketed in Chicago.

Turnock: Absolutely. Two of the most interesting public health crises that occurred *anywhere*.

Czaplicki: This is the largest salmonella outbreak the state of Illinois had ever experienced, correct?

Turnock: This may well have been the largest foodborne illness outbreak in American history. In terms of the number of people that were actually affected by it, probably more than 200,000 people got sick. The number of reportable cases reported is far less than that. Salmonella is only rarely fatal, so there's not a lot of fatalities attached, but in terms of the scope of this, the number of people that actually ingested contaminated milk and became sick, we're talking a couple hundred thousand.

Czaplicki: And I believe the source of this was the Jewel grocery stores owned a dairy, Hillfarm Dairy?

Turnock: I'm not sure whether Jewel owned them or Hillfarm existed independently. I think it was more the latter.

Czaplicki: But they provided milk that was sold through Jewel.

Turnock: Yeah, Jewel and other outlets, but largely through Jewel. It was a massive outbreak, a huge crisis, an ongoing media event—everything you'd want. (laughter)

Czaplicki: What did the source ultimately come to be?

Turnock: Well, there was no…

Czaplicki: I read a couple of different theories, something about some lines coming together, something about the mixing process?

Turnock: Yeah, I don't think there's a definitive cause. I think the conventional wisdom, based on all of the investigations that were done, was that there was a cross link between pasteurized and non-pasteurized milk in this dairy, a pipe that periodically seeded the clean milk with the salmonella, and that's probably what caused this. A lot of milk that comes into dairies is contaminated with something; that's why you process it and pasteurize it. So the fact that there were some contaminated herds found in some neighboring state is kind of a red herring here. But it appeared to be something that went on with the infrastructure in the dairy itself , the piping in there, that allowed for this cross-contamination to occur.

And it happened, apparently, on several occasions, not just on the big event; especially a year before, when there were probably thirty or forty cases identified. The state health department and some of the local health departments in the western suburbs investigated these cases, and the only thing that linked them together was they had bought milk from Jewel. But when they did more extensive investigations, they couldn't find more

contaminated milk; they went to the dairy, they couldn't find problems at the dairy, and so they kind of let it rest. There was no source found, which is not uncommon for these kinds of investigations. Then maybe a half a year later, this problem came up again, and I think the folks who had been involved with the original investigation just slapped themselves on the side of the head and said, "Well, here it is again." And you kind of knew what to expect this time.

Czaplicki: While this is a public health crisis, it also becomes something of a political scandal as well because of Public Health's response. There's a lot of questions about the agency's investigation, and primarily their decision of when to shut down the dairy. I wonder if you could speak to that at all, whether you thought some of those criticisms of the agency were fair.

Turnock: Well…

Czaplicki: I know during the cyanide investigation, you weren't very happy with how the media was portraying what was going on, and I'm wondering if there was more of a basis with salmonella.

Turnock: I don't know that the media was unfair here. I mean, these cases were mounting day by day, week by week. They started to drop, and they bounced back up again when, apparently, another batch was contaminated. Obviously not all milk or milk products from this dairy were causing this problem, and the dairy, no doubt, took every step it could take to identify and alleviate this problem. Their own best interests drive all of that, and their liability concerns. I don't know that there was ever enough information for the health department to close the dairy itself. I mean, without knowing exactly what's going on, it's dropping a nuclear bomb: just close the whole place, and whatever problem that's in there won't persist. But you really don't know that you've ever solved the problem until you pinpoint the cause. So the fact that this would go on for day after day, and a couple of weeks, and get a lot of attention, and people are looking for some sort of magic solution here, that may be a little bit extreme. I don't think the health department had a clear idea of what the cause was, and to take that drastic of an action—I think this was the largest milk producing facility in the Midwest, if not the country.

Czaplicki: Yeah, I was wondering.

Turnock: That's a huge decision to make, and by the time the health department was ready to make it, the dairy closed voluntarily, which is generally what happens anyhow. These places have more of a self-interest in what happens with their products than even the regulators at times, and they'll often move more quickly than regulators to protect their own interest. And they don't gain anything by being at risk of selling more bad milk.

Czaplicki: Is there a bit of a sliding scale? Had it been a smaller producer, do you think there would've been an easier decision, more willingness to shut it down earlier because it's not as big of an economic impact?

Turnock: Perhaps. I don't know that I want to get in that debate. Really, you have to know what the problem is and that the solution that you're taking is a proper one, that it's measured, that it's the least restrictive one that you can to accomplish what you want. So dropping the atom bomb on it doesn't make a lot of sense, other than it is a way to seemingly resolve this, even though you don't know what the problem is. It's tricky business. And I don't know where the state failed here, because during this, they would go into the dairy plant and investigate, and couldn't find contaminated product, couldn't find cross-contamination. So what are you left with? It was very tricky.

I don't want to be overly critical of the failure to act, because on the one hand, I don't have all of the information that they had, and from what I do see, there doesn't appear to be enough clear evidence as to what the problem was, to know that this would be the proper solution. Why wouldn't the proper solution be recalling just the milk products that were contaminated, because different brands of milk that were produced there under different labels and different strengths weren't the problem. There were two; on different occasions, there were two different brands. And that may not speak to the whole facility needing to be terminated.

Czaplicki: So how do you end up back at Public Health?

Turnock: It dragged on for a while and the media attention was growing, and the media was getting fairly regular updates from, largely, the state health department. I guess one enterprising reporter asked where the state health department director was one day, you know, in getting the staff review. And they found out that the state health department director was in Mexico, taking advantage of a timeshare there. This then became the story, that this must be why things are—you know, "People are getting sick, and we're not finding out what's going on, and nobody's taking any strong action against the dairy, and this just isn't acceptable." It's an embarrassment to the state health department and to the governor, and the governor acted.

Czaplicki: This would've been Thomas Kirkpatrick?

Turnock: Thomas Kirkpatrick, a very fine public servant, absolutely. He had been director of the Department of Alcoholism and Substance Abuse, and he'd done a fine job. He wasn't public health trained, but he was appointed public health director.

Czaplicki: Yeah, what was his background?

Turnock: He was a lawyer.

Czaplicki: Lawyer?

Turnock: He was a lawyer, but he had extensive experience in behavioral health, substance abuse, alcohol. I mean, he went on to have a great career. I think he was chairman of the Chicago Crime Commission for a good while. He's just an outstanding public servant who was very much the fall person for this media circus that took place.

Czaplicki: It still leaves the question in my mind, do you suppose someone with a background in public health would've taken a vacation at this time, or would've come back if they were already on vacation when this emerged?

Turnock: I would think that someone would not take a vacation, or they would come back from their vacation if this persisted. They probably wouldn't have left. Given the mounting scope of illnesses, given the attention that's being placed to this, I don't think you'd want to turn that over to staff and do it via telephone. But I don't know all the circumstances here. But yeah, I think it was bad form. I don't think it necessarily impacted anything that went on, other than it created kind of another gotcha opportunity.

Czaplicki: I'm pushing you a little bit on this just because I was struck by the statement that you made in the press at the time. In your remarks, you were pledging, "To bring public health leadership back to that agency." You also mentioned, "Things we'd not attended to in recent years."[20] So I was very curious what you were thinking of when you made that remark, and even how that statement came about. Was that something you worked out with Dave Gilbert and the press people? Was that all your own doing?

Turnock: No, these sound like things I'd say on my own, (laughter) without a lot of pre-thought. I mean, realizing that at the time, the health department was viewed as a problem. Whether it was or whether it wasn't, I don't think anybody really knew, but there was the perception that the public health protections organized by the state health department had failed, and that lots of people had gotten sick because of this. And yes, Tom Kirkpatrick wasn't a public health professional, but the person before him wasn't either. That was Bill Kempiners, a former legislator. So had there been a period of time in which the state health department didn't have a public health trained leader? Yes. Was that something that was relevant to this? I don't know. But I'm sure the reason I got the position was because I was public health trained, and I was a physician, and I had all of the credentials that someone might question in my predecessors. I probably took advantage of that in making whatever statements I made there. (laughs)

Czaplicki: So you were concerned about the legitimacy of the organization?

[20] Jon Van, "Turnock Always Wanted to Be 'Epidemic Buster,'" *Chicago Tribune*, April 25, 1985.

Turnock: Absolutely.

Czaplicki: Would that be a way to put it?

Turnock: Absolutely. I'd worked there and I knew the people there; I knew, probably, more than half of the staff who worked in Springfield. I liked them and respected them, and I wanted to do something for them. So some of this is taking advantage of the opportunity here where this organization is being disrespected and there's a crisis of morale. They don't feel good working for an organization that gets this kind of bad publicity. And yeah, I would like to take advantage of that and let them know that things were going to change.

Czaplicki: You mentioned your credentials were almost certainly important to getting you this job, but could you go into more specifics about how the actual offer came about? How did the governor actually reel you in?

Turnock: I think the main link that I had with the governor at that time was his chief of staff, Jim Reilly. Jim Reilly was a state representative from Jacksonville when I first got to Springfield as director of emergency medical services in 1976, and I began working with Jim Reilly on legislation related to emergency medical services. We had a very good working relationship and got a bill enacted, got a solid program put up. I think it was because of my prior working relationship with Jim Reilly, and the fact that I was working in Chicago and modestly visible in that role, that Jim called me and asked me if I'd be willing to talk to him and the governor about the position.

Czaplicki: So Reilly called you?

Turnock: Yes.

Czaplicki: And what did you tell him? Did you have to think on it?

Turnock: I didn't have to think about it, no. I was okay where I was, but I wasn't totally happy working in the role that I was in Chicago.

Czaplicki: What did you talk about when you met with Reilly and the governor?

Turnock: I don't think it was a long meeting, as most meetings with the governor aren't, (laughs) and it was mostly them talking about what they hoped to accomplish. It largely revolved around bringing some sense of credibility back to the agency and the public health activities, and they thought that I was qualified to do this. They didn't care about whatever political affiliations, or lack of political affiliations, I might have. And that I'd have reasonable autonomy within that agency to do the things I thought were necessary. And I thought that sounded like a good deal.

Czaplicki: Did he express any priorities for the agency, or was it mainly more this legitimacy of the agency, the public perception of it? Credibility?

Turnock: I think it was restoring credibility, and certainly this helps the governor's perception. He acted decisively in both dismissing Tom Kirkpatrick and in hiring somebody with public health credentials. I think what he wanted after that was for someone to help restore a sense of morale and good feeling and credibility within the agency, and that was my job.

Czaplicki: Were you the first person they turned to, or were there other candidates they were considering as well?

Turnock: I don't know. Unfortunately, there are very few people with the kinds of credentials that they were looking for as a result of this situation. There may have been two people in the state with that, and I was handy.

Czaplicki: You mentioned that your political background didn't matter, that you'd have authority to structure the department, and the press reports that you would examine the department's leadership and recommend who you wanted in the department. Did he keep that promise?

Turnock: Absolutely. Yeah, there were a number of changes made at the highest levels fairly quickly. A number of the people that had been there with Tom Kirkpatrick were, I think, good people, but loyal and devoted to him personally, probably more so than to the agency. And I don't mean that in a demeaning fashion. I had discussions with them, and they pretty much indicated they would be looking to move on rather than to stay and develop those relationships with me. I had other people in mind for some of these positions myself, so it worked out very harmoniously.

Czaplicki: That's interesting, did you get a sense for why people made that choice? Were some people put out by Kirkpatrick being let go?

Turnock: Absolutely. I think they felt he was left holding the bag, that he was a scapegoat for this, and I can understand their perceptions. I mean, they had come with him to work for him and were personally invested in him. Just as I would hope the people I put in those positions would be personally invested in me and what I wanted to do. I took no offense at that, and I understood why they would think that.

Czaplicki: Who did you seek to bring in? Were particular people in mind, or was it certain traits you were looking for?

Turnock: As I said, I'd been there a while, so I knew all of the people in the middle management in their thirties and forties, the well-trained people, and had an

idea of where people would fit in leadership positions and could be bumped up. I had one person that I was actually trying to hire at the Chicago Department of Health for a good while. (laughter) We encountered all kinds of problems in hiring him, and by the time I left, I decided to hire him at the state health department in a very important area in terms of the health regulations. He was a physician with an emergency medicine background who was interested in completing his public health training. And that was Dr. John Lumpkin, who was my successor. I made a point of putting him in a very key position, which is regulating the health facilities—the hospitals, and the nursing homes, and ambulatory surgical treatment centers, and inspections, and all of the stuff like that—where a solid medical background and a lot of integrity and good leadership skills were necessary. The governor's office helped me find some people. They felt we needed a strong director of communications and/or public health information officer. Although I'm sure they believe that they made me take him, I thoroughly enjoyed from our first meeting, and I've always enjoyed, Paul O'Connor, Len O'Connor's son.

Czaplicki: Oh, the reporter from Chicago?[21]

Turnock: Yeah. Paul was someone that I think the governor's office thought I could use, who was very savvy in terms of media communication strategies, as well as political strategies. We clearly needed somebody to help shape that. And he came in very soon. We put together our senior team. As the kind of more or less chief of staff, but I think we called him the deputy director—I don't know if we called it first deputy or whatever—was somebody that had worked for the state health department as the budget person when I first worked there. He'd come over from the Department of Transportation. He was just meticulously committed to following things through and understanding the details of stuff, and I felt he would be very personally loyal. He wasn't a public health trained person, but he was a top-level manager and trusted operating officer. So I brought him in. I think he was working as a deputy director at Children and Family Services at the time. So I brought him over to a number two role.

Czaplicki: And what was this person's name?

Turnock: Dave King. So we made a lot of changes, and I think the changes we made were very well received within the department. I think that's the major advantage I had; I had been there, I'd worked there, they saw me as one like them and not another Chicagoan appointed to run a Springfield-based agency. I think a lot of the people there felt that, really, it was like having somebody from their own ranks rise up to be director, and that did as much for morale as just about anything that I could've imagined. I was well accepted, well liked, and this was a good thing from their point of view. They were tired of having

[21] Len O'Connor was a popular television reporter and editorialist for NBC and WGN.

externally based people come in and be director. Even though I was going to continue to live in Chicago.

Czaplicki: Oh, so you didn't move down to Springfield?

Turnock: Mm-mm.

Czaplicki: You had mentioned earlier that when you first went to work for the department in the seventies, there was a pretty strong spirit or culture there, a lot of sociability. Most of those people, were they still around?

Turnock: Yeah, just about all of them. And that made my job a lot easier. I knew the people and they knew me, and there was no surprises here, no hidden agendas, and it worked out real well that way.

Czaplicki: Just out of curiosity, how come you couldn't get Lumpkin hired in Chicago? I mean, you're the deputy director then you're the acting director. (laughter)

Turnock: Isn't that an interesting question? It takes *forever*, partly because of the restrictions that were placed on hiring as a result of the Shakman decision. I mean, you're under the microscope all the time in terms of hiring, and it just took months. He was going to get hired, but it probably took at least four or five months. And just when we were at the point where we had overcome all of those, I was going to leave, so I just convinced him that you'd be happier with me at the state level than having this middle management kind of position here at the Chicago Department of Health. That decision served him well.

Czaplicki: In the investigation and discussion that follows the salmonella outbreak, the General Assembly forms a legislative committee to investigate. I understand you're also conducting your own investigation, from your position as director, into the department's response. At least that's what the media reported. And there seem to be two main lines of critique about what happened. One is very similar to the claims the transition report of Washington's administration made against Byrne, right? That the department had been decaying under the burden of patronage. I'm wondering if you thought there was any merit at all in that, how patronage at the state level influenced the Department of Public Health. The other line is austerity, but we can talk about that after. Some of those criticisms were being made by people in the department who were testifying before the committee, and then others, of course, are given more airing by the Democrats on the committee, like Jim McPike or Thomas Homer.

Turnock: No doubt there were people hired in state government because of their political connections. And to some extent, the system allows that to happen in certain protected positions. I don't know if that was that *Rutan* court case?[22]

Czaplicki: Right, that gets decided in 1990.

Turnock: Yeah. So, yes, but I don't…

Czaplicki: I believe the governor had a hiring freeze in effect.

Turnock: Yeah, for a *long* time.

Czaplicki: So everything basically got run through the office, right?

Turnock: That's right. The hiring freeze started very early, the early eighties, right?[23]

Czaplicki: Mm-hmm.

Turnock: Because there was always a hiring freeze on. You could hire people, but it did require approval through the governor's office, and no doubt, people with political connections got positions. But people without political connections and with the professional credentials got positions too. It seemed to me, in comparing the Chicago system and the state system, there was much less patronage at the state level than I saw at the city level. That's not to say that it's at an acceptable level with the state. I'm not sure what an acceptable level is, but yes, it existed, but far less than what I had seen at the city. And I didn't really perceive it to be a huge problem, because I think most people in key positions had professional credentials. Maybe they had political connections in additional to professional credentials.

Czaplicki: How did hiring work after you were hired? Because on one hand, you're promised you'll be given a free hand to shape the department, but there's also this system of approval and clearance running through the office. Did that ever get in the way?

Turnock: It might've slowed hiring—especially when we got additional resources to hire more communicable disease investigators, or food inspectors, or laboratory people, because there's a fair amount of money provided to the department after all of this to help rebuild the capacity in these skill areas. I don't recall specifically, but if there were problems, it would've lengthened

[22] Reference to *Rutan v. Republican Party of Illinois*, 497 U.S. 62 (1990).

[23] Governor Thompson discussed patronage extensively at several points in his interview. James Thompson, interview by Mark DePue, July 30, 2014; September 10, 2015; and February 17, 2016. For other perspectives on patronage in the Thompson administration, see Gregory Baise, interview by Mark DePue, August 7, 2013; Robert Mandeville, interview by Mike Czaplicki, February 11, 2014; David Gilbert, interview by Mark DePue, March 27, 2014; Jeffrey Miller, interview by Mike Czaplicki, June 15, 2015.

that process. But those weren't things that needed to be done today or next week. If it was done next month, those are acceptable delays. But I can't recall any problems—certainly not the high level positions.

Even the people that might have been sent through political channels were really totally acceptable to me. I remember a couple. I mentioned Paul O'Connor. He obviously had strong political connections, but my God, he was more committed to restoring the credibility of the organization than just about anybody else. And he was able to do it from a vantage point that the professionals don't have, in terms of the external communications and relationships. He's really good at that, and he's doing it to help you. Chris Atchison was another referral who seemingly came through the political channels. And Chris eventually became the assistant director, which is a position that requires Senate confirmation; I think only the director and the assistant director position do. Chris was somebody who had worked a lot in political activities—I think he'd run a few campaigns and stuff like that—but he had a masters in public administration. He was *really* interested in what the agency did, and became very skilled at it. When he left the Illinois Department of Public Health, he became director of the Iowa Department of Public Health; he's a luminary nationally in terms of public health administration. Born-again public health professional. You know, if these are the people they're going to send me that have political connections, it's not a problem. They're good people.

Czaplicki: When you say a political person got sent to you, how did that happen in actual reality? Did you get a file on your desk, did somebody knock on your door and say hey?

Turnock: It would probably come from some sort of discussion with the governor's office, or the legislative liaison-type people who have direct connections to the political superstructure. We'd be searching for a physician, like a director of communications, a public information officer, and they would say, "Here's somebody that we're aware of that we think could fit this bill." And in large part, it was somebody that they were very comfortable with. They don't make you hire them; they kind of give you the opportunity to determine whether you believe that they can do these things. And as I said, a number of them were just outstanding professionals who just happened to have political connections; they live in that world. It's not that they're political animals or politically driven all the time, they just have an additional set of skills that some of us scientists and professionals don't have.

Czaplicki: You had said one interesting thing about Paul O'Connor's hiring. You said the governor's people probably think that they had to force them on you. Why would they think that? Were you initially cool to the idea, and then you met him and saw what he could do, and he changed your mind?

Turnock: Very much so. And I don't want to overanalyze the situation. I'm sure that even though the governor would give me assurances of autonomy, they would worry, What do we got here? (laughter) We found this guy in Chicago; he has the right credentials, he doesn't seem to have any loyalties to anybody—we've got to keep an eye on him. Let's make sure we didn't make a big mistake here. I can imagine that the governor's office would like to have people in-tune with what's going on in the agency, and they could help me, or help somebody stop me. (laughter)

Czaplicki: Your reception was also received very well externally.

Turnock: Mm-hmm.

Czaplicki: As well as internally with the agency. And in June of '85, before this very same legislative commission, Chicago-area health officials lobbied for a health board that would appoint the department's director, taking the power away from the governor, ideally, to get more people like yourself in there. Dr. Steven Potsic was the executive director of Lake County Health Department, and he was arguing for a professional, non-partisan environment to successfully recruit good candidates. What did you think of that proposal? Was that something you agreed with?

Turnock: I doubt that I made any public pronouncements on it. I totally understand Steve Potsic's view, and that of a lot of the local health department people, that they would want to take this out of the political sphere if they could, take it out of the governor's hands, and have some sort of body intermediate. I have mixed feelings about that. I think it's laudable, yet my basic civics lessons would suggest to me that the governor's in charge; that is a reasonable duty for a governor to do and to be held accountable for, and it would work better that way, rather than some board selecting somebody who would then go work for and relate to a governor. I see many more opportunities for misunderstandings and working across purposes with that. I doubt that I would've supported that notion at the time, but I can understand how the local health department people would feel strongly about that, in view of the people that had preceded me and the fact that they had been appointed. So I'm schizoid about that. I understand it, but I don't think it's necessarily desirable.

Czaplicki: The other problem that was frequently cited was austerity. And as we've talked about here and there, the early eighties were fairly lean years both statewide and at the municipal level, and particularly within Public Health. Yeah, if you could take a look at that chart there. The legislative committee turned up an October 1984 memo, which was written by the state director of the Dairies Division within Public Health. And it cited personnel attrition for

rendering the laboratory's capacity to respond to a health emergency "almost nonexistent."[24] So I'm wondering why those cuts went so deep.

Illinois Department of Public Health General Fund Appropriations

Fiscal Year	General Fund Appropriations	Pct. Δ	GF Appropriations, in 2012 Dollars	Pct. Δ
1973	19,877,900		105,685,265	
1974	21,533,000	8.3	105,113,368	-0.5
1975	20,922,000	-2.8	91,942,343	-12.5
1976	22,614,000	8.1	92,779,566	0.9
1977	35,493,000	57.0	137,638,054	48.3
1978	37,566,000	5.8	136,509,126	-0.8
1979	44,893,000	19.5	149,162,727	9.3
1980	47,717,100	6.3	139,893,671	-6.2
1981	48,668,000	2.0	127,871,132	-8.6
1982	41,872,000	-14.0	101,266,985	-20.8
1983	38,500,000	-8.1	89,277,636	-11.8
1984	39,640,000	3.0	88,625,383	-0.7
1985	46,927,000	18.4	100,982,526	13.9
1986	69,063,000	47.2	144,451,574	43.0
1987	84,811,000	22.8	173,535,963	20.1
1988	85,107,000	0.3	167,214,041	-3.6
1989	86,671,000	1.8	162,769,604	-2.7
1990	101,310,900	16.9	181,597,644	11.6
1991	109,150,900	7.7	185,508,984	2.2
1992	107,912,600	-1.1	177,709,311	-4.2

Turnock: Are you talking about cuts in the department prior to 1985?

Czaplicki: Yes, before you come on board.

Turnock: I haven't looked at that in great detail to understand what happened there. Obviously, looking at the general revenue funding for the state health department in those years, it was lean, and it had diminished, I guess, from 1981 through '84. But to highlight the discussion we had before, the incident in 1985, you can see a dramatic increase in state general revenue funding; it increased 50 percent. So yeah, I don't understand the total reasoning that went behind that, other than the dollars were scarce, and the Illinois Department of

[24] Jon Van, "Salmonella Cases Continue to Surge," *Chicago Tribune*, April 20, 1985. Figures in table are from the annual budget books prepared by the Bureau of the Budget. The constant dollar figures were based on the Bureau of Labor Statistics CPI-U series, recalculated from calendar years to Illinois fiscal years.

Public Health was not at the top of the priority list of the administration. Again, those are priorities that are arguable.

Czaplicki: Invisible. It reinforces that theme.

Turnock: I think so, but you're also competing. I mean, I don't have the full context here, so I wouldn't want to make a definitive comment. I don't know what you're competing with. You're competing with education, you're competing with public aid expansions, you're competing with scandals in the Department of Children and Family Services, you know, Public Safety—I don't know what the environment was like that resulted in these decisions, but there wasn't a lot of money, and it's clear that the state health department wasn't identified as a priority need. That's the reality of it, and that's very difficult for program-level people to understand. And when somebody retires and a position doesn't get filled, they react, I think, viscerally. I don't want to get into the philosophy of doing more with less, but certainly productivity, technology, and communication gains do make it possible for people to do more than they did in the past. So some of the arguments that we have to maintain the level of staffing we had in the past, you know, can be hollow.

Czaplicki: I interviewed Dr. Mandeville, the budget director, several months ago, and he explained that rather than firing people to rein in costs, he preferred to do it through attrition, not replacing people.[25] So some of what's going on there would seem to bear out his philosophy.

Turnock: Well, it is, and it places the onus, I think justifiably, within the agency to figure out how to best use the resources you have to get the most important things done, to get as much out of the money that you have. You have some flexibility to move things around, and if food, drug, and dairies is a priority need and the loss of a position there would seriously damage it, maybe, you'll take one from Emergency Medical Services, or Maternal and Child Health, or Health Planning, or Hospital Licensing, and resolve it that way. It at least lets the managers within the agency help address the problem. You just can't blame it on no money, that's…

Czaplicki: Yeah, I wanted to ask you about this change in funding. For fiscal year 1986 on this chart that we're looking at, there's a huge increase, a 47 percent increase in general funds appropriations for Public Health. If we put that in constant dollars, 2012 dollars, it's a 44 percent increase in the total general funds appropriation. You would've been coming on right around the time the legislature is considering that budget, so did you have much of a say in that, or was your first budget really fiscal year '87?

Turnock: No, it would've been '86. I mean, if you come in '85.

[25] Mandeville, February 11, 2014.

Czaplicki: You came in April of ’85?

Turnock: Yeah.

Czaplicki: Was that enough time?

Turnock: In those days, what was it, July to June? So the budget doesn’t get set for the next year until July 1st, virtually. That budget would’ve reflected an effort to deal with the perceived shortcomings of the salmonella outbreak. Several million dollars in there were earmarked for things related to that. This is also about the time that the Parents Too Soon Program got up and running. And shortly thereafter, the governor supported a massive infant mortality reduction program called Nine By Ninety, an effort to reduce the infant mortality rate to a rate of nine per thousand by the year 1990. That entailed a significant infusion of state general revenue dollars, and the governor did that. I think it was our request that he do that, but it was, I think, in part to show that he was highly supportive of the state public health agency. I think all of those things came together, and the next few budget years were very good, big growth years.

Czaplicki: The following year you went up 23 percent, practically, the general funds.

Turnock: Yeah, and I would trace all of that to the crisis and the aftermath of the crisis, where both political leaders and the legislature feel that they have to do something about it, you know? They have to show that they’ve done something about it, and they do. They use the tools they have, they pass bills and provide funding, and life goes on.

Czaplicki: So last time we talked, you mentioned that the size of the budget frequently was a proxy for the power of the agency, your ability to compete for funds. Did it also determine access to the governor or his staff?

Turnock: No, I don’t—I mean, I feel foolish saying no. But I think access to the governor relied more upon the sensitivity or importance of specific issues than anything else. Now, would an agency with more funding and more tentacles out there likely encounter more—probably. But the governor let agency directors run their agencies and brought them in when there was something big going on that he wanted to make sure he was involved in. I think it was more the issues than the funding of the agency that prompted meetings with the governor.

Czaplicki: Any particular meetings that you recall? As I understand, he wasn’t a cabinet-style manager, with regular meetings of all of the agency heads and things like that.

Turnock: No, he would have his chief of staff or deputy governors hold those kinds of meetings, and they were mainly communicating policies, or upcoming issues and things around the horizon and state government, or the financial picture—they weren't decision meetings. The governor infrequently met with me; we didn't meet regularly, probably three or four times a year.

Czaplicki: In terms of the internal structure of the Thompson administration and the relationships within there, did Thompson have an inner circle? Were there particular advisors who tended to…

Turnock: I'm sure he did.

Czaplicki: That you perceived at the time?

Turnock: Because I don't deal with all of the issues the governor deals with, I don't know who he relies on for what, but in health and human services, yes, he relied heavily on folks like Paula Wolff and Jeff Miller—Jess McDonald, when he was in the governor's office.[26] And of course, Jim Reilly when he was chief of staff. Those were the senior policy people that ordinarily would be involved in a meeting that you would have with the governor around some issue. Often it would be something that they thought he needed to be aware of.

Czaplicki: Any examples of that you remember all these years later?

Turnock: HIV legislation.

Czaplicki: Was it difficult to integrate yourself into the administration when you first arrived? Maybe because he had already been in office for so long and has these established staffers that are there, and you're the new guy, as it were, at that level?

Turnock: No, it was not. I think Jess McDonald was the main point person, and Paula Wolff above him at the time, and Jess went out of his way to make sure that I was comfortable in my position. Since I had not played that role before, he would help me figure out what I needed to do or who I could talk to. Paula, as well, is just a very—I think they thought of themselves as nurturing me. They're very embracing; they were very supportive, and they're both very nice people, so it made dealing with the administration very simple. They were good people; they, I think, were reasonably in-tune with the kinds of things that the public health department ought to be doing. They had good connections with the other agencies, where we needed that, and they were very helpful.

[26] Jess McDonald, interview by Mark DePue, September 3, 2010; Jeffrey Miller, interview by Mike Czaplicki, especially June 24, 2015, and July 7, 2015.

Czaplicki: I wanted to ask you about relationships with particular people, just get a sense of the personalities, because often we see faceless bureaucrats, so it's useful to get some of the color and character of these people. If I could just run through some names with you?

Turnock: Sure.

Czaplicki: You've mentioned some of them already, but Jim Reilly, who you knew as a legislator, but now you're seeing him as chief of staff and deputy governor. How would you describe Reilly? What's he like as a person? What's his management style?

Turnock: Jim Reilly's one of a kind. He's very understated, a seemingly gruff personality, (laughs) and just is very direct. He's just very enjoyable. He doesn't mince words, you know? And very short, choppy thoughts like a lot of us Irishmen project. I mean, he comes across as kind of a gruff guy, but he's just a treasure. He's *really* smart, he sees the connections, and I never quite understood how he fit in with the other state legislators, because just personality-wise, he doesn't appear to be driven by a personal agenda. He's just very unique.

Czaplicki: You say seemingly gruff, so he's not actually gruff?

Turnock: No, he's not; he kind of talks in a gruff—(laughter) almost a whisper at times.

Czaplicki: Jess McDonald, who you just mentioned.

Turnock: Jess is very thoughtful and articulate, and maybe not compulsive, but he just never drops things; he follows through all the time, every conversation you've ever had with him about some program or project. He always does his share and goes beyond it. He's just got a *big* world view, especially of the linkages and connections among the social issues, and the health and human service issues. And he's willing to share it.

Czaplicki: Paula Wolff?

Turnock: Paula, she's hard to characterize simply. She's another policy wonk, she's interested in everything, and she was always direct and to the point with me. We disagreed about a fair number of things, especially in the HIV and AIDS area, but she always made a cogent argument. She was always polite and respectful, and a pleasure to be in a meeting with, and she was always very upbeat.

Czaplicki: Did you encounter Joan Walters at all? I think she was on the program staff at this time.

Turnock: She eventually became budget director?

Czaplicki: Under Edgar, she becomes budget director.

Turnock: No, I don't recall her.

Czaplicki: Jeff Miller, you mentioned him a few times. He was at Public Aid, and then he's chief of staff when Reilly gets elevated to deputy governor.

Turnock: Yeah, Jeff is another real hard charger. I think he's a real organizer. I actually used to date his cousin in high school, I found out, in upstate New York. So we had a connection to New York together. His wife, Linda Miller, ran the Parents Too Soon Program for us. That's what I admire most about the Thompson administration: they hired bright people—open minded, hardworking, and team players. They weren't pursuing their own agendas. And Jeff was like that. But Jeff's a little bit more high energy. (laughs)

Czaplicki: Did you have many dealings with Gene Reineke, who was director of public affairs in '85, then became director of personnel from 1987 through '88?

Turnock: No. I knew who he was, though. (laughter)

Czaplicki: Dave Gilbert, I guess he left shortly after you arrived.

Turnock: After he made his fortune with the lottery. Dave won the lottery.[27]

Czaplicki: He did?

Turnock: Yeah. We thought it was all fixed, but… (laughter)

Czaplicki: I didn't realize state officials could play the lottery.

Turnock: I didn't either. I'm sure they weren't exempted in those days, but he won three or four million dollars, and he stayed in his job for a couple of years after that. I didn't have a lot of connections with him. I think he generally operated through whoever our public information officer was. I've met him a few times, but don't have a strong opinion one way or another.

Czaplicki: How about Ilana Rovner. Wasn't she deputy governor of the Chicago office?

Turnock: Yes, but I really had no interactions with her.

Czaplicki: Since I knew you were based in Chicago, I wasn't sure if you'd be dealing with the secondary Chicago officials.

[27] Turnock is thinking of another press officer named Dave: Dave Fields won $6.7 million in 1987. Kim Blackwell Fox, interview by Mike Czaplicki, July 14, 2014.

Turnock: Not too often, yeah.

Czaplicki: How often would you go down to Springfield?

Turnock: I would spend at least two days a week in Springfield, two days a week in Chicago, and one day a week somewhere else—whether it's in the state traveling to stuff, or outside the state, the larger public health stuff, or CDC, or Washington. As I looked at it, even if you lived in Springfield, you'd spend two days in Chicago, and if you live in Chicago, you'd spend two days in Springfield. It kind of all washes out.

Czaplicki: So would you drive to Springfield, or take the state plane?

Turnock: In those days we had several options. Midway Airlines did a lot of flying from Midway Airport. Also, there was Meigs. It's kind of been bulldozed out of my memory.[28]

Czaplicki: Right, the lakefront airport.

Turnock: Right, did a lot of flying out of Meigs. There were a couple of small commercial airlines that did it. I did the state plane occasionally, but not very often.

Czaplicki: Did the state plane fly into Meigs?

Turnock: It did.

Czaplicki: I might've asked this last time, but it slipped my mind. Did you deal with Jim Edgar much in his role as secretary of state and on the drunk driving campaign?

Turnock: Minimally. I've met him a couple of times, and actually, his brother was a local health department administrator in Coles County, Fred Edgar. I knew Fred, and I met Jim on several occasions. But not intensively.

Czaplicki: Anyone I left out of this?

Turnock: George Ryan, lieutenant governor.

Czaplicki: You dealt with him much?

Turnock: Yeah, we had a lot of dealings with George.

[28] Pun referencing Richard M. Daley's surprise destruction of Meigs Field the night of March 30, 2003, when he ordered city bulldozers to plow Xs into the concrete runway.

Czaplicki: How come? Normally, you hear that the lieutenant governor is a poor, sad position that has little role in state government. Is that not the case?

Turnock: I'm not disputing that contention, but George Ryan, pharmacist by training, had a lot of interest in health issues and became very involved with rural health issues. His office and my department developed one of the first state rural health associations. There was always an annual meeting, and we would generally be the headliners there. So I had a lot of casual discussions and meetings with him, and whenever there was health stuff going on in Kankakee County or something, he would invite me down. I probably had more interaction with him than a lot of the other constitutional officers, except maybe our attorney general. (laughs)

Czaplicki: And that was Fahner at the time, right?

Turnock: Neil Hartigan.

Czaplicki: Oh, Hartigan after Fahner, that's right. So what was Ryan like as a person?

Turnock: Oh, very enjoyable. Very engaging, very affable, very down to earth. He was a nice man, just a very, I think, honest—I should be careful about that. He was enjoyable to be around, and I think everybody would like him. I liked him a lot. I'm sorry to see what happened to him.

Czaplicki: Oh, a name I should've mentioned, Bob Mandeville, director of the budget.

Turnock: Only saw Bob once or twice a year, and it was generally under very difficult circumstances where we were trying to sell him on something that he didn't want to buy. Bob was smart, hardworking, took his job as seriously as anybody in state government, and knew where every dime in your agency was, even though you didn't and you should've. (laughter) And he hired good staff.

Czaplicki: Yeah, what were those meetings like?

Turnock: A lot of them are just perfunctory. You have half an hour or an hour scheduled where you go over and discuss next year's budget and what you're requesting. He outlines the dismal picture for what's going to happen, and you try to make your best case for things that would add on to what you're doing. Then you'd leave the room, the decisions would be made somewhere else, and later on you'd hear about them.

Czaplicki: How would you hear about them?

Turnock: Sometimes you'd get advance notice before the budget book came out, but sometimes you wouldn't. (laughs)

Czaplicki: The way he described the process to me, he always implied that the court of last resort was to have a meeting with the governor, where you could both present your cases. Did you ever have any of those meetings to appeal a decision by Budget?

Turnock: I don't think so. Not around budget issues, no. I think part of that is because in fact, we got a lot more money in those years than we'd had before. And it's hard enough to spend money; it's harder to spend money than it is to get money.

Czaplicki: Really?

Turnock: Oh, starting programs up takes a lot of time and energy. What often happens is that you're not able to spend everything that you have available to you. And that creates problems and issues with folks like Dr. Mandeville, who are looking at your budget and saying, "How could you ask for more, you didn't spend all the stuff we gave you last year." So it's tricky business. Sometimes it's easier to ask and get money than it is to actually program it in a way that you would hope to be able to do, given the natural constraints that exist in state government for preventing you from hiring, preventing you from spending stuff, the big contracts …

Czaplicki: Runs counter to conventional wisdom, right? The ease with which government spends money.

Turnock: Yeah, there's controls that are put in place to control spending. (laughs) That's why they call them controls, I guess.

Czaplicki: And they work.

Turnock: And they control; to some extent, they restrain you from moving as quickly as you would like.

Czaplicki: I read a few articles that convey, for lack of a better word, tension between the Bureau of the Budget and the program staff, sort of this broad fault line within the administration. Was that a real division, or was that something reporters were reading into things for the sake of a narrative?

Turnock: Like, departments?

Czaplicki: Within the staff level, people like Paula Wolff or Jess McDonald pushing programs, working with you…

Turnock: Well, they're advocates for the agencies.

Czaplicki: And on the other hand, budgeting.

Turnock: I'm sure that occurred. A lot of those people in the governor's office came out of the Bureau of the Budget. So I'm sure they understand it better. Yeah, and I think the same thing for agency staff and heads—we're all advocating for something. We realize that there's a finite limit here, we're not aware of or exposed to all of the real issues that might affect decisions on other priorities, and you have to trust that the process is fair and open, and that you have fair-minded people making the decisions. I don't think people in the governor's office, or agency heads, ever felt that Dr. Mandeville or the governor were unfair; they're just dealing with the whole pie, and we're dealing with a slice of it that's really important to us—more important to us than it is to them, to the decision makers—and we understand that.

Czaplicki: Were you generally satisfied with the budgets that you were getting?

Turnock: Yes. I'm sure there were years when we asked to do things that weren't approved, but I think that the growth and the amount of state general revenue support for public health activities during that time period is probably unprecedented. I would never say that we were totally satisfied, but I certainly wouldn't say we were unsatisfied. I think we were treated well, because of the circumstances that preceded the change in leadership at the department.

Czaplicki: How about the morale for the administration as a whole? I mean, you spoke about Public Health's morale. But within the Thompson administration among the agency heads, how would you characterize it? What was it like to work for the Thompson administration in this era?

Turnock: It was largely positive. I think folks had a good feeling about the governor, and for good reason: he's a very capable leader. Looked like he might be there forever. These were good jobs in a good administration, and it attracted a lot of bright people throughout the leadership of the agencies and the governor's office. So I think it was a very positive, constructive atmosphere. I didn't feel that morale was bad. I don't think I was there when the close election occurred.

Czaplicki: Eighty-two.

Turnock: Eighty-two, yeah. I guess that was a particularly hairy time. But the next election was a no-brainer, right? That was the one where Stevenson ran as a third party because of the problems with the primary.

Czaplicki: Right, the LaRouchie candidates.

Turnock: I don't want to call it invincibility, but there were no serious challengers. The governor was clearly in charge, these folks had opportunities to do good stuff, and that's uplifting.

Czaplicki: What about activities to build camaraderie? I've often heard the tales of parties at the mansion, or the skits that Thompson would have where they poke fun at various issues that happened during the year or agency people. Were you part of any of that? Does that ring any bells?

Turnock: No, I don't recall any parties at the mansion. And skits, there was some sort of press gathering every year that they would have and poke fun at everybody.

Czaplicki: That's where they give the pickle award?

Turnock: Yeah, yeah.

Czaplicki: I don't remember the exact name, it's a plastic pickle.

Turnock: Yeah, golden pickle or something. So no, that may have occurred, but living in Chicago, having a bunch of kids and a wife at the time, I wasn't privy to a lot of socializing that they might have done.

Czaplicki: Of course, Thompson was in Chicago a lot of this time too, because Samantha was in public schools in the city.

Turnock: Okay.

Czaplicki: So did you ever meet with him in the city at his home, or State of Illinois Building for your meetings?

Turnock: Yeah, certainly the State of Illinois Building for some things. But never his home.

Czaplicki: Upon taking control of the agency—you've gotten your senior staff, you're thinking about what you're going to do—what were your priorities? What was top on your agenda?

Turnock: Based on my previous time there, my top priority was always in the area of maternal and child health and infant mortality reduction, because Illinois was notoriously poor in that statistic and the amount of state money that was devoted to it was scandalously scant. That was my personal priority, coming out of my maternal and child health, public health training, and being state maternal and child health director. So that's what I wanted and saw as the highest priority. Probably the second one was providing some sort of leadership to the local health departments so that there would be a more unified network of state and local public health agencies operating on the

same principles and concepts. And when HIV came along, that became another priority for everybody, one that was cast upon us.

Czaplicki: Then on that note, maybe we'll leave off there. Next time, we'll pick up with AIDS, and I'll get your response to that.

Turnock: Sounds good.

Czaplicki: We can wrap this up, so thanks very much.

(End of interview 2)

Interview with Bernard Turnock

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Interview # 3: April 22, 2014

Interviewer: Mike Czaplicki

Czaplicki: Today is Tuesday, April 22nd, 2014. This is Mike Czaplicki, project historian at the Abraham Lincoln Presidential Library, and I'm here for my third and final session with Barney Turnock as part of the Gov. Jim Thompson Oral History Project. How are you this morning, Barney?

Turnock: I'm fine, good to be with you again, Mike.

Czaplicki: Today, we have a few big issues to talk about: HIV/AIDS, a very important abortion case that you were involved with, the question of politics and public health, and some general reflections on your part. And that should close out our series with you. To start off with HIV/AIDS, when and how did what we know as HIV/AIDS first come to your attention?

Turnock: Boy, I think it came to my attention the first year I was working with the Chicago Department of Health, which would've been in 1982. I came back from the annual meeting of the American Public Health Association, where there were, really, the first reports of the disease that we now know as AIDS and HIV infections emerging from the East Coast and the West Coast.[29] So one of the first things we did in Chicago was to try to identify whether there were, in fact, cases in Chicago at the time. We assembled a group of community leaders, largely from the gay community in Chicago, and formed an AIDS task force. I can't remember exactly what we called it. We certainly believed that AIDS was going to hit Chicago, and we wanted to be aware of when that occurred, get things in place to begin to count cases, and initiate whatever prevention and control efforts we could.

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[29] The Centers for Disease Control and Prevention (CDC) *Morbidity and Mortality Weekly Report* for June 5, 1981, was the first official report of AIDS cases in the United States; however, the CDC did not use the term "AIDS" until September 24, 1982. U.S. Department of Health and Human Services, "A Timeline of AIDS," https://www.aids.gov/hiv-aids-basics/hiv-aids-101/aids-timeline/.

Czaplicki: Did that process involve case reviews too? Were you looking back?

Turnock: We wanted to find out, especially from the specialists in the academic health centers, whether they were actually seeing cases that might qualify under these definitions, and really find the first cases. And I think within a few months, the first official cases in Chicago were identified. We were right there on the ground floor.

Czaplicki: So how long until its seriousness and its high mortality became apparent?

Turnock: The seriousness and the case fatality was immediately apparent because people with this diagnosis weren't living very long at all. We knew it was a serious condition, and the reports from California and New York certainly validated all of that. We knew it was a serious problem—we had no idea how big it would become—and we knew it was an emerging epidemic that had to be dealt with.

Czaplicki: Was this the kind of thing where you would brief Mayor Byrne, or do you generally do your work and wait until called upon to have those levels of discussions?

Turnock: At the time, I was the deputy commissioner in Chicago, so the idea would be to certainly brief the commissioner, and certainly the news reports were becoming well known. I don't recall briefing the mayor specifically on this, but things evolved very rapidly. And the few cases that we were aware of in January of '83 grew steadily over the next few years.

Czaplicki: Chicago's in a budget crunch in this time period, so how were you funding these efforts? Was that limiting your ability to respond, or were you repurposing?

Turnock: Well, we didn't know a lot about how to respond at the time. I think the initial effort was to try to develop a surveillance system that would make AIDS cases reportable. Since it was a new condition, it wasn't one of those that was mandatorily reportable by doctors and hospitals and laboratories. We enacted some regulations through the Board of Health to get that done, and we hired staff, or probably drafted staff who were working in sexually transmitted disease or other infectious disease programs, to begin to put that together. The first step is figuring out what you're up against, how many cases there are, and trying to keep track of that. Certainly, knowing cases allows you to investigate contacts of those cases. And to the extent that we knew how to prevent or control it at the time, providing that kind of information. Testing services were somewhat available—well, this is '82, so this is actually before the test that was eventually used by the blood banks, a quick test for antibodies to the HIV virus. Those testing centers and those testing capabilities evolved over time, and during '83, '84, and '85.

Czaplicki: What would a reportable case entail? Are they sending over entire medical records?

Turnock: No, there's a case definition in terms of what the clinical and laboratory characteristics need to be in order to qualify as a case. Hospitals or physicians would then report cases that met those definitions, just as they would report cases of tuberculosis, gonorrhea, syphilis, or any of the other thirty or forty reportable diseases that were already on the books.

Czaplicki: So is it just a number, or is it a brief synopsis of contact?

Turnock: They provide a name, and there's demographic information about the person who's diagnosed with this condition. And again, depending upon what the infectious disease is, there's different measures that the health department would take in terms of interviewing the individuals, attempting to identify any contacts who were at risk, and providing what information we had at the time about the best ways to prevent or control the disease.

Czaplicki: It sounds like from the get go, you really involved affected groups in the community through your outreach. What we were some of the more important groups that were involved in this?

Turnock: I think the most important group, initially, was the Howard Brown Memorial Clinic on the North Side of Chicago, which serves a large gay population. They have been involved with the health department for a long time in terms of various sexually transmitted diseases and hepatitis, and they have a number of infectious disease physicians closely associated with them, people who worked at Northwestern, Cook County Hospital, and Rush. So they were a key group, and they were a group that felt most threatened by the spread of this disease. A good number of the early cases occurred among gay males in Chicago, so they were the most active group initially and the most supportive of the city and the state getting involved as quickly as possible.

Czaplicki: They serve a particular geographical area, correct?

Turnock: Mm-hmm.

Czaplicki: Were there groups, say, on a smaller scale on the South Side, on the West Side, sort of these areas we talked about in your last interview?

Turnock: To some extent, yes, but the gay community on Chicago's North Side has long been very well organized. They jumped right into this. You know, they're active socially, politically, and culturally, and they were particularly poised to get involved early. Because the first cases occurred among that group, they were involved heavily from day one until the disease began to

appear in other parts of the city, which really took some time. Other groups didn't feel as much threatened by it. The early cases were largely among gay males and IV drug users, and it was believed at the time, the Haitian population. Among all of those, clearly, the gay community in Chicago was the best organized group to protect their own interest and to advance the cause.

Czaplicki: Was it possible you were missing cases in other areas, just because of lack of access to care?

Turnock: Absolutely. It certainly is possible that if you don't have a system out there that's looking for a particular condition, you're not going to find it. Getting the surveillance system up, and getting the doctors, the hospitals, and the laboratories aware that this was now a reportable disease, takes some effort. No doubt some cases slipped through, but the evolution of AIDS occurred somewhat later in Chicago than it did on the East Coast and the West Coast. And to some extent, that later start resulted in fewer cases eventually in comparison to the epicenters of the epidemic in Northern California, New York City, New Jersey, Miami, and places like that.

Czaplicki: Right. Especially if you do it in terms of rates rather than raw numbers, our rates were significantly lower.[30]

Turnock: Exactly.

Czaplicki: Not triple digits.

Turnock: It was a later start, and I think that was reflected throughout the Midwest; most of the metropolitan areas in the Midwest lagged behind the East and the West Coasts, certainly in the onset of AIDS in the U.S., but also eventually in the overall case rates that occurred.

Czaplicki: Did that fit with past diseases, public health threats in the U.S.? Is that a similar pattern that you find, or was AIDS different in any way?

Turnock: I don't have a lot of basis for comparison there. I don't know that that occurred with other conditions, like syphilis, or gonorrhea, or tuberculosis, or, again, the dozens of other reportable diseases. AIDS is a unique phenomenon that began right before our very eyes, and a lot of these other conditions had been around for centuries or longer.

[30] By December 1989, Chicago ranked last out of the twenty metropolitan areas that had the highest number of AIDS cases, with 46.6 cases per 100,000 people. For comparison, San Francisco's rate was 443.7, New York's was 263.9, and Miami's was 164.9. Illinois Department of Public Health, *The Illinois Response to AIDS and HIV Infection* (April 1990).

Czaplicki: We talked a little bit about Lonnie Edwards last session. I wanted to come back to him on this issue, because he was a frequent target of criticism, particularly from gay leaders but also from some health officials. It got to the point where he had announced his intent to resign in '87, but Harold Washington died and Mayor Sawyer asked him to stay on. Then in 1988, he fired Dr. Linda Ray Murray, who was developing anti-AIDS programs for the city, and several city staffers resigned in support, including the new administrator of Chicago's AIDS Education Office.[31] Why do you suppose Edwards was such a lightning rod, and why was there such—I don't know if I'm mischaracterizing it—a tumultuous relationship with the AIDS workers on his staff in Chicago?

Turnock: I don't know all of the details there, because I wasn't working for the city those last few years that Dr. Edwards was commissioner. But certainly, the Chicago Department of Health, and other health departments, have had a difficult relationship with the groups most affected with AIDS. Many of those organizations have long felt that the government didn't act quickly enough or didn't move strongly enough, and that that reflected some underlying devaluation, or undervaluation, of the population groups most impacted with AIDS; especially early in the epidemic, when just about all of the cases were among gay males and IV drug users, people that are—at the time anyway—somewhat marginalized from the rest of society. So there's been a constant battle about whether government acted quickly enough, strongly enough, provided enough resources, placed AIDS at the highest priority level that those groups felt it ought to be. That kind of tension and contention has existed with AIDS from the beginning. It's part of the landscape; there are just some groups that are so impacted and so threatened by it, it becomes their prime cause, and if that's not reflected in what they see government doing, they battle the government agencies. And it wasn't just Chicago, it was San Francisco and New York City, and just about every other place that had significant numbers of AIDS cases.

Czaplicki: But in this case, you also had people from the health department resigning. Were they tied to the community, or was this a separate issue?

Turnock: Again, I don't want to generalize, but a good number of the staff who worked in the AIDS program early on came from the high-risk groups, especially Chicago's gay population. I think they felt a special affinity towards those groups, and politically, if that's what this was, would have supported greater attention by the government and the health department to AIDS programming. But that's not really unusual with any kind of a program within an agency. The staff there are often the strongest advocates for doing more, rather than less of that. So I think a lot of these influences may have come together, and the staff that were involved felt that the agency they were working in wasn't

[31] Howard Wolinsky, "Leaders Blamed for Care Crisis," *Chicago Sun Times*, January 31, 1989.

doing enough, and their efforts would be better directed somewhere else. I can't speak for them, I don't know exactly who did it.

Czaplicki: Any workers stand out in your mind in that initial response to this crisis? People you don't often see in the headlines, internal staffers—who were some of the important actors?

Turnock: There were a number of people associated with Howard Brown who were just standout people, and they were true leaders when we formed this initial working group. David Ostrow, PhD, who was the research director at Howard Brown Memorial Clinic. I believe Harley McMillan was the director at Howard Brown. I think he subsequently died. A number of the people that we initially worked with from the gay community ended up dying from the disease. They acquired it before people even knew it existed or had any sense about what to do about it. A number of those people that were part of this initial formulating group are no longer with us. A number of physicians were very actively involved from the get go. Renslow Sherer at Cook County Hospital and his partner Ron Sable, another physician, were two of the physician leaders who were actively involved in serving individuals diagnosed with AIDS in those days. A number of physicians at Northwestern University, similarly. As I said, there were a good number of community leaders from the gay community—as well as medical professionals, especially infectious disease specialists—who were heavily involved.

Czaplicki: So those losses, when you actually have some of the responders being taken by this disease, how did that…

Turnock: It's devastating. When I was state health department director, we had a number of lecture demonstrations at high schools that I did with our senior health educator in AIDS. His name was Gary Monachino. And Gary died from AIDS after we did this for a year or two.[32] It affected a lot of us in the public health business personally, because a good number of our coworkers, who were so heavily invested in this program and worked so hard in this program, left us as a result of being victims of the epidemic.

Czaplicki: Did Chicago pursue any of the policies that caused such controversy in places like San Francisco and New York? Like closing down the bath houses or regulating some of the spaces?

Turnock: Certainly. And I think those were some of the frictions that would occur, especially with the gay community. There certainly were bath houses and bars that were largely frequented by gay males, and there was an effort to focus on them in terms of providing information and outreach and referral to the testing centers when they became available. So yes, efforts to reach them, either through education or through regulatory approaches to minimize the harm, if

[32] Monachino died August 18, 1992, at age 35.

possible, certainly attracted attention, and some of those things resulted in battles.

Czaplicki: Just to talk a minute about higher level leadership, so Harold Washington and Eugene Sawyer, and how they're responding to this. In 1989, Renslow Sherer called for the new mayor—this is during the mayoral election—to take an active role in AIDS education. He said, "This sort of leadership has been seriously absent to date."[33] And I was curious if you agree with that assessment, either at the time or looking back.

Turnock: Well, I'm not sure what context Renslow made this statement. I hold Renslow in high esteem. When we developed our own state AIDS council, and it was actually embedded in legislation that was enacted, Renslow was appointed the chairperson of that. So I'm sure he had a good reason to challenge the political establishment to do more about AIDS. I suspect his comments were on target, at least in terms of representing his feelings, and that of a lot of health professionals, public health people, and individuals in the affected risk groups in communities, that not enough was being done. I'm not sure if…

Czaplicki: I guess one thing I'm wondering is if you need to get the word out in some of our underserved areas, the West Side and South Side, and you don't have as dense a network of institutions that are responding to this, we do have the city's first African American mayors, right, in Harold Washington and Eugene Sawyer. Are they out there waving the flag for awareness in those communities?

Turnock: I don't know. I don't know that I can judge the priority that either of them placed on AIDS, especially Mayor Sawyer. I never really worked with him when he was mayor.

Czaplicki: How about Harold Washington?

Turnock: Harold Washington took AIDS very seriously, but at the time, there was lots of confusing information, lots of political agendas being played out, and not a lot of tools that were available to really combat the condition. I think that many people in government and in the health industry by and large felt somewhat powerless. This epidemic was growing so quickly, we were barely able to keep up with counting new cases, and there was really little to offer in terms of medical care. Getting access to people at risk who might be sexual contacts of these individuals was difficult from a civil rights, and of course privacy, as well as political level. So there was just lots of back and forth, and the interplay, and no real solutions on the table. I think everybody felt frustrated by this. I'm sure Dr. Sherer did as well, serving so many of the early AIDS victims here in Chicago, and called out for more to be done. But at the time, there wasn't an awful lot to offer.

[33] Wolinsky, "Leaders Blamed."

Czaplicki: You arrived in the Thompson administration in April 1985. At that point, and I know very quickly, you start to do some things, but upon arriving, what was the state doing in terms of responding to AIDS?

Turnock: I believe by then, the state had also moved to make AIDS reportable, so there was a surveillance system available statewide in which Chicago and other local jurisdictions participated. And ’85, I think, was when the ELISA test, the first large-scale affordable test, became available for use in the blood donation centers to protect the blood supply.[34] People began to use that test to begin to identify individuals who had been infected but hadn’t quite reached the clinical stages associated with AIDS. There began to be a greater focus on the preceding infection, HIV, rather than the full blown AIDS, with the hope of being able to prevent the spread of the disease to others, as well as the feeling that perhaps there would be some treatments coming down the road soon that could be offered to individuals.

Czaplicki: When does AZT come out? Is that’87, late ’86?[35]

Turnock: I don’t know exactly when, but it was in the second half of that decade. And that wasn’t a terribly effective treatment by itself; effective treatments really didn’t become available for another decade. There was a lot of research going into this, lots of efforts to try to do what you could. But I think a lot of the attention in ’85 was on trying to use the test judiciously; trying to increase public attention and awareness; reaching individuals, especially in the high-risk groups, to offer them testing and counseling services; and attempting to prevent person-to-person spread of the disease.

Czaplicki: You’ve mentioned the importance of developing these surveillance systems. How easy is it to set one of those up? Is it just a matter of defining the condition and putting the word out? Or are there other things you need to do?

Turnock: I don’t want to make it sound easy, but surveillance for AIDS builds upon the system that has long been established for other infectious diseases that are reportable. There’s been thirty or forty that are mandatorily reportable for decades, and we keep adding to that list. So first, AIDS, and then HIV became reportable conditions, and the systems that collect that information—which means physicians, hospitals, or laboratories—were required to report it to local or state health departments. It was an add-on to the infectious disease reporting systems that largely were already in place. It wasn’t terribly difficult, but getting those parties to understand and to do it is an education in outreach activity in and of itself.

[34] Enzyme-linked Immunosorbent Assay (ELISA).
[35] Azidothymidine (AZT) was the first drug approved for treating HIV/AIDS.

Czaplicki: So presumably, salmonella is occupying the majority of your attention when you first get into the job at the state level?

Turnock: I wouldn't say that, no. The governor had appointed a task force to look into the salmonella situation, and the legislature had its own body looking at stuff. And within a few months after I became director, that was all behind us. They found what they could find, but they never came up with a definitive cause as to what happened. Hillfarm Dairy never reopened their huge dairy plant ever again, and nobody had the courage to go in and buy it and make milk there. So the focus of attention moved on to other things. Certainly, HIV and AIDS were one of those, but there were also issues that I think we discussed last time—infant mortality, certain services for moms and kids in order to prevent infant mortality, teen pregnancy, and parent support services. Those things would probably consume more time than cleaning up the salmonella issue.

Czaplicki: And I imagine that those issues would often overlap when you're talking to teens about pregnancy as part of a health education campaign?

Turnock: Yeah.

Czaplicki: Governor Thompson took his first significant steps to address AIDS in 1985, because he signed the first two AIDS-related bills that the General Assembly passed. I guess they had passed a resolution in '84, but in terms of legislation, it wasn't until '85. That was also when he created, as you've mentioned, the AIDS Interdisciplinary Advisory Council. I was curious about this group—where it came from, what its responsibilities were, what was the motive force behind its creation?

Turnock: I think the reason why we needed something like that was to bring together the people who had some experience and expertise with this new condition. This wasn't something that was well understood. In the medical community, there were relatively few practitioners and institutions that were serving persons with AIDS. And if the state was going to begin to develop policies, programs, and services in this area, it needed a fairly broad-based group that represented the professional interests and the community interests, in terms of the high-risk groups, to help guide that. And certainly to help guide thinking within the administration, but hopefully to help guide thinking within the General Assembly.

Czaplicki: How did you decide on the board's composition, and who made those decisions? Did Governor Thompson do that? Did you come up with a list of who to appoint? I saw conflicting reports in the press, so it was unclear.

Turnock: Well, the governor makes these appointments.

Czaplicki: Right.

Turnock: But no doubt, most, maybe all of the recommendations, would've come from the Department of Public Health, and me as director. I'm sure we played a significant role in it. I don't know to what extent there were shifts or changes, but most of the statewide health organizations, the professional groups, the Medical Society, the Hospital Association, certainly were represented, and there were some of the folks that were kind of frontlines people dealing with this, like Dr. Sherer, who were in there as well. It was a best effort at the time to identify those folks who would hopefully provide wisdom that would help shape the state's response.

Czaplicki: Were you developing this list, or is that something you delegated to your aides?

Turnock: I don't recall. I'm sure I played a significant role in it, because like I said, I was really one of the first public health people in the state to be engaged in this when the first cases were identified in Chicago. So from a public health point of view, I probably had as much grounding in this as anyone else, including any of the staff we might've hired.

Czaplicki: How did Renslow Sherer become the chairman of this? What was the thought process in making him chairman of this commission?

Turnock: Dr. Sherer was a highly respected infectious disease physician and a very caring and compassionate individual who really had no political agenda. He's just a real solid health professional without any apparent political motivations or axe to grind, and he's extremely articulate and thoughtful, a good convener of bodies, a natural leader. He was a great choice.

Czaplicki: I was surprised by at least one appointment, right? I noticed that Rep. Sam Vinson, Republican from Clinton, was on there. I came across several statements he made in the General Assembly when it was considering AIDS legislation. Do you know what the intent was of adding him to that board? He didn't seem the most sympathetic person, I'll say.

Turnock: I don't know about sympathetic. He certainly was one of the most active legislators early on. He definitely had a very conservative view of what needed to be done, and I think he represented a significant number of legislators. I think the effort was to try to, I won't say balance, but represent the different camps or viewpoints within the General Assembly so that they would have a place to have their voice heard as these policies are being considered, so that they wouldn't be excluded. I think Sam was put on there for that reason.

Czaplicki: Is there also hope to educate that wing?

Turnock: Again, I don't think there was a clear consensus as to what all of the right and the wrong things were. At the time, there were highly varying viewpoints of what this condition was and where it came from, who was responsible for it, and what role government should take, if any, in dealing with it. Those kinds of viewpoints go on with just about any kind of significant issue, and AIDS was a significant issue at the time. Folks like Sam Vinson and Penny Pullen needed to be part of the discussion, otherwise they could theoretically undermine it, or the General Assembly could deal with these issues without considering the recommendations of this interdisciplinary council.

Czaplicki: December 9, 1985, you have the first meeting of this commission, and Vinson attacks the selection of Harvey Grossman, who was an ACLU lawyer, who had been appointed to be the legal counsel for this commission and consider the legal issues related to any measures you might pass. His quote was, "I think the public wants to know if this group is concerned about public health, and not about the concerns of *those* people who might be spreading AIDS."[36] Were many of the meetings this contentious? And how did Grossman come to be appointed to the committee? Do you recall that?

Turnock: Harvey Grossman was the chief lawyer for the Chicago ACLU. And ACLU certainly had an interest in the rights of the individuals who either had AIDS and HIV or who were at risk of it, and how government might deal with them. He was included on this council for that reason. I don't know how many other lawyers there were; I suspect there were a handful, including some of the legislators. But certainly, Harvey Grossman probably represented a more liberal or progressive view towards AIDS and AIDS policies than individuals like Sam Vinson. So I can certainly foresee how that kind of conflict would materialize in the course of meetings or people talking about meetings.

Czaplicki: Would his presence be a sign of Governor Thompson's views on the importance of civil liberties on this issue?

Turnock: Who, Harvey Grossman's?

Czaplicki: Mm-hmm.

Turnock: Not necessarily. The governor has his own legal staff, and I'm sure they have a wide range of views. I think Harvey Grossman, representing the ACLU, is very much focused on civil rights issues, and that's the line of work that he's in.

Czaplicki: I just thought it was interesting that he was picked to head the subcommittee that would be considering legal matters around any potential legislation. More than just being a presence, he seemed to have a little bit of control over that.

[36] Dave Schneidman, "Stormy Beginning for AIDS Task Force," *Chicago Tribune*, December 10, 1985.

Turnock: That may be. Harvey Grossman is an activist, and a very well-respected activist at that. To be honest with you, I don't recall how the different committees were formed and chaired. I would suspect Dr. Sherer probably made that appointment, and I suspect Dr. Sherer and Harvey have had some pre-existing relationship in dealing with some of these issues, and that Dr. Sherer had confidence in Harvey. And as I remember, most of the other members of the council were comfortable with this, but there may well have been some who were opposed to this, and very vocally opposed to it.

Czaplicki: Overall, how would you assess the committee's effectiveness? Did it carry out the duties, did it meet the expectations you had for this body? Because I think it's gone by 1989.

Turnock: It was intended to fill a void that existed early on in the days when the state was beginning to deal with AIDS as a public policy and a public health problem. It was an intent to bring together that kind of expertise and to help guide things. Three or four years later, there's probably less of a need to have a body doing that, and the capabilities of the state health department and others ostensibly would have been built up. There might not be a need for some body outside government to play that kind of role. I think these bodies work themselves out of a job as policies and programs and services get implemented. Then there's less of a need for folks to help point you in the right direction.

Czaplicki: Just to back up for a second, did you say there was a legislative mandate to form this committee initially?

Turnock: I think it was eventually…

Czaplicki: Or was it an initiative out of the executive?

Turnock: I think we formed it without a legislative requirement or authorization to do so, but I believe one of the pieces of legislation that was enacted in '86 or '87 then authorized it and kind of institutionalized it. There are a number of other advisory bodies that state agencies use, and the state health department uses, to get input from the stakeholders that are involved in an issue. I don't think it was unusual, but because the topic was so hot, it probably got more attention than a lot of these others. You know, I can't remember the newborn screening test advisory board having this kind of high profile. But yeah, I think we put it together because we needed it, and then when there was the ability to institutionalize it, I think it was included in one of the bills.

Czaplicki: Do commissions like that, whether you want to call them a blue ribbon panel or something, serve a useful function just in terms of raising awareness, providing a focal point for community output, or people who are interested in

seeing this issue get addressed? It's such a visible way to do it, as opposed to handling it at the agency level.

Turnock: It certainly expands the participation to where it includes a broader group of interests. Maybe that gets more attention, maybe it doesn't. I think the real intent is that it provides a broad-based, thoughtful set of assessments and policy recommendations that the state health department, other state agencies, or other levels of government might consider. Since it's outside of government itself, it has the potential to inform and advise a variety of bodies. I think that's the real value of it, and as I said, because AIDS was such a hot political and media issue, this council got a lot more attention than similar ones that had been developed for other purposes. And certainly, that's good for attention and awareness and perhaps education, but a lot of these issues were so politicized that you just had a lot of back and forth, and he said-she said; We think you ought to do this/No, you ought to do that; We need more money/No, you don't need more money, you're wasting the money you have. (laughs) Yeah, it's just…

Czaplicki: Speaking of that politicization, 1987 is really the watershed for addressing AIDS in Illinois.

Turnock: An outbreak of legislation.

Czaplicki: Yes, from the General Assembly, which had previously tried. In '86, there were many measures, but they all failed to pass when they deadlocked. But in '87, the General Assembly passed seventeen bills, several of which were controversial. We don't have to get into all of the details of this, but what were the main issues with this legislative package? To you, what were the most objectionable bills that the GA passed?

Turnock: The General Assembly didn't pass very many objectionable bills, but there were a couple. But I think the backdrop here is that there were seventy-five or eighty pieces of legislation introduced that year. So the seventeen that got passed largely represented the most thoughtful approaches. And an awful lot of the bad bills, bad ideas, did not get passed.

Czaplicki: What would be an example of a bad idea?

Turnock: Many of the bills attempted to take advantage of the test that had become available, to test anybody. I'm sure you want to talk about testing marriage license applicants—

Czaplicki: Yes.

Turnock: —which is one of the bad ideas they got passed. But there were probably fifteen other bills to test teachers, or healthcare workers, or food workers, or

toll booth employees—you just name it. There was a whole effort to take this test, which had been devised to protect the blood supply, and to use it on all kinds of populations, to test them for AIDS and HIV. A lot of those bills were bad ideas, for the same reason that the marriage license applicant testing was a bad idea and proved to be a bad idea.

So the backdrop here is that there was really a flurry of legislative activity. I think this was about the time when AIDS began to be perceived as a threat to the everyday person, since some big celebrities had been identified to have AIDS, including Rock Hudson. And this began to shift public thinking away from this being a disease that only affected certain kinds of marginalized, at-risk groups—gay males, IV drug users, and a few others. Now it was a threat to everybody, so the General Assembly, kind of responding to that public concern and anxiety, attempted to do what it does in any kind of a situation, legislate something. That's the tool that it has, so it takes its tool out of its tool chest: "We're going to craft a piece of legislation. What do we got? We don't have a cure, we got a test; let's apply the test." And that was pretty much the thinking. Again, it was an effort to try to do something, but having very limited tools to deal with this massive outbreak in the making. So a lot of the ideas were bad ideas from a public health point of view, or a public policy point of view, and they did not get very far.

The bills that eventually were signed as a package had a huge number of *really* outstanding provisions, and many people looked at the package nationally and thought it was kind of a very progressive package because of the way that it protected the rights of individuals who had AIDS, who were at risk. It expanded the anonymous voluntary testing in counseling centers, where people who thought they might be at risk could go very confidentially, in fact, anonymously, to get tested at a health department site. Then they could be followed up if they were positive. There were lots of really solid ideas in this package, but there were a couple of things that we had fought from the get-go.

One of those was the idea to test marriage license applicants. We felt it was a very, very, very low-risk group, and that if you tested those individuals, you would create all kinds of problems, some of which were associated with the test. There'd be a significant share of those people who looked to be positive but weren't really positive.

Czaplicki: False positives.

Turnock: False positivity. The proportion of false positives could become a problem, because people would be making decisions as to whether they're going to get married, whether they're going to have kids, whether they're going to continue a pregnancy—huge, major, important personal and family decisions are being made on information that is somewhat unreliable. We thought that about half of those tests would be false positives in that population, and they were. So we said this is not a good use of this test; it's likely to create problems like this.

We found it created even more problems, because the number of people getting married declined by 25 percent. And they weren't all getting married in neighboring states. So some of the people who proposed this legislation were concerned that now, "People are living in sin, they're not getting married. This is anti-family." That's bad for their worldview, and they kind of backtracked when they saw that going on. The county clerks got upset because they weren't getting their marriage license fees. Grace Mary Stern and some others got together as a political influence to try to get the bill repealed.

Chet Kelly, who was the director the AIDS program, and I did an evaluation of the first six months. It was published in the *Journal of the American Medical Association* and showed how low the return was. It also showed that it cost $300,000 to identify a positive tester, half of whom weren't really positive, and that we could, in fact, spend that money much more effectively on other kinds of activities to identify individuals or prevent and control the disease through education, outreach, and other kinds of services. Eventually, I think wisdom prevailed: the General Assembly backed off, the governor backed off, and the bill was repealed.[37]

Czaplicki: Yeah, when did that get repealed? Is that '89?

Turnock: The law was in effect all of '87, and for the first eight months of '88. So it got repealed in the summer of '88. It was in effect for twenty months.

Czaplicki: And I think the marriage licenses dropped…

Turnock: They dropped, I think, almost 25 percent the first year. Then the second year, because it was in effect for only eight months, they were still down, like, 15 percent . And as soon as the next full year, when the law was no longer in effect, the number of marriage licenses returned to the year preceding the bill's implementation. I mean, it really had a dramatic impact on marriages. And as I said, one of the problems with it was that people who didn't want to be tested that way could get married somewhere else if they wanted to.

Czaplicki: I guess Kenosha was a popular destination.

Turnock: Kenosha, and Paducah, and Evansville. The study included examination of the number of Illinois residents getting married in those neighboring counties, but it fell far short of the total number of marriage licenses that weren't issued. That was a wakeup call to some of the conservative Republicans who backed this bill, because they didn't want to be seen as supporting something that was anti-family. The scientific information, the moral considerations, the political

[37] Bernard J. Turnock and Chester J. Kelly, "Mandatory Premarital Testing for Human Immunodeficiency Virus: The Illinois Experience," *JAMA* 261 (June 16, 1969): 3415-3418. On the state's response to AIDS, see James Thompson, interview by Mark DePue, September 10, 2015, and Jeffrey Miller, interview by Mike Czaplicki, July 7, 2015.

influence of county clerks, which can never be underestimated (laughs) as a group—all of those things came together.

Czaplicki: As part of their income, did the clerks get a share of the fees?

Turnock: They get the—marriage licenses are on a fee basis, so you pay your fifteen or twenty-five dollars. That concerned them because they're small shops.

Czaplicki: And in '87, didn't Surgeon General Koop come to a meeting in Chicago and speak out against the premarital testing provisions?

Turnock: I don't know. If he was here, I'm sure he did. (laughs) I mean, there were no public health or medical people anywhere that supported this. It's unfortunate; only two states enacted this, so we're in the fine company of the state of Louisiana, who dismissed their effort after six months without even evaluating it. We had the unique experience of having this in effect for twenty months, and I think there were 250,000 people who were tested as a result of it. I think a little over fifty were found to be positive, and we felt that the background false positivity rate was about twenty-five. So everybody who was told they were positive, there was a 50 percent chance that that information was wrong.

Czaplicki: So why did the governor back this? Is this something you had discussions about with him?

Turnock: Yes, I did. I think the governor's feelings came down to two arguments. One was, If this saves one baby's life, it's worth it, whatever the costs. Damn the torpedoes, you know, one life saved is worth whatever this costs. And it wasn't all public money being spent on it, because people were paying this out of pocket themselves. Whatever those costs were, the several million dollars, it wasn't coming out of the public budget. So there was no harm there. And I think the other issue that played a small role in this was that Illinois had an archaic provision on its books for a long time, which required that people getting married present evidence from a physician that they're free of infectious diseases. It had totally been ignored, and I don't believe anybody followed it for decades, but it was on the books. Some made the legal argument, and it goes something like this: Well, if we test for syphilis, which doesn't kill you, why shouldn't we be testing for AIDS, which does?

Czaplicki: I was going to ask you that very question. (laughter)

Turnock: Right. Yeah.

Czaplicki: I didn't realize that law was being ignored in practice.

Turnock: Absolutely, absolutely. Most states had fortuitously repealed those ancient provisions for this communicable disease testing with marriage licenses, but

Illinois, and probably ten or fifteen others, still had them on the books. So that was cited, I think, in the discussions with the governor. But I think the primary thing that moved the governor was the concern that he had for fetuses, unborn children, who might be affected by this. His belief was that this justified it, this was worth it. It's a very difficult argument to counter. It's a firm belief, a basic value that the governor had. And I think one or more of his advisors felt the same way, so we were not successful in getting him to change his mind. He only reluctantly changed it after all of the bad stuff happened with the twenty months of testing.

Czaplicki: When you talk to him, just on a personal level, is it a debate, is it legal argument, or did he just listen to your views? Did he push back?

Turnock: Well, the governor enjoys arguments. (laughs) He enjoys differing viewpoints, but he's the decision maker here. I think he listened to everything, and just in his own mind, he weighed it and felt that saving one or more infants' lives was worth all of this other stuff, all of this abstract stuff about not finding many and the problems that could occur. And he really didn't know at the time what the impact would be from people leaving the state and all of that other stuff. I think he was compelled by his basic principles to uphold this view, and he pursued it.

Czaplicki: Was this the sort of thing where you had multiple opportunities to plead your case, or did you just get one meeting, and that's it?

Turnock: There weren't a lot of meetings. There was more than one, probably two. This was a hot topic, and unfortunately a lot of attention surrounding this package of bills focused on this lemon. (laughter) So a lot of the good things that were in that package and enacted were under the radar here. But everybody focused on this because it was unique; the same bill had been introduced in dozens of states, and it was not enacted in any place other than Illinois and Louisiana. So some other viewpoint prevailed in those places, but not here, and he made the final call.

Czaplicki: How did you fight it in the General Assembly? How does the Department of Public Health resist a measure that they think is bad?

Turnock: We go and testify, and we have legislative staff who deal directly with key legislators on these issues and try to figure out what information they might need to help them adopt this position. There's several opportunities to do so, but the majority of the General Assembly thought this was a good idea.

Czaplicki: Would a larger budget help sway opinions?

Turnock: A larger budget?

Czaplicki: Back to this earlier theme, because it seems like with several of the provisions, they're not listening to what health professionals are advising them to do.

Turnock: They hear from lots of different people, and I think the members of the General Assembly, at that time, were really looking to try to show that they were doing something about AIDS.

Czaplicki: Was it '87 or was it '88 when downstate really starts to see its first cases? There was a big expansion in the counties outside Chicago.

Turnock: I don't recall. There had been some cases even in '85 and '86 in the metropolitan St. Louis area, and others. So the disease began to spread and appear throughout the state during that timeframe. But I really think it was the feeling that they wanted to show their constituents that they were doing something. The test was misunderstood and perceived to be some silver bullet that could in fact make a dent in this terrible epidemic, and it was the only scientific tool, or technical tool, that was available. A lot of legislators felt that this education, awareness, and outreach stuff was *soft*, you know, "It's just not *hard science* and technology like a test," and to show how serious we are about AIDS, we need to deploy all of the technology and science that we have, and forget this social science stuff. I think a large number of General Assembly members, because they didn't have anything else, went along with this. And some of the proponents were really aggressive and pushy, and influential, and intimidating to their fellow legislators. I speak of folks like Sam Vinson and Penny Pullen; they whipped a lot of people into shape to—

Czaplicki: And they had leadership roles, correct?

Turnock: Penny did, yeah, absolutely. And Pate Philip strongly believed this as well. (laughs) I mean, the Republican leadership was very much aligned with this view, and it prevailed.

Czaplicki: Once this package got passed and people were focusing on the lemon, as you called it, Governor Thompson took his time to consider what arrived on his desk. He apparently decided that he would shape this further through his mandatory veto powers, and also through a very overlooked area, which is making the rules for how you're going to actually administer these laws.

Turnock: Sure.

Czaplicki: Did you have a lot of input in that process?

Turnock: Absolutely. And as I said, just about all of the pieces in that package were things that we strongly supported. The marriage license applicants was one we didn't. Unfortunately, that just drew more attention than it deserved. There

were a couple other small pieces in there that—I think one had to do with notifying school officials if there was a child with AIDS in the school.

Czaplicki: Superintendents and board of education presidents.

Turnock: That's an area that we opposed as well, in terms of confidentiality and stigmatization, and a dozen other similar reasons. But we didn't feel that that was nearly as backwards as testing marriage license applicants. Other than that, I can't think of anything in that package that we strongly opposed at the time. Most of those bills were good bills, and they represented the kind of policies that the Interdisciplinary Advisory Council supported; in fact, a lot of them came from the thinking of those members. If you had to take the package as a whole, I thought it was a good package with one real problematic component.

Czaplicki: Maybe I'm misspeaking, but I think you may have also opposed the mandatory tracing of sexual contacts for a seven-year look-back period?

Turnock: I think there's lots of misunderstanding about mandatory tracing.

Czaplicki: Wasn't that how the bill got passed out?

Turnock: Not really. All contact tracing is voluntary, because you can't mandatorily track somebody's contacts if they don't tell you who they are. (laughs)

Czaplicki: But I thought there had been a proposal initially to potentially impose a fine if people refused to divulge the info. Did that not pass?

Turnock: Again, these are kind of nutty. How do you know that they [aren't cooperating] unless they say, "I refuse. I know who they are, but I'm not going to tell you." In order to maintain contact tracing, you have to have the trust of the people that you're getting the information from. Contact tracing for syphilis, gonorrhea, and other sexually transmitted diseases has been going on for *decades*. It relies upon a trusting relationship, and when you turn that upside down with language, or purported penalties, what you do is you don't get the information from the individual, and you deter other individuals from coming in to get tested in the first place. So you gain nothing, and you lose a lot in terms of prevention and control, by mandatory macho approaches to contact tracing. We had this debate back and forth with Aldo DeAngelis and Penny Pullen, and a lot of the legislators. What got passed and enacted was similar to what we do with the other diseases. It may come with language like mandatory, but it's meaningless: you can't have mandatory contact tracing; you can't make people tell you something you don't know.

Czaplicki: And as part of this debate, didn't Pate Philip threaten your confirmation?

Turnock: Oh, for sure.

Czaplicki: Did that come up in the hearing?

Turnock: Oh, absolutely. In fact, I have a picture. Here's me getting up from a Senate hearing over here, right in the corner; that's me getting up from the hearing table.[38]

Czaplicki: Oh, that's what that is.

Turnock: And you can see Aldo, Billy Marovitz, and some of the gang. (Czaplicki laughs) But yeah, they threatened to withhold my confirmation as director unless I changed my views on this, the marriage license testing, and other things they didn't like. But that didn't work.

Czaplicki: Why not?

Turnock: Why not? I think it's a political stunt and a bluff, and the governor wasn't going to stand for it. I think the people who were doing this were from the governor's own party. So it really was kind of nonsensical.

Czaplicki: You weren't worried about it at all?

Turnock: I wasn't worried about it, no. In fact, that would greatly increase my value as a public health professional. If I got fired under terms like that, I could get a job anywhere. (laughter) Don't throw me in the briar patch, don't make me a hero, you know?[39]

Czaplicki: Martyr to the cause of public health?

Turnock: Yeah, I'm just doing my job.

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[38] *Chicago Tribune* photographer Phil Greer took this photo at Turnock's reappointment hearing on April 30, 1987. The newspaper's caption the next day read in part, "Turnock defends Illinois' education-oriented anti-AIDS policy." Assistant minority leader Aldo DeAngelis (R-Olympia Fields) is standing at far left, while Sen. William A. Marovitz (D-Chicago) is seated at far right.

[39] Reference to a Brer Rabbit folktale.

Czaplicki: Who else on the governor's staff were you working with as you were deciding how to modify these bills?

Turnock: That's hard to remember everybody. The primary people were Jess McDonald and Paula Wolff. I'm trying to remember if Jeff Miller had became chief of staff by then; maybe Reilly moved up to deputy governor.

Czaplicki: So those folks, as opposed to the legal team, the chief counsel?

Turnock: Well, we had lots of lawyers in the Department of Public Health, and we had a very strong legal team. No doubt, they coordinated with the governor's legal folks, but yeah, I think a lot of this planning was done by the department. Most of the rules were enacted through the Department of Public Health.

Czaplicki: The divide you see in the General Assembly, a more conservative wing in terms of the proposals they're presenting, did that extend into the executive office? Were there members of Thompson's staff who were more sympathetic with that approach?

Turnock: By and large, no. I think just about all of the governor's staff agreed with us. The marriage license was one where I know the governor didn't, and I think Paula didn't, but I think just about everybody else saw the marriage license testing as a poor idea.

Czaplicki: Were Paula's reasons similar to the governor's, or did she have her own logic?

Turnock: In fact, I wouldn't be surprised if she had a strong influence on the governor in that area. But no, I think that was kind of a principle, a moral concern that justified that program and kind of minimized the arguments against it. Some of these were abstract, they may or may not occur. It's not money we're spending, it doesn't cost us anything, and it's a good result to have.

Czaplicki: While the governor was considering these measures, August 16, 1987, DAGMAR sponsored a 24-hour vigil outside Thompson's Chicago home on Fullerton Avenue, with one hundred activists outside. Six protestors, including David Bell, who had AIDS, chained themselves to a fence for two and a half hours outside his home. Then in 1988, they targeted his house again, this time over testing without patient consent.[40]

Turnock: Oh, that's another one they snuck in.

Czaplicki: Mm-hmm, so that was a year later, and they were chanting, "Shame, shame!" outside of his house.

[40] Dykes and Gay Men Against Racism/Repression/the Right Wing (DAGMAR). The Thompsons had moved from their home on Fullerton to the 800 block of West Hutchinson Street in 1983. Susy Schultz, "Gay Protestors Ask Governor to Veto AIDS Bills," *Chicago Sun Times,* August 17, 1987.

Turnock: That one was snuck in with no debate at the behest of the Medical Society, something that very much upset me and others in the public health community, because it really backtracked from the confidentiality guarantees that were built in to the package that the governor crafted in '87. That was thrown in by Representatives Pullen and Vinson, just as the legislative session ended on June 30. And I felt that was not good.

Czaplicki: What motivated the Medical Society to do that, do you suppose?

Turnock: They believed that they were responding to concerns that physicians would have raised about the red tape, the paperwork involved with getting a special consent signed by an individual for HIV testing, and believed that whatever consent the patient would provide for any and all testing would cover that. I think it was a perception that this placed a burden upon practicing physicians, and this was an effort to reduce that burden.

Czaplicki: But the governor signed it, correct?

Turnock: Yes, the governor signed it, despite a series of public opinion letters that the state health department director wrote and published in a number of newspapers around the state. (laughs)

Czaplicki: Oh, you did a campaign?

Turnock: Yes.

Czaplicki: How did he respond to that?

Turnock: He never responded directly to me; he never said anything negative, never discouraged me from doing that kind of stuff. I always thought he kind of liked it. But I clearly tried to get him not to sign that bill, and it didn't work.

Czaplicki: Do you know what his motivations were in that case?

Turnock: The governor comes from a family of medical practitioners. His dad's a doc, and he maintains very close relationships with the State Medical Society. Not knowing all of the details, I would strongly suspect that the Medical Society asked him to do it, and he did.

Czaplicki: Back to this question of protest. What are your thoughts on protests of that nature, DAGMAR picketing the house or this later protest? Do they influence the governor? Do they make your job easier or harder?

Turnock: I don't know that they influenced the governor, but the governor's a very thoughtful person about these issues and gets lots of different viewpoints

before he makes decisions. I think things like that get a lot of media attention that may then add to the governor's considerations about a particular issue. But it's not unusual in Illinois, or any place else, for AIDS activists to do those kinds of things to challenge the government in terms of what it's doing and how much of a priority AIDS is, and to push the issue. I mean, they have friends and family members who are dying…frequently. And as I said earlier, in those days, the diagnosis of AIDS was virtually a death sentence. Few people who were diagnosed with AIDS lived more than a year or two after the diagnosis. There was a sense of urgency that no longer exists. So those kinds of events were staged to draw more attention to those issues by legislators and by the governor.

Czaplicki: It seems Illinois follows a similar track as the U.S. in terms of the timing of its response. So only in 1987 does the surgeon general send out his famous letter to every household in America explaining AIDS and trying to promote awareness. You've spoken to this already in many ways about Illinois, but just in general, especially at the federal level, why the lag in response? Or do you think the lag's overblown? Do you think things were being done?

Turnock: There's several different perspectives one could take. One is, governments respond slowly to everything. Governments are huge, big bureaucracies, with lots of forums, lots of different viewpoints and opinions. It's hard to move things quickly; it's hard to gain a national consensus. This was a health issue, a public health issue, that didn't initially appear to be a threat to everybody. The primary stakeholders are these disenfranchised and marginalized groups who don't have a lot of influence in the process, and a good share of the population would claim that this disease was their own doing, a result of their own behavioral choices, therefore they're getting what they deserve. I think with different moral viewpoints as to what's going on and the slow-moving wheels of government at all levels, it's hard to both decide upon and then execute a meaningful response. Plus, in the eighties, as we talked about before, there weren't solutions. So what is the response? The response is to prevent person-to-person transmission of the disease. And that means something different to different strata of society, and different groups in terms of their own risk, and culturally. It's just a huge undertaking that would take a while to gear up and do. It took five years from when the first cases were identified to when the federal government—largely through the prodding of the surgeon general, not through the president of the United States—began to do stuff.

Czaplicki: That was my next question. Thinking about the president of the United States and the symbolic politics, even if you don't quite have the scientific resources yet to address the problem, how important is rhetoric, using the office as a bully pulpit? Did Reagan's silence, did the noise of people like a Jesse Helms work to shape the debate in Illinois in certain ways?[41]

[41] Jesse Helms was a deeply conservative Republican senator from North Carolina.

Turnock: No. We have our own counterparts here in Illinois playing similar roles, so I don't think the national debate shaped what goes on here.

Czaplicki: That doesn't empower them? Because Reagan did name Penny Pullen to his AIDS committee.

Turnock: He absolutely did. And she was as disruptive there as she had been for the interdisciplinary council here in Illinois. But that didn't stop them from promoting reasonable policies that they pushed up through DHHS. Eventually, there were federal programs and services for prevention and control through CDC, and Ryan White Services for victims through the Health Resources and Services Administration a year or two later. Eventually it got through. You know, I don't know how critical people can be of the timing here. This wasn't going to happen in a year or two, and the fact that it happened in five might even be a positive assessment. There were still widely varying viewpoints about what this disease is and where it came from, who was at risk, what needed to be done, and how much of a priority this should be.

Czaplicki: Any thoughts as to why Reagan named her to his panel?

Turnock: I don't know who named her to the panel. I'm sure he appointed her, but somebody had to suggest her.

Czaplicki: Exactly.

Turnock: Just as we did with our own council, no doubt there's a need to have a forceful representative of that viewpoint. There were lawmakers from other states who were appointed to that council and represented a different viewpoint. I think she gained enough notoriety through her leadership and the actions that she instituted here; she was visible, and she would be a good spokesperson for that point of view on that kind of a committee. They probably felt the need to have somebody, and she was experienced, she had the credentials.

Czaplicki: So you're not sure who suggested her, though?

Turnock: I have no idea. And I'm trying to remember even who was involved in the Department of Health and Human Services, and CDC, and others at the time. I would doubt that they did.

Czaplicki: We'll ask the governor. Maybe he'll have some ideas on how her name came up.

Turnock: (laughs) I didn't recommend her.

Czaplicki: I'm shocked. (laughs) Why do you suppose this moral framing of health issues is so prevalent? I mean, you have Reagan saying we need to "recognize that, when it comes to stopping the spread of AIDS, medicine and morality teach the same lessons." Sex education, health awareness, and things like that, right, would be opposed on the grounds, in the words of Representative Jane Barnes, Republican from Palos Park, "I myself don't feel we should be passing out contraceptives in high schools. I think it promotes promiscuity." This is a frequent formulation you see, not just in this time period, but on other issues. Why do you suppose that is? And how do you crack it as a health professional?[42]

Turnock: I'm not sure how you crack it, because these are behaviors that result in health, and they have the possibility of being determined by someone else to be good or bad behavior, moral or immoral behaviors. I think that's what frames a lot of this. Many people have different basic value systems when it comes to what they expect from others, how they perceive and treat others, and what kind of behavior on the part of others is acceptable or not. And for AIDS and other behaviorally mediated health conditions, that colors people's views of what needs to be done—or not done. I think that's just an expression of the underlying social values that different people have, and social values are as important in public health as the science of public health is. It's what do you want to do with the science that you have and the knowledge that you have about diseases and conditions. What do you choose to do with that? Sometimes we choose not to, because underlying social values suggest that people aren't behaving properly, and therefore, they don't deserve attention or resources or programs or dollars—or they are, and they do.

Czaplicki: So this would be one reason why you always find decent support for childcare, for justifying health programs in the name of children, because they're seen as innocent?

Turnock: Yes, they're more innocent than adults. Unfortunately, they grow up to be adults, and then they become less innocent.

Czaplicki: Similar issues of social values arose with a very notable event when you were trying to raise public awareness through a public service announcement that you developed, right? And a particular song called "The Condom Rag" featured the line, "Pardon the pun, it's in the bag, all you've got to do is the condom rag."

Turnock: Right.

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[42] Barnes made this argument on behalf of a bill she sponsored to ban school health clinics from offering contraception to students. "Panel Acts to Bar Birth Control Aids in Schools," *Chicago Sun Times*, June 11, 1987. Reagan made his comment at the National Institute of Health on July 23, 1987. "Remarks at a Panel Discussion on AIDS Research and Treatment," John Woolley and Gerhard Peters, *The American Presidency Project*, Santa Barbara, CA, http://www.presidency.ucsb.edu/ws/?pid=34595.

Czaplicki: Apparently, the editorials had a field day with this, and the governor was none too happy about this as well. Do you remember the ruckus over this?

Turnock: Certainly. This was a skit in a day-long series of events that were scheduled in Springfield for the first AIDS Awareness Week. Somebody took offense to the words of this early rap song, and they contacted the governor, I think, late at night one night, and asked him if he condoned the words to the song. He said of course not, and banned the playing of that ditty ever again under the auspices of a state agency. (laughter)

Czaplicki: What form did the ban take? Did you get a memo? Did he call you up?

Turnock: No, no one ever called me up and told me that we couldn't do it. We all read about it in the newspapers and realized that this had attracted the governor's ire. Yet the controversy itself probably did more to promote AIDS awareness and what was going on that week than if we'd done the same series of activities without the song in seventy-five places rather than one.

Czaplicki: Early viral marketing, right?

Turnock: Yeah, absolutely. It was the controversy that was the story, and the backdrop that it had something to do with AIDS gave it a lot of exposure and free publicity. I think we did several studies a couple of months later tracking condom use, and found an association with about that time. So it probably did more good than bad, but we couldn't use the song, although I'm sure the song has been played and done somewhere else.

Czaplicki: Did you anticipate that controversy?

Turnock: Not at all, not at all.

Czaplicki: Did you ever get a call about this?

Turnock: No.

Czaplicki: So that's interesting. I'd never thought of that as a strategy, I assumed Reilly or someone would've called you up. Did you often get messages through the press, as opposed from a formal channel?

Turnock: Well, there may be others who got a message. I don't know if the communications director, the public information officer may have gotten a more direct communication from their counterparts in the governor's office. But it was clear the governor took a position and we could all live without the song, so what's the problem?

Czaplicki: Who worked on that campaign? Where did the whole idea even come from?

Turnock: We had a staff that worked in our AIDS Activity Office. Their job was to do things that promoted awareness of HIV, and these kinds of events were part of an outreach and education campaign. It was the kind of thing that they did normally, so there's nothing offensive in the whole activity. It was that this song offended somebody. The governor took a position when they asked him about the words of the song, and he then went on to take another position that it wouldn't be played again. And that's cool; this isn't about the song.

Czaplicki: So you never knew who ratted you out?

Turnock: I don't think anybody ratted me out. I mean, dealing all the time with the media, there are folks who are looking to get you on something or create a controversy where there isn't, and that's the environment. They found something, they called the governor late at night and got the response that created the headline, and they're very successful.

Czaplicki: Another issue, and a bit more consequential, perhaps: New York and Tacoma were experimenting with needle exchange programs, providing clean needles for IV drug users. And you essentially ruled that out, saying you'd follow it, it'd be an interesting experiment, but you felt that you couldn't do that in Illinois because it'd be such a political hot potato.

Turnock: Because we already had a law on the books that made possession of needle works a crime. I mean, it wasn't like starting from ground-up and saying here's something we wanted to initiate. First we've got to decriminalize the activity, which takes you into an arena where it's bigger than the AIDS component of that issue. And that wasn't something that we thought the law enforcement community in Illinois, or the legislature, was willing to tackle as a major new initiative. It didn't seem to be worth fighting something that was so clearly going to be a loser at the time.

Czaplicki: I was curious how you defined what was possible. Was that something you and your staff would figure out on your own, or was that something that you talked about with the governor's office?

Turnock: Yeah, certainly the governor's office staff would be engaged in these discussions. But this would've been a unique approach, a very, very aggressive approach, that might work in some states where you had a different view of IV drug use, IV drug users, and penalties for that crime, and for even being associated with the needles and the stuff. It just opens up a whole different set of issues that would take a lot of time and effort, and probably wouldn't result in a huge gain, in terms of preventing future cases, in terms of the time and effort, and the resources that would be put into it. This is not a

state that is disposed to those kinds of things. (laughs) It's just not a battle we chose to take on at the time. Most states, you know, still haven't taken it on.

Czaplicki: Did you raise the possibility of doing this with the staff?

Turnock: I think what we ended up suggesting was pilot programs. If we're going to do this, let's do it at a small scale, in some controlled environment, where we can evaluate the results and have hard data to try to sell the program to the law enforcement community and the legislators who would be hard sells. So just kind of relying upon the arguments and the progressive thinking that might take place in Washington State and New York City, that didn't exist here. If we're going to do it, maybe try to get some funding for some pilot programs. If there's not enough support to get funding for pilot programs, there's not going to be enough to change the whole policy.

Czaplicki: Did you make a pitch to the legislature, or did it not even get that far?

Turnock: I'm sure we made a pitch in the budget process, but these would be small little demonstrations.

Czaplicki: I guess I'm curious whether or not Thompson's administration let that go forward to the legislature.

Turnock: No, no, I don't think it ever got proposed. Whether it was for budgetary reasons or because there was opposition to the idea and the program, I don't recall.

Czaplicki: Looking back, and you've already addressed this in many ways assessing the city and the state response, is there anything you would've done differently in responding to the emergence of AIDS, or that you wish had been done differently?

Turnock: I wish so much of this hadn't been personalized. Being the head of the public health agency during all of this, I certainly became the target for a lot of opposing viewpoints—left somewhat, but certainly from the right side there. And I think a lot of these debates kind of served to legitimize some of these bad ideas, including the marriage license, mandatory contact tracing, and other things. All of these charges and threats and public debates about these things, in the end, did serve to add greater credibility to some really bad ideas and arguments. If there were a way to better avoid that, that would've been good.

I always would've liked to have come up with a better argument for the governor, in terms of the marriage license testing being justifiable if it saved one baby. I'm still at a loss to come up with an argument for somebody who believes so strongly that if just one thing happens, it's worth whatever it might cost and what harm it might create. That's another thing I sure would

like to have come out differently. But in the end, I think we put that idea to bed once and for all. We did have the unique opportunity of being able to evaluate that, and we demonstrated that a lot of the scientific thinking and the public health approach was, in fact, correct there.

So yeah, I think there were a few things I would change, but it was a very tumultuous time. And trying to be responsive in an organization in which you don't have unlimited resources, and where AIDS was a growing problem but not perceived to be public policy issue number one on the agenda, is sobering. I think a lot was done, a lot of good people worked on that program, and I think Illinois has fared reasonably well in comparison to a number of other states over the course of the HIV epidemic. But we lost a lot of people.

Czaplicki: While this is all going on, the public health department's responsibility to regulate medical providers gets you embroiled in another highly contested issue, and that's abortion. Ultimately, your name ends up on a very important case, *Ragsdale v Turnock*. How did that come about? What was the particular issue at stake in that case?[43]

Turnock: It all began when the sole abortion provider in northwest Illinois lost his lease, and he'd been providing abortion services in the Rockford area for a long time. His name is Dr. Richard Ragsdale. When he began his search to find another location, he encountered some problems, and he encountered the need to go through a process that, in Illinois and other states, is called certificate of need. It's kind of a health planning process that requires new facilities and programs of service to demonstrate that they're needed, before they're approved by this board and can go forward. And one of the provisions of that process is a public hearing. They held a public hearing for a proposed new site for his abortion facility, and it brought a lot of anti-abortion forces together, drew a lot of attention, and made him feel very uncomfortable.

So with the assistance of the ACLU, he challenged the statutes that he thought prevented him from being able to reopen his abortion services wherever he might want to. He challenged several state laws that related to the certificate of need process, but also to the regulation of facilities that do outpatient surgeries, including abortions. He was successful in his court challenges, and the lower courts tossed out the ability of the state health department to regulate any facilities that perform abortions, and the ability to regulate abortions in facilities that were licensed to do other kinds of outpatient surgeries. In effect, the state health department had no authority to set standards—in terms of health and safety, or medical practices, or credentials, or anything like that—for abortion procedures in the state. So the state health department continued to appeal this decision, and eventually, it was appealed up to the U.S. Supreme Court.

Czaplicki: And they had set a hearing for December 5, 1989, but it never got to that point because you reached a settlement.

[43] *Ragsdale v. Turnock*, 841 F.2d 1358 (7th Cir. 1988).

Turnock: Well, there were a lot of things going on. This whole process took several years, and actually started in ’85 or so. There were ongoing legal issues, and at each step, the courts would reaffirm the lower court’s decision, which, in the perspective of the state health department, gave us no authority to set health and safety standards for women who were receiving abortions in these facilities. We felt that was wrong, unacceptable, and we needed to regain that authority. So that’s why we continued to challenge this. At about the same time, the composition of the U.S. Supreme Court was changing somewhat, and its views were shifting a little bit away from those that resulted in the *Roe v. Wade* decision in the early seventies.

Czaplicki: Right, this would be the Rehnquist Court that takes shape in ’86.

Turnock: And there were a couple of cases that were heard the year before, which suggested that the Supreme Court was looking for a case that involved the question of a state’s ability to regulate abortions, and they might use that case as a vehicle to go beyond whatever the narrow questions were in that case itself to overturn or change the ground rules for *Roe v. Wade*. So with that in the backdrop and our case going to the U.S. Supreme Court, we thought we’d probably win there. In fact, we were really sure we were going to win there, based on the merits of our case and the composition and current thinking of the U.S. Supreme Court. But we were concerned that the court might take advantage of our case and go beyond its scope to reverse *Roe v. Wade*, something we didn’t think was appropriate—nor did the ACLU, who was honchoing the Ragsdale legal team. They were fearful as well that if this case did sit before the Supreme Court, they would lose doubly: they would lose whatever advantages they gained with the lower court decision, and they’d lose the whole ballgame with a larger decision reversing *Roe v. Wade*. So we had common interests here, in terms of not wanting the Supreme Court to take advantage of our case to do something beyond the scope of what we were challenging.

We ended up compromising, developing a settlement agreement that would restore the ability of the state health department to regulate abortions in these facilities. Not all of the standards that would apply to ambulatory surgical treatment centers would apply to abortion facilities, or abortions in these facilities; there would be a cut-down set of standards that we thought were necessary and medically appropriate, which they felt they could accept as not being unduly burdensome in limiting access to abortion services by increasing the cost of the services. So we settled, and that needed to be affirmed by the lower courts, and it was. And the pros and the cons, you know, got together around all of those decisions, but the court reaffirmed them, and that’s pretty much how that was settled a couple of weeks before it was to be heard orally before the Supreme Court.

Czaplicki: Neil Hartigan was handling the legal case for the state, correct?

Turnock: The attorney general's staff had always been handling the case for us, but he came in when it was clear this was going to go to the U.S. Supreme Court. So he played a very personal role in taking over for his assistant attorney general staff, and in the discussions and eventual settlement negotiations.

Czaplicki: There was some criticism that he waited an awfully long time, because I think you finally had the settlement talks to hammer out the agreement in November, a month before it was supposed to show up in Washington before the U.S. Supreme Court. Any thoughts as to why it came so close to the wire?

Turnock: It's a settlement, so you have two parties trying to come to an agreement. The lawyers representing Dr. Ragsdale—and I mean basically the ACLU lawyers, Colleen Connell and staff—truly believed that the laws that had been overturned did restrict access to abortion, that there was an additional cost involved, and that cost didn't justify whatever health and safety protections those standards brought with them. There was a lot of back and forth about specific standards in terms of structures, hand-washing facilities, credentials, space between beds—all kinds of things embedded in medical standards. Each and every one of them was almost challenged in terms of, Well, show me that by keeping the beds two feet apart, you prevent more infections than if they're eighteen inches apart. So it was a very tedious set of discussions that eventually resulted in the ACLU believing that the remaining standards were not improper and, in fact, served a good solid public policy purpose: they protected women's health and safety. They would prevent many of the abuses that Pam Zeckman had written about and the BGA had found ten or fifteen years before, which prompted the inclusion of abortion facilities under the Ambulatory Surgical Treatment Center Act. It was tedious that way, there was a lot of back and forth, and it took a while to come to some kind of basic agreement that these standards are okay, the rest of them we can dispense with. These provide enough health and safety protections, and don't unduly burden women's access to these services.

Czaplicki: Did Attorney General Hartigan's gubernatorial ambitions play any role in his decision making? Because in our interview series with Governor Edgar, he suggested that Hartigan, at one point, had been pro-life and anti-abortion, and that his run is what converted him to pro-choice.[44] Had he not been running, might he have let this go to the Supreme Court?

Turnock: I think the attorney general was on board with all of our thinking here, that regardless of whether one supported or opposed *Roe v. Wade*, we didn't want this case to provide the vehicle for that decision to take place. That wasn't anybody's agenda here. I believe Attorney General Hartigan was pro-choice, actually, at the time. But I mean, he's an Irish Catholic, the director of the state health department is an Irish Catholic, and the lead lawyer for the ACLU

[44] Jim Edgar, interview by Mark DePue, September 2, 2009, 461.

is an Irish Catholic. This is a difficult, uncomfortable situation for all of us in terms of carrying out our professional agendas, given whatever underlying religious and moral directions that we follow.

Czaplicki: Did you have any pressure from the Church?

Turnock: Not me, no. I'm led to believe, at least from the news articles, that there were some church officials that threatened Attorney General Hartigan. I mean, he's a much more visible and important person in all of this than I was. Clearly, we knew where the Catholic Church would stand, but there were lots of other viewpoints and stakeholders in this, and at various points they would let us know what things they liked and what things they didn't. That played out throughout the appeals, and it certainly played out throughout the settlement hearings that took place in several courts.

Czaplicki: Did Governor Thompson have much of a role in these? You have two different constitutional officers. Did they coordinate at all or get involved in the discussion?

Turnock: No, the governor was very comfortable with the direction we took. I think he well understood there's really different languages being spoken here. We're talking about public health protection, health and safety standards. You can make a strong argument that there's no reason why women undergoing abortions shouldn't have the same protections as women undergoing bunionectomies. It just doesn't make sense; it doesn't make sense that a facility can provide any old kind of outpatient surgery and be regulated for those, then provide abortions and not be regulated for what goes on for that. I mean, it's just prone to abuse and disaster. I think the public health protection arguments are very strong, as are the basic civil rights and privacy arguments embedded in *Roe v. Wade*. I think we've developed a comfort level with that decision, so whatever side you fall on, that decision is not unreasonable. And we don't look for opportunities to replace it with something else.

Czaplicki: Just in general, abortion is such a key battleground, it inspires such passions. Because of the role public health has in inspecting these facilities, was there a lot of pressure on the agency to use that ability to try to restrict abortion? Regardless of whether you did or not, were there legislators, were there activists who wanted the department to take a more aggressive posture in its inspections?

Turnock: I don't think—from a regulatory point of view, and from a medical and public health point of view, an abortion is like any other outpatient procedure.

Czaplicki: Right, but from a non-public health perspective, from someone who really wants to stop abortions, did they look at your agencies and think, Oh, here's a way we can do it?

Turnock: There have been instances where people have complained about atrocities taking place in these regulated facilities for the patients receiving abortions, or fetuses or infants being born truly viable, and then being murdered or killed. I mean, it's just all kinds of incredible tales that are told to try to stir up this debate. As I said, I think from a regulatory point of view, the regulators don't go in and look at the abortions any different than they do other similarly complex outpatient surgical procedures. They want to make sure that the people that are doing these have the right credentials and qualifications, there's backup in referrals from emergency services that are available when you need them, and that there's good quality care provided for whatever this specific procedure is. And there's no moral or religious axe to grind, or way to really do it when you're inspecting facilities and writing reports.

Czaplicki: Well, there'll be a few issues we don't get to, but that's always the nature of these things. But I just have a few general questions on your time in the administration as we wrap up here. You were very motivated to try to build up a strong public health system, bringing in community clinics and integrating those with established hospitals and other institutions like that. Is it difficult to carry out that mission when a lot of the key functions seem to be under Public Aid? For instance, I was struck by the disparity in AIDS funding. There was one year where the total budget Public Health had was $7 million. Meanwhile, Public Aid's general funds portion for AIDS control was $30 million. Or the issue of Medicaid, right? It seems like if you had the power to control Medicaid reimbursements, you could actually do some things to get these institutions to coordinate more.

Turnock: But I think that's reflective of the different resources that are provided to prevention versus treatment. Public Aid is involved in providing services, and medical services, treatment services, are very expensive. On the other hand, prevention-oriented services are relatively cheap in comparison to treatment. In the whole health sector, we spend 97 percent of our resources on treatment, and 3 percent on prevention and public health. So I think you see that kind of situation play out, even among the state agencies. Those state agencies that pay for services have a lot of money. And those that pay for prevention, which an ounce of prevention is worth a pound of cure, right? So there ought to be sixteen times as much spent on cure as there is on treatment, according to that old adage. And we're not far from that. So it's not so much the dollars that shape the landscape here, it's what business you're in. If you're in prevention and population-based activities, it's relatively cheap in comparison to providing services for people who have conditions and problems that require medical and other social support services. That's the expensive end of it.

Czaplicki: I guess I was thinking that earlier, you talked about trying to get the city and the county to coordinate services better. And I know there was an attempt to have a big health summit shortly before you left. So would having oversight

of Medicaid and determining reimbursement rates be a way to bring actors to the table and impose some sort of order? Would that provide an opportunity?

Turnock: Well, states go back and forth between approaches that have standalone health and welfare agencies or have these umbrella human service agencies. Ultimately, the focus of responsibility ends somewhere, and there's still somebody in charge of it all, making decisions that result in how the standalone agencies or the multipurpose human service agencies act. I don't think there's anything that suggests the best way to do this. The best way to do this is to have people throughout that decision tree who are like-minded and committed to clear consensus goals and objectives. Yeah, it would be nice to have run all of those, but now the governor runs them all, or somebody at that level runs them all. And who's to say that somebody at that level would do a worse job than someone like me at running a multi human service agency? I don't know. The jury's long been out on this, and there's no best way to do it, and states change all the time back and forth without having any real difference in what goes on.

Czaplicki: Looking back on all your years of government service, anything you would've done differently? Any programs you wish you could've implemented, or tasks left unfinished?

Turnock: That's what careers are for. In public health, you don't have to work in government to have an impact on the public health system. There's other ways to achieve what you want. I think we're all somewhat limited, in whatever environment we're in, in terms of what we can accomplish and would like to have done more. But I think the years in the Thompson administration in Public Health were very good years, in terms of the programs that were developed, the resources that were obtained, and the visibility and credibility of the agency in the eyes of the public and the legislators. Yeah, there were things here and there that didn't work out, or that flew back in our faces, or that got us into political or economic difficulties, but those were good years.

The governor was a good governor, and he provided solid leadership. And beyond that, he provided incredible support for agency directors like me. I mean, he was not one to pick up the phone and ream you out after you did something that he didn't like. He might let you know if he didn't like something, but he placed his full confidence in the people that he appointed in these positions, and that's really an incredible environment in which to work.

Czaplicki: So what are you most proud of from your time in the administration? Is there a particular program?

Turnock: The things I'm most proud of would be the things that I did to unify the state and local public health network, in terms of developing standards, sharing resources, and considering them to be peers and partners to the state agency, that they weren't expendable local contractors, they were part of the team, part

of the club. They were just as important as the people who worked for the state health department, and they were part of a system in which we play a role in the state, they play an important role at the local level, and we're in this together. I think that was always my greatest concern. And we accomplished much in that area. A lot of these other things were interesting and important. AIDS, clearly—just starting from ground zero, trying to do the right thing until science would advance some real hope for people who have these infections. That was important.

Czaplicki: You've talked before about public health moving in cycles, crisis to crisis. And sometimes, things backtrack, backslide. But is there anything that identifies the Thompson legacy? Is there something unique or particular he imparted to Illinois that still endures?

Turnock: Governor Thompson is an honorable man and a principled man, a thoughtful man, and a real leader who gives his delegates full autonomy to carry out their jobs under his general supervision and vision. I think that's a legacy that I'm not sure has continued through state government here in Illinois. He was an honorable man, he had great people working for him throughout state government, and I think it was an honest, relatively open, and reasonably progressive administration that I'm sure he's very proud of, because I think people who worked for him were very proud of working for him.

Czaplicki: Any closing thoughts, something we didn't bring up, or you want to add before we end?

Turnock: No, I'm tired of talking.

Czaplicki: (laughs) Well, I very much appreciate all of the talking that you did, so thanks very much, Barney.

Turnock: Okay, thank you, Mike.

(End of interview)