Kenneth R. White, PhD, AGACNP, ACHPN, FACHE, FAAN

Narrator

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Interviewer

Eleanor Crowder Bjoring Center for Nursing Historical Inquiry

University of Virginia

Biographical Sketch

Kenneth White was born and raised in Okmulgee, Oklahoma. He earned a BS in biology from Oral Roberts University in 1979 and an MPH in health administration from the University of Oklahoma Health Sciences Center in 1980. He spent 13 years with Mercy Health Services as a senior executive in marketing, operations, and international health-care consulting before moving into academia and a career in nursing. He earned both a Bachelor of Science in nursing and a MS in executive nursing leadership in 1995, and a PhD in health services organization and research in 1996, all at Virginia Commonwealth University. Between 1995 and 2001, Dr. White served as associate director of the MHA and MSHA programs at Virginia Commonwealth University, and from 2001 to 2008, as director of VCU's MHA program, while holding the inaugural Charles P. Cardwell, Jr., Professor of Health Administration. He was named the inaugural Sentara Healthcare Professor in 2012. Dr. White left VCU in 2013 and was named Professor Emeritus of Health Administration.

In 2013, Dr. White joined the University of Virginia, where he served as Associate Dean for Strategic Partnerships and Innovation at the University of Virginia School of Nursing and held the UVA Medical Center Endowed Professorship in Nursing along with joint appointments in the McIntire School of Commerce, the Darden School of Business, and the UVA School of Medicine. In 2020, Dr. White retired from the University of Virginia and was named Professor Emeritus. During these years, he worked as a registered nurse and went on to a earn a Post-Master's Certificate in the Adult/Gerontology Acute Care Nurse Practitioner program at UVA in 2013 and maintained a clinical practice as a palliative care nurse practitioner. In July 2021, Dr. White was appointed Dean and Professor of the MGH Institute of Health Professions School of Nursing in Boston; a position he held until he retired in May 2024 and was named Dean Emeritus.

Dr. White was inducted as a Fellow of the American Academy of Nursing (AAN) in 2012. In 2017, he was elected to serve a two-year term on the AAN's Board of Directors, and in 2019, he was elected to serve a four-year term as AAN president-elect (2 years) and president (2 years) through October 2023. In 1990, he was inducted as a Fellow of the American College of Healthcare Executives, where he also served as a former regent and member of the Board of Governors. He was the founding chair of the LGBTQ Forum of the American College of Healthcare Executives from 2015 to 2018. In 2019, ACHE awarded Dr. White its highest honor, the Gold Medal Award, acknowledging his lifetime achievement as a health-care executive, scholar, leader, and pioneer in LGBTQ inclusion. Dr. White also holds a visiting professorship at the LUISS Business School in Rome, Italy, and is the author of several books, including the award-winning *The Well-Managed Healthcare Organization*, 9th edition (2019), *Take Charge of Your Healthcare Management Career: 50 Lessons that Drive Success* (2015), and *Boost Your Nursing Leadership Career* (2017).

Interview Abstract

Kenneth White begins by discussing his background, including his family, upbringing, and education in Oklahoma, and his experiences working as a hospital orderly as a high school student. He discusses his experiences as a student at Oral Roberts University and the University of Oklahoma, and his early career in hospital administration at Catholic hospitals in Oklahoma City and the Dallas-Fort Worth area during the 1980s. He then discusses his consulting work for Mercy International at Guam Memorial Hospital in Guam in the late 1980s and early 1990s. He also discusses his sexuality, his first marriage, and the process of coming out. Next, Dr. White discusses his decision to pursue careers in academia and nursing, and his experiences as both a PhD student and a nursing student at Virginia Commonwealth University, followed by his experiences as a palliative care nurse practitioner, highlighting the role of mentors during these key transitions and experiences. He also discusses his experiences as a faculty member and administrator at VCU and the University of Virginia. Other topics discussed in the interview include barriers experienced by men in nursing; his experiences as a gay man in nursing and healthcare administration; the impact of the managed care movement on hospital administration in the 1980s; his personal and professional experiences related to the HIV/AIDS epidemic in the 1980s and early 1990s; his research on Catholic hospitals; his advocacy of LGBTQ issues in nursing and healthcare, including the establishment of the Rainbow Healthcare Leaders Association and LGBTQ Forum of the American College of Healthcare Executives; Chamorro nursing and the role of Catholic hospitals in Guam; and his commitment to diversity and inclusion as president of the American Academy of Nursing.

Interview with Kenneth R. White

Interviewed by Dominique Tobbell

Interviewed for the Eleanor Crowder Bjoring Center for Nursing Historical Inquiry, University of Virginia

Interviewed at the Home of Kenneth R. White, Afton, VA

Interviewed on August 4, 2021

Kenneth White – KW
Dominique Tobbell – DT

DT: And then we'll get started.

KW: Yeah. I might make sure, this is coming off [referring to cell phone]. The only reason that I had this on is—had it with me—is because I'm at work right now.
[LAUGHTER]

DT: Yeah, no. Totally understandable. And obviously, if you need to take any calls.

KW: I'm scheduled out, but—

DT: But it doesn't stop people. You are the dean.

KW: Right, I know. And I have had a few urgent things happening lately.
[LAUGHTER]

DT: OK. Well, I'm Dominique Tobbell. I'm here with Dr. Kenneth White. And it is August 4, 2021. And we're at Dr. White's home in Afton, Virginia. And so, thank you for meeting with me today.

KW: Sure. It's my pleasure.

DT: So to get us started, I thought I'd ask you if you could tell me a bit about your background, where you grew up, educational information, before we get into the nursing and health care area.

KW: Sure. This is a good week to ask me, because I'm putting together a slide presentation for our retreat that I'm leading this year up in Boston. And I had my sister send some photographs that were in my mother's scrapbook. I was born and raised in Okmulgee—O-K-M-U-L-G-E-E, Oklahoma, June 28, 1956 in Okmulgee City Hospital.

And interesting to me, the man who delivered me, Doctor Miller, I was named after. His first name was Ray, and my middle name is Ray. And then, he just died two months ago, actually of COVID. I was brought in by the family to assist him with decision making at his death. I had been best friends with his daughter. We started kindergarten together, and we're still very, very good friends. She lives in Tulsa.

Okmulgee is about 60 miles south of Tulsa. And my family—it's a pretty rural community. And my parents-my father's name was Miles Delano, but not because he was a part of the rich Delano family, but because my grandmother liked FDR. And Miles Delano White, and my mother's [maiden name] was Jane Roberts. And they both grew up with parents that either didn't have an education at all—my grandfather couldn't read or write—my father's father.

My grandmother, his mother, had a high school education. And my mother's parents had a fourth- or fifth-grade education. They had all immigrated to Oklahoma from the East Coast at one point. And generations before they arrived in Oklahoma, this is a new state, and then they came from Arkansas. So most of my ancestors on both sides are [from] Arkansas.

Okmulgee is named for the Ocmulgee River, which runs through Macon, Georgia. And actually, that's where Carl's from. And it's spelled differently, with a C, in Georgia. But the reason that the town was named Okmulgee is because, when the Native Americans were driven out of Florida and Georgia's southeastern part and were herded up to Indian territory, they thought that this town—because of the river—looked like Ocmulgee River in Georgia. And that's how they named it.

And so, I went to school there—public schools. I have a sister Brenda who's two years younger. We have the same birthday.

DT: Oh.

KW: My mother was a telephone operator. My father was a loan officer. Neither of them had a college education. I graduated in 1974. But before I graduated, I had this fascination with the hospital. It was the new Okmulgee Memorial Hospital, which was built about four blocks from our house. So I watched it being built and took tours of it when it was brand new. And I was fascinated by it. And I became a member of a Boy Scouts Explorer Post.

Explorer Post met at the hospital as a way to introduce health-care career options to people in high school. And I started going to those meetings. And it was fascinating. They took us to Tulsa to see burn centers, and we got gowned up to go in the OR [operating room] and watch a surgery, and all those things. And it fascinated me. And so, I became a volunteer. And then, when I turned 16, I was hired into a full-time job.

That was in 1972. I just found—I saved it to show you. My original contract, it was $1.73 an hour. I was being paid as an orderly. And so, I did that in my junior and senior year of high school full time. I worked the 3 to 11 shift. And I was able to do it, because I'd had enough credits that I could get out early for my job. And it was there in that job, and it was really my most formative years.

And I always tell my Mr. Fisher story. I don't need to tell it now—but in another context I will—was my first patient who died. I was 17. And it greatly, greatly affected me. Because we did horrible things to him that he did not want and then he died. And I just couldn't get it out of my mind that "this is going to be my purpose.” I need to be a voice for those people who don't have a voice, and especially a poor Black man without any family in rural Oklahoma in those days had no voice.

And I just kept thinking, this is just not right. I'm a pretty simple person, but this is just not right. And so, that's when I knew that I wanted to be a nurse, or I wanted to do something to help vulnerable populations. I didn't call it that then. I wasn't that sophisticated.

[LAUGHTER]

Probably still am not. So I applied to nursing school. And I was accepted to start in the fall of 1974, right after I graduated. So I moved to Tulsa in '74. And got a job full time as an orderly at Saint Francis Hospital. And then, there was a class action suit, saying that it was a discriminatory job title. Because they paid more than nursing assistants. But women were not allowed to apply to be an orderly, because it was thought that they didn't have the brawn, and they couldn't lift patients, and deal with inserting Foley catheters in men.

So the class action suit did away with that job title. And so, my job title changed to nurse assistant three. And then I became an orthopedic technician in the emergency room. And I worked my way full time through college. And I'm a student in my first year in a junior college, taking the prerequisites for this diploma program. And at the end of that first year, it closed. So I had to decide what to do. So I knew that I couldn't afford not to work.

So I did a semester at the University of Tulsa but didn't really like it. I didn't really fit in. It was a very preppy rich group of people that they were all in fraternities and sororities. And that wasn't my thing. I was scared of that actually. And so, one of the doctors at work said, that he—he was on the board at Oral Roberts University. And this is where it gets really crazy. I can't believe what I didn't know about myself then.

But Dr. Winslow suggested that I transfer to ORU, and he would support me. They were planning a new medical school. And he would support me to get into the medical school there. And so, I transferred my second semester of my sophomore year to ORU and began a degree in biology with minors in chemistry and music. And the reason that I felt like this was so attractive, first of all, I grew up in a very religious fundamentalist family. And so, that was not at all foreign to me. It didn't fit with me exactly perfectly, but I was given a scholarship—a very nice scholarship—because they were looking for someone to play oboe. And I played oboe in high school.

And so, I auditioned. And I received second chair, second oboe, the whole time I was there in the orchestra. And I'd never played in an orchestra. We only had a band. And so, I got this scholarship. And so, I didn't have to work as hard or as much. But I actually became so

engrossed in the social life at ORU, with a lot of fun people. And there wasn't that Greek thing that always made me feel uncomfortable. And in those days, I didn't drink. I had never had alcohol. And so, I mean, these people were very almost too clean.
[LAUGHTER]

But it was a utopian weird place. I had to go monthly for a hair check, because if my hair was too long, I wouldn't get a meal card. It was very strict, and just stuff like that. But I finished. I knew it wasn't a good fit. But I was too far into it. And I was required to live on campus unless I had a letter from my parents. So my mother was complicit. She helped me get my letter, saying that—she worked in Tulsa at that time at the Southwestern Bell. And so, she put her name on a lease, and she wrote a letter saying that I lived at home. And it was true. It was her home. So she helped me.

I would be remiss if I didn't mention that it was my grandmother—my mother's mother—who was probably the most influential person in those early years. And if she could have been a nurse, she would have been. She was a domestic servant. She arrived in Okmulgee in 1920 after the flu pandemic from Arkansas, because she was looking for a job. She had two small boys. And her husband, alcoholic, ran off with a woman and left her with these two children and no money.

So she found a job being a maid, a cook, a gardener for these people in Okmulgee. Okmulgee was a big oil town. They struck oil there. And so, she got on the train. And she met my grandfather at the back door, because he worked at the hardware store and delivered the first ringer washing machine. But so, she was a hard-working person, and very smart, very savvy. She was a gardener. She taught me many, many things that I had to take care of myself. And they lived in a two-room house.

And so, fast-forwarding now, I graduated from ORU. And I did apply to medical school, I didn't get in. But someone—serendipity, a turning point I call them—a turning point, someone mentioned a master's degree in hospital administration. And that was very appealing to me. And I applied to the University of Oklahoma and was accepted. I didn't apply anywhere else. And got in, did that program, moved to Oklahoma City, took a job at Baptist Medical Center as an emergency technician, and graduated in December of 1980 with an MPH in hospital

administration, and was sent—I didn't get to choose—I was sent to Mercy Health Center, a Catholic hospital in Oklahoma City. Was sent there to do my administrative residency.
And about six months into it—actually no, about three months into it—the president and CEO, Sister Mary Alvera offered me a job. And I took it. And it was director of hospital planning. And here I was, 23 years old, director of hospital planning. It was a pretty big hospital—432 beds. And this was when certificate of need laws were big during the Reagan era and all that. So I did that for a while. And then, I was promoted [with more line responsibility]. And then, in 1986, I was contacted by a search firm for a job in Fort Worth, Texas. And it was with Harris Methodist Health System as the Vice President of operations [at Harris Hospital - Hurst-Euless-Bedford Hospital.].

I took that job and moved to Dallas, Fort Worth area [Bedford]. And I had that job for a couple of years. And then, I was recruited back to Mercy by a whole new administrator, administrative team, as vice president of marketing and business development. And so, I went back. And I made a big mistake. It was not the place I left. And life lesson number one, you can never go back. Because the organization you left is not the organization you return to. And so, what I loved about it, it was not that organization. I knew I'd made a big mistake.

But I need to rewind a bit. Because in 1981, I met Ginger. And Ginger Velotta, V-E-L-O-T-T-A. Ginger Velotta. And I was struggling with my own sexual identity. But I was afraid to go there, because of so much guilt that I had grown up in the church that I attended, and so much hell and damnation, and so much fear of burning in hell, and all those things, and people not loving me. And so, I just tried to cover. I tried to pass. And anybody—I mean, I don't think I passed very well.
[LAUGHTER]

But obviously—I'm always ever conscious—thank God I don't worry about these things anymore—I was even conscious about my voice, the tone of my voice when I would answer the phone, things like that. So I didn't want anyone to have any clues. And so, I got married to Ginger in 1983. Ginger was an oncology nurse. And we were like fireworks. I mean, we didn't—she was a very strong-willed person. In that relationship, I was very passive. It just didn't work out. It was more than my sexual orientation. That part of my self was underdeveloped at that point.

And so, in 1989—1988—no. January of 1989, Gary Blan, who was the CEO of Mercy Hospital where I'd gone back to work, called me in his office. I had just gotten a bonus. I just got a raise. Called me in his office, and he said that the Mercy Health system out of St. Louis had acquired some additional hospitals. And they were merging a couple of the management teams. And they were developing a regional structure, and there was two of everything. And so he couldn't have a vise president of marketing and business development and offered me the job of director. And I refused. I would not take a demotion. So we parted ways. He gave me a six-month severance package.

And I spent the next six months in kind of a shock and depression. This place, this hospital that I loved so much, and the people there, I couldn't imagine—this shadow side of health-care administration. And so I went to a therapist. Someone recommended a therapist. So I went to a therapist, very scared, reluctantly. And that began my journey of not only reconciling who I am but learning more about my purpose and what I was supposed to be doing.

And I think that's what I was depressed about. I mean, I was not authentic. I wasn't authentic in my sexuality. I wasn't authentic in my job choice. I wasn't authentic to my friends. But most of all, I wasn't authentic to myself. I was trying to be someone that I wasn't. And so, before the end of the six months, I got a call from Glen Haydon with Mercy International Health Services, which was a division of Mercy out of the Detroit office.

And I had done some work—Ginger and I had done some work for Mercy International in 1984 when we spent three months in the South Pacific in Micronesia and Palau, helping, doing some consulting work. We were on loan from our hospital. He wanted me to go to Guam to be the administrator of the hospital and to hire someone and train someone to be the administrator. So we wouldn't have a permanent presence there.

And so, I decided to do it. And at the last minute, Ginger said, I'm not going with you. And so, we decided that it would be a year of trial separation. And I went. And while I was there, I really liked the work. I really liked being away. And I sort of could reinvent myself. Although I had to be sort of circumspect about my gay identity. But I began to explore that.

And so, I moved to Guam. And Ginger and I decided in that first year—at the end of that first year—that we were going to get a divorce. That it was not going to work. And so we did. And then, I had my first same-sex relationship with someone there. And that's when I said, so this is what I'm missing.
[LAUGHTER]

This is the part that I don't have to try so hard. I mean, this is just natural. And I got to travel. I love the Chamorro people, the people of Guam are very generous. And I learned a lot about cultural humility. Because everyone was from somewhere else there. I mean, it was a melting pot, and a really great place to be. And it was also a great way for me to get the hell out of Dodge until all the dust settled from everything else.

So when my contract—my contract was only renewed yearly, because it was being supported by a Department of Interior grant that paid Mercy for us to do the consulting work to the government of Guam. So I knew when I was there, I met the dean of the University of Guam School of Nursing, who had come from northern Michigan. And Maureen Fochtman, F-O-C-H-T-M-A-N influenced me greatly about nursing. And she said, Ken, you're a nurse. You love nursing. You want to be a nurse. You just need to go be a nurse.

And so, I knew at the end of my contract that I wanted to get a PhD, but I also wanted to be a nurse. So I applied to Johns Hopkins. I got into Johns Hopkins nursing program. And I applied to some PhD programs—Michigan, Johns Hopkins, and later applied to VCU [Virginia Commonwealth University]. And that was the one—so I decided not to go to nursing but to do the PhD program [in health services organization and research] in Richmond with Jim Begun. Because he was the best.

And Jim Begun is the one who just retired from Minnesota, married to Jean Wyman. And he really wanted me to come, and I wanted to study with him. And I told him what I was interested in. And he was interested in it. And his PhD was in organizational sociology. So it was a great, great relationship, and it still is. Great decision number two was choosing to go there.

Decision number three happened in January of my first year as a doctoral student. I realized that I'd been used to working 60 hours a week, and here I am taking three courses. I'm not

working. I started teaching [marketing] that second semester. And I told Jim—I saw a flyer for students for an accelerated second-degree program pilot. They were admitting 12 students to see if it would work. And the deadline was in a week. So he said, he would support me. And I went over and talked to the people and applied.

And the second person who made decision number three so wonderful was Janet Younger. Janet Younger is still alive. She's retired. But she was a very influential person. I'd received a lot of other blocks of people who were not encouraging me, because I had this other career in health administration. They were not encouraging me to go to nursing school. And a lot of them were at VCU. But they kept saying, no. They kept shutting doors.

And finally, I get to her. She was the associate dean for undergraduate studies. And this was her brainchild, this A2D [accelerated, second degree] program. And she said to me, I don't care why you want to be a nurse. She was very upfront about it. My job is to get, this is a direct quote from Janet Younger, "My job is to get the best and the brightest people into this school and into nursing. And you're a no-brainer." Those are her exact words.

So she got me in. And Jim supported me doing a full time PhD, full time nursing. And I started the PhD program in the fall of '93, I started nursing in the spring of '94. I graduated in December of '95 with a BSN and MS [executive nurse leadership].

DT: Crazy. [LAUGHS]

KW: And continued to May of '96 where I was awarded the PhD in health services organization and research. So that sort of launched my career. I wanted to stay there. They were doing a search. I applied and got it, and took a tenure-track position. I was immediately asked to be the assistant director of the master's programs and took that, under advice not to do it. Because administrative jobs don't help you get tenure usually. But I made that happen and went up early, actually. Went up at the end of five years.

And then continued to teach and write and elevate the program and its status from—the first year of rankings I think was in maybe '93 or '94 they were ranked number 13 or 14. And a couple of years after I left, there was a lag, it was up to number two—the MHA [Master of

Hospital Administration] program at Virginia Commonwealth University, one of the oldest ones in the country. Loved doing that. I loved promoting the program. I loved the students there. I loved teaching.

And it was my good fortune in 1999 to recruit Steve Mick. Steve Mick had been a faculty member at the University of Oklahoma when I was at Mercy [in Oklahoma City]. And he contacted me—because I was an alum with that program—he contacted me to be a preceptor for his students. And I accepted. And that's how I met Steve Mick. And then he went to various places and ended up at [the University of] Michigan as the director of the doctoral program. And I'd stayed in touch with him over the years. And when we were recruiting for a chair, I contacted Steve. Said he wasn't interested, loved Ann Arbor. But I nominated him anyway. [LAUGHTER]

And so, he becomes a finalist without even applying.
[LAUGHTER]

He becomes one of three finalists. And so, he was invited to come for a talk. And we had him for dinner. And we reconnected. And so the rest is history. I mean, he took the job. And he moved to Richmond with his wife Blair, and where they promptly got a divorce. Actually, they didn't get a divorce that soon, because that's him in the painting with a glass [pointing to a large painting in the hall near the room of the interview; “A Seat at the Table” by Greig Leach]. And that's her up at the top with the red glasses.

DT: Yeah.

KW: The artist, Greig, when I went to see [the proof]—he had left her out. And he said, you told me to paint what I saw, and she wasn't there. And I said, this is my boss's wife. At that point, I didn't know they were having trouble. And I said, this is my boss's wife, and they're coming for the unveiling. And I cannot have her not there. And he said, well, she wasn't there. So he added her in. He moved me over. And he added her back in, but with one way glasses. She can see out, but no one can see in. And the artist said to me, they're history. And within weeks after the unveiling—

DT: Wow.

KW: They were [emphasis added] history.

DT: Yeah.

KW: It's interesting what he saw. So Steve was my chair for about 10 years. And he gave me a long leash, and he let me do whatever I wanted, I mean, to run the programs. I could create, be innovative. I love that. I don't like micromanaging. I don't like being micromanaged, and I don't like doing it either. And during that period and shortly after, a couple of things happened that were turning points four and five.

Four was meeting John Griffith. John Griffith was a—and I have an oral history of John Griffith downstairs I want to give to you. He is a major figure in health administration education in the 20th century. He was at [the University of] Michigan for 50 years. He's still alive. He's 88, 89. But he wrote *The Well-Managed Community Hospital*, the first four editions. And he was looking for a co-author. And because Steve worked with him at Michigan, Steve told him that he thought I would be a good co-author to take on.

So he came to Richmond and interviewed me and offered me the job. And he didn't offer me the job at that interview, he offered me the job a few months later in Chicago at a national meeting. And so, I came on the fifth edition. It was renamed The Well-Managed Healthcare Organization at that point. And we switched roles. I became the first author, I think, on the seventh, eighth, and ninth. The ninth came out in 2019. But that partnership really helped me get tenure, and helped me to be better known in the community. The book is used by many health administration graduate and undergraduate programs. So that was a really nice turning point.

The next really nice turning point was in 2000 when I met Carl. We met 9/9 at 9[pm] in 2000. That was the invitation for a party. It was on the front invitation, it said, 9/9 at 9. And I got there about 11[pm], because I'd had another party at my house. And Carl was leaving. And so, I was coming, but I came in through a different door. And I saw him across a room. And I knew just about everybody else that was there. There were a lot of people.

And I saw him across the room, and I started walking toward him, and I saw that he was with another guy. So I thought that was his partner. And he made it clear that he had just given his friend a ride, and that he'd be taking his friend back home. So we chatted at the party. And I said, do you want to get together? It's like midnight. (And I'm usually in bed by nine nowadays.) I said, do you want to get together for a nightcap or something? I said, how about cognac? Do you like cognac? He goes, yeah, that sounds good. I said, I'm not a real bar person. Why don't you just come to my house? So he said, OK. So he said, it'll be about 30 minutes. And I said, OK.

So it was about a 15-minute drive. So I got there, and I could pick up stuff. And he arrives. And it was much later on that I realized the reason it took him so long is that he'd decided the day before that he was going to come out. He had never been in a relationship—same-sex relationship, and he wasn't dating anyone. And he decided that he was just going to change that. And so, before I got to the party, he'd made a date with someone else at the party. So when I left, and he took [his friend] Robert home. He had to go back and tell this guy, sorry, but I'm not able to keep the date. And he came to my house for cognac. And we've been together ever since.

DT: That's beautiful.

KW: 9/9 at 9, 2000. So this will be our 21st year. And in March—March 11th of 2011—we got married in a courthouse in Washington D.C., before it was legal in Virginia. The next turning point in my career was when I made the decision to step down as program director and pursue a graduate—a post-master's certificate to be a nurse practitioner. I was more and more wanting to get back to the bedside. Someone had—I have it somewhere. But someone did an interview with me and said, now that you're stepping down from the program director role, what will you do next? And I said, without thinking about it, I'd like to end my career the way I started it—at the bedside. And that was printed.

And I came home that day and I said, I don't know where that came from, Carl, but it's going to be in print now. So maybe I want to pursue this. And so, I did some homework with some colleagues. I was doing research in palliative care, but my research was more about organizational outcomes and satisfaction and the business case for palliative care units. And so,

I went to see Pat Coyne, who was a clinical nurse specialist and one of the big names in palliative nursing in this country and globally. He's a big name. And said, Pat, what do I do?

He said, well, you need to be an advanced practice nurse. And you're not that. I said, well, what do I need to do? And he said, you need to get your advanced practice as an acute care, not family. Acute care nurse practitioner, and then specialize as palliative. And so, he said, and I recommend you go to UVA. And so, I did. I got in. I went to UVA [the University of Virginia] part time. Started in January of 2011 and graduated in May of 2013. While I was there, Dorrie [Fontaine] recruited me. We had been looking for a house. We had a realtor, Bob Hughes. We'd been looking for a second house somewhere in the mountains. We were thinking a cabin, real kind of rustic. As rustic as to gay collectors of decorative arts can be.
[LAUGHTER]

And I had always loved this house. I found this house in 1993 when I moved to Richmond. Just driving around, I saw this house. And I said, someday I'm going to live in that house. And I drove Carl up here when I met him. I said, someday we're going to live in that house. And he went like, yeah Ken, but we have two houses in Richmond. And we work in Richmond. And so, I decided I'm just going to go look and see if that house is still there. Again, I would visit it periodically. And there was a for-sale sign up that had been knocked over. It was taken off the market. It was had become really dilapidated. So we bought this house.
[LAUGHTER]

And I didn't have a job at UVA then. I didn't. We put the contract on the house in January of 2013. I didn't close the deal with Dorrie until April. Two weeks later, Diane Washington contacted me that the dean wanted to meet with me. And she offered me the job. She had offered me a job two years prior. And I went through the whole search process. And I withdrew. It wasn't the job for me. It was a job for a funded researcher. And I wasn't that kind of person. So she had the UVA health system endowed chair [to offer me], which was someone who had a connection to practice.

And I negotiated a practice as a palliative care NP [nurse practitioner]. And she gave me pretty much everything I wanted. And it was a really wonderful job. And so, the next seven years until she retired, that's what I did. And I retired in September thinking that Carl was going to retire

six months later to nine months later. And then, I had a call from Paula Milone-Nuzzo, who is the president of Mass[achusetts] General Institute of Health Professions.

She's a nurse, a member of the Academy, a fellow of the Academy [American Academy of Nursing]. And I knew her on the board. She was the treasurer for a couple of years. She contacted me and asked me if I would be interested in applying for the dean of the job there. I was already in two other dean searches. And one of them wasn't a good fit for me. So I withdrew from that one. The other one I really wanted. And I was the second person.
[LAUGHTER]

So things happen for a reason. I firmly believe that. And then, this one really, I think is a much better fit. Geographically it's a much better fit. Also the welcoming attitude of the LGBTQ community is much better in Boston than where we could have ended up. So we're thrilled. We're thrilled about being in a place like that. So that brings us to the present. So now I'm Dean. I'm starting my second month. And in three weeks, we'll be moving to Boston to a one-bedroom apartment.
[LAUGHTER]

And we're keeping the house here. We have a caretaker who will be staying in the carriage house. So looking after the gardens. And I'll continue to love it here. This Rockledge—this is our haven. We've created all these gardens.

DT: Mm-hmm. They're beautiful.

KW: I'd like to show you some of the before pictures at some point.

DT: Yeah.

KW: And it's just the most peaceful place that we could imagine being. So sorry I took so long with that. But that's—

DT: No. I love it. I love it when I can ask a question, and then you can just keep going. And I'll ask follow-up questions. But I'm glad that you told the story.

KW: Did I leave anything out? I think I told you the education. I think I told you about family, tried to contextualize where I was, and why I was the way I was.
[LAUGHTER]

DT: Well, if you'll permit me, I do have some follow-up questions.

KW: Yes. Yes. Yes. Of course.

DT: And we'll go backwards in time again. You mentioned that you were accepted to a diploma program in the '70s, and then that program closed, and then you ended up graduating from Oral Roberts with your biology degree and then applied to medical school. I wonder, at any time then, did you consider applying to nursing school again?

KW: So thank you for that question. The answer is, when I was at the University of Tulsa for that one semester, I was in their program—their BSN program. I chose to go—this has been completely honest—I felt like there were too many clues starting to sort of focus on that were leading people to focus more on my sexuality—my sexual identity. Because so few men in the '70s were in nursing schools.

And in fact, in the nursing school I was accepted to, they only started admitting men in 1972—St. Johns Hospital in Tulsa. And many of them were not admitting people of color either. And here I was. I'm trying to be straight. And there was this—and still is—this idea that if you're a man in nursing, that you're a homosexual. Which is why I love that article that you shared with me [Rachel Elder, "White suits and kangaroo kills: making men's careers in American nursing." *Gender and History* 34, no. 1, (2021): 1-26.]. So that article says it all.

DT: Right.

KW: And I shared it with some other people, and I said, look, something about some men nurses at the Institute where I work now. I don't know if I would have passed for the—I don't know if I was butch enough for the standards in the '30s and '40s.

DT: Yeah.

KW: Poor Luther Christman, having to go through all of that. But I think there were just—I just thought, but I was also thinking, if I can be a physician, I just love taking care of people. So yeah, I think I would have been a good physician. But I think the real reason I pivoted was because it was getting a little too close to home. Not that I would have been ashamed of it. But I don't know. Yeah, maybe it was about shame. Maybe it was about shame. I think it was. I think it was about shame.

DT: Well, and this was the '70s. And the DSM [*Diagnostic and Statistical Manual*] diagnosis of homosexuality was only just removed at that point.

KW: In ‘72.

DT: Yeah.

KW: Yeah. And so, it's interesting. I worked a lot of second shifts in psychiatry at the inpatient psychiatry unit at St. Francis Hospital. And they were still doing a lot of really experimental treatment on people for conversion therapy. And they were doing insulin shock therapy. They were doing a lot of wrapping people in cold towels and giving them medication. A lot of weird stuff was going on then. And you probably know about Tommy Dickinson's book [Tommy Dickinson, *“Curing Queers”: Mental Health Nurses and Their Patients, 1935-74* (Manchester, UK: Manchester University Press, 2014)].

DT: OK, so, yes, we were just talking about the treatment of homosexuality.

KEN WHITE: In the '70s, and I still had that very powerful guilt of—that church guilt and not wanting to disappoint, especially my grandmother and other family members. And so I was also encouraged a lot by the physicians I worked with, and I really hadn't received any encouragement from my family. I mean, they didn't expect me to go to college. My mother wanted me to be a teacher preacher.

She had three wishes for me—be a teacher preacher, and live nearby, and bring me [her] grandchildren. And a couple of years ago, she—or maybe more than a couple, maybe five years ago, she said to me, I'm still praying for a miracle. And I said, what's that? And she said, that you'll be a preacher teacher, move close to me—move closer to me, and bring me grandchildren.

And so by this point, I was over arguing with her, trying to convince her. She's not going to change. And I said, well, mom, aren't you being a little greedy? Those are three miracles. And she didn't think it was very funny, but I went—well, I'll stop there. This is on tape.
[LAUGHTER]

So I stopped caring along the way so much about how others—how I appear to other people. But it was really huge for me at that point. But these physicians that I worked with, mostly orthopedic surgeons, because I worked with—that's what I did. That was my area of expertise.

I put the casts on people and did all that stuff. And they encouraged me to go to med school. And I had a lot of nurse mentors, and I really always, always wanted to be a nurse. And I'm glad I didn't get in to medical school because I don't think it would have been the best path for me. I mean, I ended up where I was supposed to end up.

DT: Yeah, do you think at that time when you were in the BSN program at [the University of] Tulsa—what was your sense of how you would have been received as a gay man in nursing? I mean, obviously, you had your own internal issues, but I'm wondering—

KEN WHITE: Well, at that time, I thought I was straight.
[LAUGHTER]

Or bi. But the famous line from "Sex in the City" [HBO television series] is that bi is a stop on the way to Gayville.
[LAUGHTER]

I believe there are true bisexuals, but in my case, I was—that's where I was, on a stop to Gayville. I think it was—I don't know. I was only in that program for one semester, so I was

taking prereqs [prerequisites] mainly. And I wasn't doing any clinical yet, so I never got to that. I never got to that stage. Yeah, I don't know.

I do know that, except for one, all the men that I worked with who were RNs were gay, and they were all my friends.
[LAUGHTER]

Even the straight one was my friend, and he's probably questionable.

DT: [LAUGHS] I mean, did you—you had worked as an orderly, so you had some perspective, some longer perspective on attitudes towards men in nursing. Did you see any change in that period over how men were received in nursing?

KEN WHITE: I worked with several men in the ER, and they were received very well in the ER. But I think we were also—the fact that we were men, either RNs, or techs, or whatever, we were seen as nice to have around because we helped the women get their patients out of bed. We were called on to do the heavy lifting. We were called on to do a lot of things that the women didn't feel comfortable doing. And most of the men ended up in psych, and OR, and the ER, and the urology floor.

And I think they were all respected for their knowledge and their expertise. I did hear along the way a lot of women comment that the men nurses were not—didn't take as much initiative. Almost implying they were lazy. And I don't think it was so much that they were lazy as that they were—at least I have a couple of people in mind. I think they were less excitable.

I mean, they had a much calmer feel, and when they were in charge, I loved it because they set the tone for the shift. And it was—it's not gender-specific. These are just anecdotes, but I do think that there was this idea that men—that nursing is women's work, and men just don't get it.

In fact, I was even taught that. I mean, I was even told that by a professor in a nursing class in the '90s at VCU. What did she say? Nursing is a woman's way of knowing. And I asked the

question. I may have said this before on that call. Well, where does that leave me? I want to know too.

DT: Yeah, I mean, it's—the history of nursing is historically gendered and racialized, and there's still strong threads of that. I mean, it's still very prevalent.

KEN WHITE: Very much so. Very much so. Yeah. To wit, I'm the first man president of the Academy [American Academy of Nursing]. I mean, there have been a lot of men that could have and should have been, but they [the Academy] weren't ready. And the other part of that is you may be familiar with the [AAN's] Living Legends, like Barbara Brodie's a Living Legend. In all the years we've [the Academy} been doing Living Legends, there have only been three men designated living legends, and they're all dead.

And so a corollary to this might be to know who those three men were. Luther Christman was one of them, and another one just died within the last year. But what was it about them that the women found acceptable to join the club? So I'm delighted that they're—through a series of things that happened, Dominique, in the balloting of the year that I was elected president-elect, there were two men on the ballot. And the nominating committee gets to decide. Of the people who apply, they get to decide who should be balloted.

And they decided that the two strongest candidates of the ones submitted were both men. And so I ran against another man, and I'm convinced that if I had run against a woman, the woman would have gotten it. And he and I talked about it, and I think he's very well-respected, a good friend of mine. We came together. We talked it over, and we both decided to run.

And we said we're going to be gentlemen about this. We're going to be colleagues and friends about this. If I win or if you win, I'll be the first to congratulate you and support you. And I said the same. And we're going to show them this is how it should be done. There's no backbiting. This is just the way it is, fair and square.

So that was Ramón Lavandero, and, Ramón, if you haven't heard of him, you will because he is the historian in our—goodness—for the American Association of Critical Care Nurses (AACN West). Good friend of Dorrie's [Dorrie Fontaine]. Knows everyone. Knows everything. He knows

a lot of history. He was the first man to be a nursing student at Columbia [University], and he came from Puerto Rico. He's really blazed a lot of trails.

DT: So do you have theories about—so you said about the three men who have been living legends, like what distinguished them? Do you have any theories about why they were acceptable?

KEN WHITE: Well, I think Luther Chrisman was acceptable because he is one of those people that went to that Penn school [Pennsylvania Hospital School of Nursing for Men] that was written about [Rachel Elder, "White suits and kangaroo kills: making men's careers in American nursing." *Gender and History* 34, no. 1, (2021): 1-26.], and he had a wife and several children. And he also had a lot of credibility with physicians. And he was—he did a couple of things that were legendary. And the first one was he was the first person to say that nurses should be doctorally prepared, and he started that DNS [Doctor of Nursing Science] program at Rush [University], and so that's one thing.

He was a Dean at Vanderbilt [University School of Nursing], and then he was the Dean at Rush [University College of Nursing]. But I also think that he was the first—he was also involved in that movement that nursing science is unique. We have our own body of knowledge, and so he raised the whole profile of the profession. And I think he was respected by people, but he was also a threat.

I have his book [Elizabeth Pittman, *Luther Christman: A Maverick Nurse – A Nursing Legend* (Trafford Publishing, 2006)]. I don't know if you've read his biography, but it's fascinating. There's a story in there that he was running for president of ANA [American Nurses Association], and they had their convention. And they were all going to vote. The delegates were going to vote the next day.

And I'm just paraphrasing this from the book. And someone took him—some well-known person who's quoted in the book took him up to a mezzanine level where they were looking down on all these people like in the exhibit hall or whatever, and there were people going around with a clipboard. And they were handing out pamphlets for this other person who was running against him. And this other person, I believe, was a staff nurse, an ICU staff nurse.

And this rumor was spread that he was a latent homosexual. We don't want him being the head of the American Nurses Association. So I don't know if that's true or not. I'm just quoting what was written in his biography, but I've read it other places. And there are people—interestingly to me, Luther Christman was Ramón Lavandero's sponsor when he was inducted in the American Academy of Nursing, so he knew him very well. And Luther knew talent, and he was able to really promote and hire some of the best and most talented researchers and academicians there are in nursing.

So do I think—so I think they did stand out, but I do think that they were not—they must have not been threatening. Like, I know how to work in a woman's world. I have worked in a woman's world my whole life. I'm not threatened by women who are smarter than I am, or who are stronger than I am, or anything. I work well with women.

I sometimes think it's challenging, but, I mean, some things that—I can't generalize here, but nursing school cultures are different. What I've experienced at UVA—and I haven't been at MGH [Massachusetts General Hospital] long enough to say. But what I experienced at UVA was the culture of the nursing school faculty was very different than a school of allied health professions where you have—everyone has a different discipline. So what's different about nursing is everyone has to be a nurse. Everyone has to pass to the same board, so everyone is an expert on everything, and the processing of curriculum, and all of that stuff down to the nitty gritty, and everyone wants to be at the table.

And all the people that I worked with [when I was in a School of Allied Health Professions at Virginia Commonwealth University] are like, Ken, you're the program director. Just do that. Tell me where to go, what to teach. And there was a different feel in an interdisciplinary faculty than in a predominantly RN faculty. But I'm one of those people. I understand there is a big debate right now about whether or not non-nurse faculty should have a role in a research-intensive programs, and I'm on the side of yes. Absolutely, I think they should. I mean, we have a lot to learn from other people.

DT: Yeah, and historically, nursing science was developed with the collaboration of scholars outside of nursing.

KEN WHITE: Right. That’s right.

DT: Would you say that you—do you feel like you have experienced discrimination in your career as a nurse and/or in hospital administration?

KEN WHITE: Yes, and no. When I was in hospital administration, I wasn't a nurse, and so because I'd had all that experience as a tech, and an orderly, and all those things, I was very patient-centered and very aligned with the nursing staff and very popular with the nursing staff. I made rounds with all the nursing units, knew everyone's name, and I had a perspective that my administrator colleagues, all white men, except for the few nuns that were left. The director of nurses didn't even have a seat at the table of the administrative council until 1990.

And I couldn't talk about football. Like, I knew nothing about Oklahoma football. I couldn't talk about golf because I didn't know anything about golf. I tried to stay out of the coffee room. And I would find myself up on the floors and being a real advocate for the nurses.

And I think that was seen as a plus. It was definitely seen as a plus to the physicians. One of the very powerful doctors came over one day looking for Sister Alvera saying the staffing was terrible in the OR [operating room], and he had a seat on the board. So I intercepted him and said, what do you need?

He said, oh, there's no one today to hold retractors. That's got to stop. I've got to do my surgery. And I said, I know how to hold retractors, so I went up. He said, really?

I said, yeah, I'll go help you. So I scrubbed in, went in the OR, and I held retractors. Well, that story got told, and I was very well-respected by the medical staff. And that's part of the reason I was recruited to come back there because the medical staff didn't have anyone in administration they trusted. They [the administration] were all new. And so I always aligned with patients and patient-centered activities, and when I was a program director, MHA [Masters in Hospital Administration] program director, I developed what I call the Patient-centric Health Administration Curriculum. And it was adopted by [the University of] Minnesota.

It was adopted by other places, and it's pretty simple. You just include perspectives from the patient's point of view and the clinical teams providing care.

When I finished my nursing degree, I got a job at St. Mary's [Hospital] in Richmond in the emergency room. I worked a couple of days a week, 5:00 p.m. to 1:30 in the morning. Had full-time faculty member teaching, trying to write articles, and I'm a staff nurse two nights a week or weekends. And I was also doing consulting. I did a lot of consulting.

I did a lot of consulting for law firms, expert witness cases, and I did a lot of board retreats and things like that. And I had two sets of cards made up. I had a set with my nursing credentials, and I had a set without the nursing credentials because the thought was—the prevailing thought was—I don't know if it was—it could have even been verbalized, overt, but I think it was more covert. If you're a nurse, if you were a nurse, and you came up as a nurse, what can I learn from you as a consultant in health-care management?

And so I no longer separate my identity in that way. I wasn't doing a service to nursing, and nurses didn't approve—wouldn’t listen to me if I hadn't been a nurse. So the audiences that I couldn't get in front of when I wasn't a nurse, the same audiences when I became a nurse wanted me. The only difference was I had been through what they had been through, so I used it to my advantage.

And I published in nursing journals, and I put all the nursing credentials out there, L-M-N-O-P-Q-R-S, just like everyone else. But when I published in other journals, it might just be my name, PhD. And so I could kind of go in two different worlds and have credibility in two different worlds. At times, they overlapped, but the assumptions people made was that I was a nurse first and I worked my way up as a head nurse, and director, and so on. And, no, it was the reverse.

So the assumptions we make about people, they're stereotypes that—and the other assumption that was made about me when I was in the ER because I was 40—early 40s by then—I looked like I had a lot of experience. Brand new nurse. Brand new RN. So it hacked off the nurses because the doctors would come to me and ask me to do certain things or—and I

didn't have the expertise. I'd have to go to my colleagues and say, what's the protocol for—what's the stroke protocol?

And so, yeah, I think there was some assumptions that I'd been a nurse a long time and that because I was a man, I could take charge, or it might have just been the fact that because I'd already been an administrator, I was not intimidated by the doctors. I didn't mind calling them at home and say, I can make your life hell in the middle of the night, or you can tell me now that I have the discretionary power to do these things for these patients. I think it's not called discretionary power. It's called discretionary responsibilities or something. So there's a nurse researcher who's done a lot of work with that, things that nurses can do if they want to but won't do it to someone who hasn't been respectful of them.

DT: Yeah, I wonder if we could—if you would say a bit more about your experiences in hospital administration because the '80s were a really interesting time in health care. I mean, every decade is, but with the introduction of managed care, the rise of a more activist patient consumer—

KEN WHITE: Yes.

DT: —can you reflect on your experiences and the impact of those movements and other movements?

KEN WHITE: Yes, so I started at Mercy in 1980 in that heavily-regulated planning movement, which was an attempt to decrease costs because health care spending was going up so quickly. And then this is when we were reimbursed by Medicare on a cost basis. And people were coming in to get—they would have two or three diagnoses, and they would—the OB [obstetrics] patients would come in and say, I want to stay at least a week because I need to be pampered. And then we would just add a big surcharge on costs on top of everything if they had—this is when we had all the charge stickers, and we'd put them all over us. And the charges would go in, and we'd be reimbursed by Medicare.

And that's when I was in an executive suite. We didn't call it that then. We called it the administrative suite. And we all had a privilege to use—to go to the country club for lunch. And

the country club was within—we could see it. It was not very far from the hospital in a very swanky part of Oklahoma City, the far northwest part of Oklahoma City and the membership number was M500.

We'd go. We'd have lunch. And this is administrators, and we can take people, sign M500. And that was all billed to Medicare as, I guess, entertainment or I don't know what. So then we had to get ready for DRGs [diagnosis-related groups], and that changed everything in 1983. So no more M500 after 1983. There was this huge effort to learn more about cost accounting.

I mean, how much does a procedure really cost? And if we can do it for less than what the reimbursement is, we make money, and if we do it for more, we lose money. So how can we streamline? So we need to learn about our doctors.

Who are the money makers? Who are the money losers? And that's what it started to get very interesting, and when—prior to 1983, we were friends and colleagues with the administrators from all the other hospitals. We didn't really see them as competitors. We all had our own niche.

And I remember Sister Alvera, the CEO, said we don't need to worry about competition. We don't need to worry about marketing. Sisters of Mercy have been in Oklahoma City for decades. Mount St. Mary's was a school, taught the children.

They're not going to not come here. We have a loyal following in the archdiocese of Oklahoma City. We don't need to be concerned about billboard advertising. We don't need to be concerned about patient choice.

So the most vivid example of that was labor and delivery was on the first floor right next to the administrative suite, and we had a back door. And I would always go to labor and delivery because I really liked the nurses over there, and they always had food. And they always—they had outgrown their space. They were laboring women out in the hall with screens up. And this is a newish kind of hospital, but they had outgrown because they had such a great share of the market for OB [obstetrics].

But something happened. One of the biggest employers in town signed an insurance company the fact that didn't—that Mercy did not participate in, and so overnight, it was so interesting. Overnight, the patients that would have come to Mercy before but now have a different provider, PPO [preferred provider organization], HMO [health maintenance organization], or whatever it was, would not pay for them to go to Mercy. They would pay for them to go to Baptist. So all these patients ended up going to Baptist and now were empty rooms, and it took a couple of those kinds of examples.

Another important example was in the '80s, the role of technology and how that changed along with reimbursement. We had a unit of 20 rooms, all private rooms, that was just for eyes. And up to that point, a person would come in for a cataract surgery, and they would stay usually two nights. They'd come in the night before, and then they'd have the procedure.

They had to lie flat with sandbags on either side of the neck. And Carl knows this well because he did that procedure as an ophthalmologist. But the invention of the phacoemulsifier, the ultrasound that would zap that cataract right out, changed cataract surgery and turned it into outpatient. So overnight, the 20-bed unit was not full, and it was turned into another purpose. I think psych.

But so many of those technologies revolutionized, but that's also in the period of time when, '70s, '80s, '90s when open-heart surgery was undergoing such a boom until the discovery of stents and interventional cardiology. So the '80s were really, really a tough time, and it was a time that none of us would have expected that we would have to advertise health care.

I wasn't taught health-care marketing in my program. It didn't exist. It was anathema, but I ended up teaching health-care marketing at VCU in the MHA program. And it's just changed so much from a seller's market to a buyer's market, so I think that transition in the '80s was really important.

I also think the transition in the '80s of the regulatory bodies were starting to see that nursing is a pretty important group of people. They employ, in many places, two-thirds of the workforce or more, but yet in some places, many places, they don't have a seat at the table. They're not making decisions at the top.

And so I think the transition to a more clinical focus, having clinicians at the table, physicians too, that was the birth of the chief medical officer too. I mean, before that, there was no paid chief medical officer. They were just chiefs of staff or presidents of the staff, and it was all voluntary. So, yeah, a lot of changes in the '80s.

I think there were also changes in nursing. A lot of up and down shortages, and nursing economics was sort of—people were starting to specialize, and there was a lot of money in those kinds of studies, doing [INAUDIBLE] manpower projection studies. I know that's [manpower] now a gendered term that needs to be struck from our vocabulary.

DT: But it was very popular in the ‘70s and ‘80s.

KEN WHITE: Yes, it was.

DT: Actually, I mean older, post-World War II period even, yeah.

KEN WHITE: Yeah. So many, many people influenced me all along. Many, many nurses have, but it's all—for me, it's always been about relationships and building relationships with people. And you asked me, I think there's been jealousy along the way too by some of my colleagues because I was popular with the staff. I was a popular manager.

And I think I was even told one time when I was at Harris Methodist, Hurst-Euless-Bedford was the hospital I was in Bedford, Texas between Dallas and Fort Worth. I was even told, gosh, you're making the rest of us look bad. In other words, back off. Like, don't be too good. Like, don't be too generous. Don't tell people they're doing a good job. Why not?

I think there was some jealousy. I guess there's that in every work setting. I mean, there's always going to be some of that. I didn't really care much, but I haven't been a person who's willing to compromise my integrity or my authenticity so that somebody else will look better. That's just not a principle that I have.

If I look good, I want others to look good around me. I want everyone to come up. I'm so proud. When I left UVA, there are lots of people that are doing so well and succeeding, not because of me at all, but there were people who needed words of encouragement. There were people who needed words of empowerment.

Delores Fields is a really good example. I mean, she was my administrative assistant from the beginning, and when I met with her, I knew we were going to get along. And I told her that she and I—this is when my office was in McLeod [Hall, UVA School of Nursing], and it was my second year that I moved over across the street [to the Claude Moore Nursing Education building]. But she continued to be my assistant until I left.

I said every year, Delores, you and I are going to go on a retreat. You should ask her about this. We're going to go on a retreat, and we're just going to take a day because what I knew about Delores is she'd been in the school of nursing for a long time. She lives in North Garden, Virginia, but she hadn't traveled much. And so I was very interested in getting to know who she was as a person, who she is as a person.

And every year I would surprise her on the day of the retreat, and pick her up at the school, and say, today we're going to—we went to a lot of places. We went to the Homestead—she'd never been to Hot Springs, Virginia—for the day. Had lunch.

We went to Virginia Museum of Fine Arts to see the Wiley Kehinde exhibit, the African-American artist that did Obama's portrait. And she was thrilled. We had the best time.

Another time, I hired a driver that always took me places. He still does. We use A&A—I use A&A limo service for pickups and things different places. I hired a limo out of my own funds, and James, who is my favorite driver, drove Delores and me to Washington, D.C.

And right after the Museum of African-American History and Culture was opened, we spent the day. Delores, and James, and I had lunch at the Hay-Adams Hotel. And they got to tell me so much about their lives, and about their family, and the generations before wouldn't have been allowed in those places, in those dining rooms.

And so just so many stories like that. I enjoyed working with Linda Hanson. Linda Hanson was—the History Center has always been a really warm spot for me in my heart because I like history. I think I'm wandering now from your original question.

DT: That's fine. I do have some more here.

KEN WHITE: Yeah. Yeah.

DT: Also in the '80s, obviously, the HIV/AIDS pandemic, and, obviously, that had a—I shouldn't say obviously, but as a historian, I know that it had a tremendous impact obviously on the gay community but also on health care workers and health administration. And I wonder if you might share some experiences about what impact that had.

KEN WHITE: So, yes. So a couple of things. I want to say something personal, and then I want to say something about the impact professionally. Personally, the more we began to learn about the HTLV-III and this mysterious gay disease, I was—I took turns being the administrator on call, and this would have been, I guess, '81, '82, '83, about that period, and '84, '85. And we had the first patient with the diagnosis. It wasn't called AIDS then. I think it was called HTLV-III. But then there was something before that, some kind of a syndrome.

DT: Yeah, it was like—I thought it was gay-related. There was gay in the title.

KEN WHITE: Yeah, and Carl remembers that well, too, but we had the first patient [in our hospital and in Oklahoma]. And I was on call, and the CDC had sent—there was someone from CDC working at the State Health Department who was sent to Mercy Hospital to investigate this, and I think they were put—he was put in strict isolation. He was in ICU, and at the time, visiting hours were, I think, 10 minutes every two hours but only immediate family.

This is where discretionary rule-breaking comes in. And I was contacted by the supervisor—it must have been the weekend, or night, or something—that his partner was not allowed to go in, and the nurses were enforcing the rules. So there were nurses who were enforcing the rules and then nurses who were not wanting to enforce the rules, but not wanting to get in trouble.

And I remember saying, can you just look the other way? I mean, if this is his partner, I think he should be allowed in. We didn't have a policy on it. We didn't have—and I guess we didn't have a policy on it until gay marriage was legal, right? I mean, we still had policies about immediate family, and it didn't include your same-sex partner.

So I remember that vividly. I remember how scared everyone was. I remember being drawn to patients. And we had—in Richmond, we had a huge—no, in Oklahoma City, there was a huge—I was in Oklahoma City in the '80s. There was a huge outpouring of community support. I mean, there were lots of nonprofits, and AIDS clinics, and lots of work being done to sort of destigmatize it, but it still was known as the gay disease.

And I think this is another contributor to me wanting to get married. And Carl says, for him, it contributed to him pouring himself into his work, developing his practice. And in retrospect, if we had come out, we both might be dead, might have never met each other. We think about that a lot because I was—it was a safe place to be, married and with the house I'd always wanted, country-club membership, the Volvo that I'd always wanted. I mean, it looked beautiful. It was a perfect, ideal situation, but I wasn't happy. But I was also very scared, very scared I would die.

So, yeah, I have a lot of stories, and I have a lot of friends who did die, not in the '80s, but fast forward in the '90s, even in the early '90s before the cocktails were developed. I had a lot—by this time—but I moved to Richmond in 1993. I moved there as out. I mean, there was no pretense ever. Since 1993, I haven't tried to hide it from anyone.

So when I was there, I quickly had a sponsor. They used to say Richmond is such an old Virginia blue-blood place that in the gay world in Richmond—the gay population in Richmond was huge, but it wasn't visible. There were a few gay bars. There were a few places where people congregated, but for the most part, people weren't public. And they weren't public because they were afraid of losing their jobs. They were afraid of being outed.

So the only way was somehow to meet someone who would introduce you and be your sponsor, and I was fortunate early on to get a couple of people who introduced me to Bill Mann. And Bill Mann is that photograph on the desk down there. Bill Mann was—he was

probably in his 60s when I met him, but he was one of the three grandfathers of—he was called one of the three grandfathers of gay Richmond.

And he was a connector, and there were three men like that in Richmond. And if you got on their list, then you'd get invitations. And if you reciprocated with invitations, you got more invitations. So we were invited to some very nice dinner parties, and that's where the gay social life in Richmond was. It was in private homes.

And we loved to set the table, and have a long happy hour, and just have so much fun together. And much of that is no more. Now people don't have to live in gay ghettos. And, in fact, for us, we have a lot of gay friends, but we probably have more friends who are not gay and—because it's people who have shared interests. And we have more interests than just who we're sexually attracted to. And body parts are important, but it's got to be more than just body parts.

So Bill Mann and I became very close, and when he—he'd had some health problems and had been in a car accident. And so we became close. I had dinner with him every Monday night for—until he died. And when he got too old to take care of himself and too sick, he was at Westminster Canterbury Continuing Care Retirement Center, and I became his health care—the proxy for decision-making and ended up being there as his advocate for his end of life.

And that experience, coupled with Carl's experience with his mother, who died in pain and agony because they didn't—after hip surgery—they didn't want to administer pain medication and didn't really know how to do it. Didn't understand peaks and valleys, and you know—and through those powerful experiences and through the research that I was doing on palliative is what compelled me to want to do something about it and learn and teach nurses on the proper way to administer pain medication. It wasn't that he didn't have medication ordered. He was on hospice, but the nurses were afraid to give it because they were afraid they would administer the last dose and then have on their conscience that they killed him.

So that's where ethics comes in and the dual effect, the principle of dual effect. You're doing it for the right reasons. So that's where education has helped a lot, I think, in our treatment. We have a long way to go.

DT: Yeah, my understanding is that there's been a lot of developments and much needed developments in palliative care, and it's been a very difficult area of health care with hospice. And that that's also been a venue in which there's a lot of interdisciplinarity as well.

KEN WHITE: You're right. I mean, it is an interdisciplinary profession. It's interprofessional by nature. I mean, we work with chaplains and all kinds of people, social workers, and I love the team of people that I got to work with. Pharmacists too. I mean, it's a—UVA has long been a pioneer in palliative care. I don't know if you know that yet.

But there was a doctor [Morton Wilhelm] who I have his biography. It's in the History Center. Forgot his name. He was a volunteer for the [Bjoring] History Center for years.

He wrote the history of the [UVA] Cancer Center, and he was one of the early ones who brought—he brought the first palliative-care doctor, before it was even a specialty, to the Cancer Center and long before it was popular. In fact, they brought Cicely Saunders, Dame Cicely Saunders, to UVA when—and she was the one who said you need—she gave a talk and said, you need to have a hospice. And so Hospice of the Piedmont was developed from the consulting advice of her.

DT: And I saw it in some of your published work that you've written about. Obviously, about palliative care but also about the palliative-care needs of LGBTQ patients.

KEN WHITE: Yes.

DT: And that seems like such an important area, I mean, related to what you had said earlier around HIV/AIDS, that the partners of people who were seriously ill weren't able to visit. And so I wonder if you could share something about your research around palliative care.

KEN WHITE: Well, I haven't—I don't think I may have done as much research as people like [Kim] Acquaviva. But I think, anecdotally, from what I observed in my practice and in starting the Rainbow Health Care Leaders Association, which is a whole other—

DT: I was going to get—yeah, that was going to be one of my next top questions.

KEN WHITE: In the LGBTQ forum, what I found out from my work with my colleagues there, that health-care organizations have a lot of work to do, and that the HRC [Human Rights Campaign] had the health-care equity index, and that what I saw at UVA Medical Center through my practice and also because I was the liaison for clinical practice to the nursing school, I didn't think we had a very good model. And so I mentioned it to Bush Bell, who he was the chief experience officer. I think that's what his title was.

And he was in charge of patient satisfaction and all that, and he was trying to get involved with ACHE [American College of Healthcare Executives], and he wanted to take the exam. And I helped him learn about that, and I said, Bush, do you know about the HRC [Human Rights Campaign] health care equity index? I think we need to do something. And I spoke to Pam Sutton-Wallace, the CEO [of UVA Medical Center], and she was very supportive of that.

And he sort of spearheaded it but appointed me to a committee to look at all the policies, and the first time they did the index, they made a D. I think they were a score of 60. But they systematically worked on improving the score. And so what I observed in the palliative-care world was, number one, there were many micro-aggressions occurring, especially with transgender populations. The issue that the name on your driver's license, and the name on your birth certificate, and refusing to address people how they wanted to be called, and all those things.

And palliative is such a wonderful—being educated as a palliative provider is so wonderful because no one knows me. I walk in, and they have seconds to decide if they want to trust me to go into a very intimate and sacred space, talking about their death, talking about their joys, their passions, what they live for. And I, early on, started asking people what I see what your name is, but what do you like to be called? And just something just as simple as that. How do you like to be addressed? The first thing I ask in every—with every patient.

Second thing I ask—the second thing I do is I don't hover over them as a tall big white man with a white coat. I sit down and speak with him on the level that they're sitting. I either get on my knee if there's no seat, or I find a chair. But often, people would tell me their story. They would tell me.

I had a man tell me that he was admitted from a nursing home, and he was a trans[gender] man. And he said that he was being abused in the nursing home, and they refused to respect his identity. I had another gay man, older gay man, who said that he went back in the closet. He'd been out of the closet all these years. He went back in the closet in the nursing home because he was afraid he would be mistreated.

And I just—I heard enough of these anecdotes that I thought that we needed to be more sensitive. So I can't say I've done a lot of research in the area, but what I did do was I planned the first-ever LGBTQ symposium and invited health-care workers. And it was—we ran out of space. There was no place at UVA that would hold the room, so we had to go to the Boar's Head Resort.

And that's when I first started recruiting Kim [Acquaviva]. I had asked Kim to come and be a speaker. And I didn't—I had never met her in person. The only way that I knew her was that I was a blind reviewer for her promotion to associate with tenure and to full [professorship]. So I knew her book, I knew her writings, and I knew of her, but she didn't know of me.

So that day, she brought the house down, but we also had Dallas Ducar, who talked on a panel, and now she is in Boston heading up Transhealth and one of my faculty members [at Massachusetts General Hospital Institute of Health Professions].

DT: Oh, wonderful. Yeah, I recently met Dallas.

KEN WHITE: Dallas Michelle—and I taught Dallas before, so she was in my class before transition, and so that's the small world. I have a call with her tomorrow. So I think that day was well-attended by physicians, front office staff, nurses. They were hungry for more, and I think Susan [INAUDIBLE] was also a speaker. We had really good speakers.

We had Tommy Dickinson was the visiting professor. He talked. He told his story about conversion therapy. That is always such a big hit. It's horrible, but, I mean, people just are appalled by it. And it happened here not that long ago. I mean, it's still happening.

So I think if I made any contribution at all in this area, I think I raised the awareness of it as this is a leadership issue. This is a clinical issue, and this is a justice issue. Again, back to my vulnerable—oh, I forgot to tell you one thing that I'm proud of.

In 1998, I was attending a church in downtown—a Methodist church in downtown Richmond. And the pastor was very charming, and just had a great personality. And he said that he wanted to serve. They had a soup kitchen every Friday at this church. It's an old, old downtown church for the homeless. And the church sponsored, and the church ladies came and they prepared the food. And the homeless people stood in line and went through it.

And so he said that he had a vision to have a partnership with Crossover Clinic. Crossover Clinic was a church-sponsored free clinic for underserved and homeless people. And they didn't charge any money. It was completely—they had some paid people. But the medical director was paid and the administrator, but most of the people were volunteers. And I did some volunteer work there.

And Tom Sweat was the pastor's name. Tom made an announcement, maybe on the third Sunday I'd visited the place, and said he was looking for a nurse to work with him to establish a clinic at the church, in conjunction with Crossover Clinic and in conjunction with soup clinic on Fridays. So I met with Tom and I met with the administrator, and we found a physician. An African-American woman by the name of Dianne Cane. D-I-A-N-N-E C-A-N-E, Cane.

And Diane and I founded the Crossover walk-in clinic at Centenary Methodist Church and staffed it. So here I am, the tall white person who's the nurse, and here she is, the short Black woman who's the doctor. Every time I said—they'd call me doc. How's my blood, Doc? How's my blood? Meaning how's my blood pressure. And we'd dispense their medications. They'd lose them, they'd forget the appointments.

I became very familiar with the homeless population, and they protected me. They would see me on streets. I loved them. And in my trunk, I kept a supply of shoes and coats and blankets, and got all my friends to donate things. And I collected all those toiletries from the hotels. I still do this. And would hand them out to people at the homeless clinic. And give them the shots, do whatever that they needed.

And so Dianne and I started that clinic, and did it every Friday. I was there 10:30 till to 2:30. And there was a show on—I think it's called “Virginia Currents,” they did Virginia stories. They did a story about Dianne and me on “Virginia Currents.” And I have the TV recording that I'd be happy to donate to the History Center.

We were celebrating our [the clinic’s] birthday. I think it might have been our three- or four-year birthday of the clinic and I brought in a cake. So all the homeless people there lined up for cake and ice cream. And they interviewed some of the homeless people. I don't want to refer to them as homeless people. People who are homeless, that's better.

And so that's been a real thing that I'm very proud of. There's a thread running through all of that I do, which is vulnerable populations. And 2000 still brings up a lot of memories. In 2000, about three months after I met Carl, we had a date on a Friday night. He was coming down to my house, and he said he would be there about 5:30.

And I went to the clinic that day, and they were doing some construction in the area where they serve lunch. And so they had made a temporary clinic up on the second floor, and it was a very small space, smaller than this. And there was a patient table, and then there was this big desk and a chair and stuff. It was just a makeshift space. We brought everything every week, we brought our stuff that we used there. We had a closet that we could lock, but we would take the stuff we needed, bandages and whatever, drugs.

And so Dianne was sitting at the desk, writing on the patient's chart. And this was a patient who had AIDS, full-blown AIDS. His [T-cell] count was 4. And he had just been discharged that morning from the Richmond jail. He had open sores, scabs, he was malnourished. He was sick. In bad, bad shape.

So we drew blood there. I drew the blood. And we had a lab at Retreat Hospital that would process the results for free. And so we had a runner to get the blood to the hospital. So on that particular day, he was so dehydrated he didn't have very good veins. And so I used a butterfly needle with a really small needle, and I'm glad I did. And I'm also wearing a lab coat. And I stuck the needle in, and took the blood that I needed, and filled the Vacutainers.

Pulled the needle out, and when I pulled it out, I was just about to turn over and put it into the sharps box when Dianne scooted back from the desk to stand up. She nudged me, causing me to sort of be bumped over, at which point, I don't know how it happened, but the needle went in my arm. And it broke skin. It went through the lab coat and went through the long sleeve shirt I had on, but I still bled. I was horrified. I was horrified, because I had a needlestick injury and I had no idea at that point, his status.

So I had to go to Retreat Hospital. The medical director got involved, and they immediately implemented the CDC criteria for prophylaxis. And I had to go to Retreat Hospital to have my blood drawn. And I had to go back and have my blood drawn every day, and then every week, and every six weeks, and then every few months.

So I had just met Carl, and I was so afraid that, if I got something, that he wouldn't want to be my boyfriend. And I was late, too. I wasn't home when I told him I would be there. And he was sitting on the front porch. And I was so scared. When I walked up to the steps and saw him on the front porch, I just burst into tears. And he said, what's the matter? And I told him if you want to leave me, I completely understand.

And then we got the results. The doctor came to our house and gave us the results together. And the patient, he had AIDS. The patient had syphilis. The patient had hepatitis C. The patient had it all. So we were given all the information that we already knew about, if you're going to convert [referring to seroconversion, which is the time from HIV exposure, to infection, when the body starts producing detectable levels of HIV antibodies], you'll probably convert within the first four to six weeks, but you have to take—and this is before the cocktails were really two or three pills. This was a lot of pills and a lot of side effects.

So I went through that whole thing for about three months. And I didn't convert [referring to seroconversion], and Carl didn't leave me, and—but it was a very, very, very scary time in my life. And I realized how hazardous being a nurse is. It's extremely hazardous. We put ourselves in a lot of dangerous situations. And now this is an example of not having the proper PPE [personal protective equipment], but we didn't even know what PPE stood for then.

If anything, COVID has heightened the awareness of protection. And don't tell us we're heroes because we're doing our job, pay us and give us respect—

DT: And resources.

KEN WHITE: And resources to do our job. We've always been heroes. I mean, we didn't do anything any different in COVID than we've done in AIDS or other kinds of transmissible diseases. So that's a side story, but I think it illustrates my personal journey with AIDS and then my professional—there was a second part to your question. I can't remember what it was. I was telling you my personal story, and then working in the clinic, and caring for a lot of people who were HIV positive in the clinic.

I think your question had something to do with—I can't even—

DT: Oh, I mean it was also to do with how it impacted the hospitals that you were working at, particularly in the '80s.

KEN WHITE: Well, we had specialized AIDS units. And basically, you had a specialized AIDS unit. And then I did a lot of research in that period. If you go way back, you're going to look at a paper I did with Allen Leblanc looking at hospitals that had dedicated AIDS units and hospitals that didn't and what were the outcomes. And not so much what were the outcomes, but what were the characteristics of the hospitals that would choose the specialized AIDS unit versus just integrating people with an AIDS diagnosis with other floors.

And that's when I discovered Susan Sontag, who wrote *Illness as Metaphor* [Farrar Straus Giraux, 1978] and then wrote *AIDS and its Metaphors* [Farrar Straus Giraux, 1989]. Which was a powerful book, a powerful read. And that's where I learned about every generation has had a disease that has been stereotyped. And in many cases stereotyped and the person who is blamed for their illness. You know, TB [tuberculosis], leprosy, some kinds of cancer. What's the first question that every nurse asks a smoker, or asks every patient has a diagnosis of lung cancer, how long have you been a smoker? Whereas so many people get lung cancer who never smoked.

And then there's HIV/AIDS, and now there's lots of other things, lots of other examples. What did you do to cause it? And so I was interested in the intersection between hospital ownership, and especially Catholic. I'm not Catholic at all. But I grew up working in Catholic hospitals, and Catholic hospitals have always claimed that they serve the most vulnerable and that they serve, as the Sisters of Mercy like to say in their vision, people who have been wounded by society. Which I think is a really good way to say it.

But I wanted to know if in fact Catholic ownership made a difference, and are they the ones that are providing the most stereotyped services. And so I developed, in my dissertation, what I called the stigmatized index. And I chose these hospital services that I could back up, that had been associated with stigma. Like TB, like HIV/AIDS, like substance use, like epilepsy, another big one.

And so I had a database from the American Hospital Association. They still collect this information. And based on if a hospital said that they provided the service—I didn't know anything about volume—but yes or no, we provide the service, they would get a score. So if they had a score of 7, let's say, they provided seven of the services that I'd identified were stigmatized. 7 out of, let's say, 12.

So hospitals were given a stigma index, and they were also given a compassionate care index. So according to Catholic theology, they all have compassionate care in their mission statement. But I went really deep into the theology of that, and what does compassionate care really mean? Is it the way care is delivered, or are there particular services that are delivered?

And what I found was that one way that they interpret compassionate care in the Catholic church Catholic doctrine is cradle-to-grave. So some Catholic theologians translated that in some of their works to say that Catholic hospitals should provide neonatal services all the way to end–of-life services. So I did another paper that was published in *Medical Care* where I looked at which hospitals are providing the most end-of-life services.

It should be Catholic, based on their claim, the hypothesis when it was that it would be Catholic. And so I did a lot of research papers early on and that area of stigma and

compassionate care and organizational definitions of compassionate care and developed those two indexes that I used. And what I found was there wasn't that much difference.

And that's how I got to know Barb Wall [Barbra Mann Wall]. I was doing it long before she got her doctorate. My research was published. She used my research, and she was interested in the nuns, providing the care. I was interested in the hospitals and the evolution of the hospitals. And I used a theory out of sociology called institutional theory, and if you're interested in more of that I've got a lot of things you can read.

But institutional theory would say that the reason that places like Catholic hospitals would have a difficult time changing is because there's so many centuries old in this male-dominated church, and highly institutionalized environments. And they have two institutions, the institution of the church and the institution of the hospital.

So they have an added layer and they also have an added layer of laws, the canon law. So how are they going to meet the requirements of the canon law, while meeting the requirements for competition and regulation in the market economy. And so that's where it gets really interesting.

I wrote a paper in the journal, *Religions*, where I predicted that one of four things would happen. That Catholic hospitals would either sell because they couldn't do both, they would get out of the hospital business, they would merge, or they would grow and become ever larger. And so in my last paper that was just published in the changing landscape of Catholic hospitals really gives examples that all of those things I predicted have come true.

But that was in the 90s and that was my dissertation. So that's how I got to know Barb Wall, and that's how she got to know me. And we invited her to give a talk at the History Center [Eleanor Crowder Bjoring Center for Nursing Historical Inquiry]. She was a friend of Arlene's [Arlene Keeling]. The rest is history.

DT: When I was looking at your CV and looking at some of your publications, I could see where the connection was, so it's great to actually have you elaborate on the connection with Barb. I

actually was wondering, was one of those stigmatized services that you looked at reproductive health care?

KEN WHITE: So that's the service that the Catholic hospitals don't offer. And so that became a real hot discussion. And I was called a lot of times by reporters, especially from modern health care, and so was Barb on this issue.

Reproductive health services was not a—I don't think it was—a service that the AHA [American Hospital Association] tracked, at least. But there were some proxies for that. And I think the question was not so much did they provide it or didn't they provide it, but when there were mergers in a community and that people had a choice. They wanted to have their baby over here because after their baby they wanted to get a tubal [ligation], but they went to the Catholic hospital, they couldn't do that.

But if those two hospitals decide to merge, that's where the sticky wicket was. And so that's when Catholic hospitals started to downplay their “Catholicness”. And that's when Catholic Healthcare West was the first to form a holding company called Dignity Health. And Dignity Health had a Catholic system and a non-Catholic system. And so they could go into local markets with their non-Catholic system. So the parent corporation was not Catholic. So they found a legal loophole, a way to get around that.

And most recently in that work that we just did, found out that in many cases, so many Catholic health-care leaders have said that they would never, never align with a for-profit, that their missions were just bipolar. And I did find that to be true in my work, my dissertation, and I repeated the same study 10 years later and the gap was narrowing. It's harder to differentiate based on some of those things. But the for-profits provided the least number of stigmatized and compassionate care services, and the Catholics didn't provide the most, but they provided way more than the investor-owned.

But the Catholics were more closely aligned with academic medical centers. Just places that do everything bigger, because of the size, they have to do everything. But now there are Catholic hospitals, and some small Catholic systems, that are aligned with a for-profit system.

I collected a lot of my information from websites in 2007 because every Catholic hospital had a web link, “About us,” and there was history. You click on “History,” and Mother so-and-so founded the order in Ireland, and blah, blah, blah. And she sent Mother someone over in Boston to start at the invitation of the Bishop, and all that stuff.

Well, I developed a spreadsheet. Every Catholic hospital then, I put on my spreadsheet. Who was the religious order, when was it founded, when did they first come to America. I got all this information off of their websites. I had a really, really good spreadsheet at that snapshot in time. I did that when I was on sabbatical in 2007 in Rome. I had nothing to do at night, I didn't know anybody.

And so I just collected all that stuff off of websites. And when we went back to those same websites, history is not there, or it's buried. They want to downplay they're Catholic. They don't say, we're a Catholic hospital. They don't say, we abide by the ethical and religious directives. They say we're a member of [fill in the blank].

And it's just so interesting. Always before it was in bold letters, we're Catholic. And now they're downplaying it.

DT: That's really interesting.

KEN WHITE: Yeah, it is interesting. And there's probably only two other people in the United States who care about this research, who do this research. And Mary Homan, bless her heart [for caring about this work], I boxed up everything Catholic the year I was on sabbatical. She was at [the Medical College of] Wisconsin and she knew my work. And she got her PhD at [the University of] Oklahoma, and she wanted to work with me.

And so I mentored her and sent her two boxes of Catholic stuff. I said, I'm over it. I'm at a dead end. And we did that paper together. And now she's taking a job with Ascension Health and she's an ethicist. And I hope she'll continue to do work, but I'm done. I'm done with the Catholic research, really.

DT: Sometimes it’s time that you—

KEN WHITE: Yeah. My contribution is recognized by two people in the world, and that's it. Yeah, so there's a lot of overlaps, there's a lot of threads, but I'm really proud of the commitment to social justice.

DT: Well, I wonder if we could turn our attention now to—you had mentioned the Rainbow Alliance early on, the LGBTQ forum. So I wonder if you could talk about those experiences and your involvement with the American College of Healthcare Executives.

KEN WHITE: Yes. So I joined the American College of—it was then called Hospital Administrators—American College of Hospital Administrators when I was a graduate student. You just did, that's what everyone did. As a student associate, and that was in 1979. And I've continued to be active. And they also are the owner of Health Administration Press. Four of my books have been published, and journal articles, some have been published.

So I was a member long before I was an academic. In fact, I went to a fortune teller when I was on Guam. A woman from Vietnam, who told me in her broken English, she read my hand and she said, someday, you'll write a book and you'll be a professor. And on the way back, she also told me, why is your wife not out here? So I had taken off my wedding ring. I was still married at the time, but we were going through a divorce. And I purposely took off my wedding ring because I didn't want her to make assumptions, and she did anyway.

So we laughed all the way back to the apartment. I said, I've never written anything, that's hilarious, she thinks I'm going to write a book. So active in ACHE [American College of Healthcare Executives] after they changed their name and different leadership roles. And the president CEO of ACHE was Tom Dolan.

He was a long-time president and CEO, and he had been administrative program director at St. Louis University. And I knew him when he was there because I took St. Louis University administrative residents. I was a preceptor for them at the Mercy Hospital because that's where my boss went to school.

So I wanted a leadership role. And so there are ways of doing that. The first thing you do is you apply to be a regent. So regents have states, each state has a couple of regents, and so there's a board of regents and you represent the people in your state. And as things evolved, I ran for regent of my state and lost.

And the board approves regents. And the board was, as I like to say, pale, stale, and male. And they were a club of who gets in, who doesn't get in. And it had a clubby feel to it, but it's also a very conservative profession, very Republican profession.

And I didn't fit into that profile in lots of ways. And so I wasn't approved as a regent. So I ran again, Carl will tell you, don't tell me no. I ran again as the regent at large, and I ran on a different platform. I was representing health administration. I was representing graduate programs, the future of our profession.

So I spun it that way, and I got in. I got in as a regent at large, which covered, I think, five states. So each region had a regent at large, in addition to the state regents. So I did that role, and I'm getting more and more visibility because every year, the MHA [Master of Health Administration] students from VCU were winning awards, winning essay contests.

We were moving up in the rankings. I got a $1.75 million gift from HCA [Healthcare] to recruit people of color and people who could speak Spanish. And I had a full-time recruiter. People were coming there, they [hiring organizations] wanted our students. It was really getting a lot of visibility with diversity.

So I ran for Board of Governors in the early 2000s. I ran for Board of Governors. It's a big deal. You have to have a committee, you have to get people who write these letters, you fly to Chicago, and you go into the airport hotel and walk into this room, and the nominating committee is there asking you questions. It's very intimidating.

And I was denied. So don't tell me no. So I was denied a seat on the Board of Governors. I also used the fact that I was a nurse, and I used the fact—I did my homework, this is where history can help—I did my homework and found out that there had only been one nurse chair of ACHE,

I believe [Jessie J. Turnbull, 1948-49]. There had been a couple of women, but they weren't nurses.

And I pointed out a fast-growing area of their membership were nurse executives. Still didn't help, I still didn't get elected. They don't elect the board. The nominating committee recommends to the board, and they decide. It's different from the [American] Academy of Nursing. In [the American] Academy of Nursing, you're elected by the membership.

So I went up again. I went up again. And this time I got it. I lobbied a little harder. And when I got it, I got on, it was a three-year term. The first year—no, I think, the second year, I ran for chair-elect. And this is when my competition was General David Rubenstein, who is a four-star general in the Army. And he was over Landstuhl Army, Air Force, Navy base in Germany.

And, of course, David was on the board, and I knew him and I thought he was a good choice. I really thought he was a good choice, and I had one more year on the board, so I could run again. And my friends were rooting for me, that I would go up the next year and had another chance.

So I went up the next year. Got new letters, got all this. It's like going up for tenure, it's really a big deal. Went for my interview. Well, so, I was the only person running, until about two weeks before the deadline. And I was out gay. Carl was my partner at these clubby things, and I have a funny story to tell you about that and Carl will make it even funnier at dinner if you ask him about. But I listed him as my spouse. Have I told you the story? I listed him as my spouse because—I have told you this story.

DT: But tell it, put it on the record.

KEN WHITE: So it's very clubby and we'd always do things with the wives, there would always be things for the wives because it's male-dominated. And I was the first person who had a same-sex partner. And so I filled out the information where it said wife, I crossed it out and put spouse. Or I put partner, I put partner. And that could be ambiguous, right?

I put partner, and I wrote Carl Outen, Dr. Carl Outen. And so the invitation came to my house, Park Avenue in Richmond, addressed to Dr. Carla Outen. And the invitation was for the wives' tea, fashion show, and backstage tour of the flagship department store in Chicago.

What was it called, Macy's bought it. It was that old, great—where we used to get the mints. What's it called? I can't remember, but anyway.

So we laughed hysterically about it because guess where I was going? I was going to have to go to a baseball game. I know nothing about baseball, and it's the most boring sport I've ever seen in my life. So Carl wasn't able to, he was not able to accompany me at that three-day board meeting. And we regret it because he would have had a lot more fun at the backstage tour of the department store.

And that's how clueless they were. And while I was on the board, before I get back to running for the second time, while I was on the board they brought forth, as they do routinely, policies for review and updating.

And they brought forth their policy on diversity. And the policy was about race, ethnicity, and gender. Their goal was to get more people of color and more women into the college. And I brought up at that meeting. You should've seen the look on his face.

I brought up at the meeting, was it time for them to consider broadening the definition of diversity to include geographic diversity, LGBT diversity—that’s when we weren't using the Q. There are other types of diversity that we might need to consider. Tom Dolan nixed it, took me aside. Ken, we're not going in that direction.

Fast forward, a few years later—remind me to come back to that because I want to say that when I was running, I was out gay and everyone knew. Carl had gone to some of the retreats, the board retreats, and all the wives wanted to be with us. Made their husbands really jealous. They wanted to sit at our table.

So I ran the second time. I was going to be unopposed because Tom Dolan had long held the opinion that he did not want people running for chair-elect who were consultants, that he

wanted it to be more traditional health-care management. So there was a man who had retired from HCA [Healthcare] and he started his own consulting company, and he had already gone off the board. So he was not on the board currently, but rotated off. Charlie Evans was his name, nice man, very nice man.

A week or two before the deadline, when I thought I was unopposed, Charlie's name is submitted by the nominating committee. So there will be someone, that I won't run unopposed. I was taken aside by one of the previous chairs of the board, who told me that, Ken, I hate to tell you this, but someone needs to tell you. You're not going to be a chair under Tom Dolan's watch.

And I don't know if Tom said that, or if that was just his observation. But he told me that he was supportive of me, but he didn't think that I had the support. It wasn't personal, he told me that, it wasn't personal. Yes, it was. That they weren't ready to in 2000. And it was 2007 when this occurred. So Charlie was elected, approved.

And I really believe that ACHE was a homophobic organization. There were lots of micro-aggressions, and I didn't call them that then, I didn't know that word. But these were all attempts to keep an openly gay person, and also keep in mind, I am now only the second nurse that's been on the board in the 75 years of its history. After me, there were tons. There have even been nurse chairs after me.

Well, Tom Dolan called me one time, after I was off the board, he was getting ready to retire. And his assistant scheduled a time to talk with me, and I'm thinking, what does he want with me. And he told me that he was in a meeting where a physician—a physician-executive member of ACHE—stood up at this meeting and made the comment that he thought that ACHE, something to the effect, was a homophobic organization. And Tom said, I have to admit, I don't know anything about this subject.

So the call was Tom was asking me, did I think it was a homophobic organization and did I think he was homophobic? I told him that I believe that the organization was homophobic. I don't believe I ever said directly that he was homophobic, but what I did say to him is what I had

observed. And by him not being willing to tackle the subject, that was an indicator of homophobia.

By him and the board not being willing to think about diversity, not only in extent to nurses and women, I mean other people. I believe what they taught about services didn't leave—it wasn't inclusive of LGBT community. And I told him what I was told, that under Tom Dolan's watch, there will not be a gay chair-elect. And I said I was very disappointed and hurt by that.

And he said, I don't know if I said that or if people interpreted that, but that was probably true. But he said, I want to fix it. He said, here's my commitment to you. I'm bringing in a consulting company that are going to look at everything in our organization, soup to nuts, and give us recommendations about how we can be more inclusive. I'm going to make sure that we write a different policy about our position on LGBT, brand new policy.

In the next issue of *Healthcare Executive*, I'm going to write a column and I'm going to publicly apologize and affirm my commitment to LGBT diversity and inclusion. And I don't know if this was a part of our conversation that day, but when he retired, there's an endowed fund for diversity education, diversity and inclusion, giving opportunities to people who belong to diverse groups. And it specifically includes LGBT, in addition to people of color and BIPOC [Black, Indigenous, People of Color].

So he redeemed himself, as far as I'm concerned, and put me on the body that reviewed the applications for this sort of leadership institute, called the Tom Dolan Diversity Leadership Institute. And I reviewed the people who got into that. And so it has changed, but I think it changed because I didn't drop it. But I think I also was respected for my contributions, I was respected as an academic, I was respected as a nurse, I was well-liked as a board member. I taught a lot of people who I required them to be members of ACHE.

And so I think it's the same in policy. When you're making policy, incremental changes. Sometimes you have to go to the table and agree to a compromise, and then come back at another time and agree to a little bit more, a little bit more, a little bit more. So I decided that I would take this up with my friend, Jerry Maki, and a couple of other people.

So informally, people were coming out to me because I was the first openly gay board member. Staff, hospital executives, people that I had known for years and didn't know that about them, people I suspected and they confirmed, men and women. And so they're saying you're our hero because no one has brought this up.

I accidentally outed myself at the very first board meeting when I was so, so careful about the pronouns. And the chair—this is the guy who talked to me in the bathroom, told me that I would never be a chair elect—asked me to stand up and introduce myself and say three things about myself that weren't on my CV. The three new board members.

I was so nervous, and all the staff were sitting around the room. And I stood up and said something about my partner. My partner and I like art and collecting art and history, and then I was so nervous I let my guard down and said he…. he is an ophthalmologist. And then I went, oops. I just outed myself. And they all laughed. But then that spread like wildfire. I don't know how it got to so many people.

So Jerry Maki and a few other people, Tari Hanneman with HRC, started the Rainbow Healthcare Leadership Association, with an original donation from Stanford Health Care, and that's because that's where Jerry was working at the time. Jerry had been an old friend of mine from Oklahoma City. We met in our early days. He was with Baptist and I was with Mercy, and he helped me pass that exam to be a certified health-care executive. And he was married with kids at the time.

And so full circle, again, it's about this small world relationships. So we started it. We got a non-for-profit—I'm going to give you all those files, you'll see the not-for-profit tax number. We had a logo, we had a newsletter, we had money, we sponsored talks. But we also paid a part-time administrative person to keep things going, keep up the list, and mailings and newsletters, and we were starting to run out of money. And none of us were willing to take it on because fundraising was tough.

And we read the *New York Times* every Sunday, and I always read the marriages. And I read about this man who had gotten married. He was a health-care executive, and he was a fellow of

the American College of Healthcare Executives and the administrator of Southampton Hospital. And he married his partner, husband now.

And so I blindly wrote him a congratulatory message, clipped out the marriage announcement, and asked him if he had any interest in joining the RHLA [Rainbow Healthcare Leadership Association]. And he did. He paid his dues and he said, wow, I was so taken aback by the fact that you looked me up and found my address, and of course I'm going to join.

And so I was the founding chair of the LGBT Forum after Deborah Bowen took the reins as CEO. She knew me when I was on the board. She was the COO. And we've been long time supporters of each other. And when we ran out of money, Rainbow Healthcare Leadership Association, I went to her and she agreed to take us on. Not to assume any of the liabilities or assets of RHLA, but to start something called LGBT Forum of ACHE.

And we put together our bylaws and our purpose, and she was in the process of hiring a director for diversity. So Cie Armstead was the first director of diversity. And they were also looking at other affinity groups, like Hispanic, Latino, Latinx, Latina members and others. So it was a good time, and Deborah was bringing us in. So we folded. We closed the RHLA, and I have all the documents. And later on the Q was added a couple of years ago.

The person who followed me was Bob Chaloner, the one that I contacted through a cold congratulatory note in the *New York Times*. He followed me as the second chair of—I served two years because we were building it. And the first cocktail hour at ACHE was billed as the LGBT forum reception.

I don't know if I told you this story, but we were given a small room, maybe just a little bit bigger than this one, where the bar was set up. It was a pay bar, ticket thing, and the members were each given, I think, one ticket for one drink. But you had to buy tickets. And the room, it was hilarious. It was so funny. I said, what's up with the small room? And Cie said, well, you know, the thought was—not her thought—but the thought was there aren't that many people at the time.

I think we had fewer than 100 people [who were members of the Forum]. They had to pay an extra $100 a year to be a member of the LGBT Forum. Well, people didn't want to be identified because they would be fired if that was in the directory that they were a member. So that's why there were a lot of barriers to joining, but they loved to come to our events. So she [Cie] said, well, last year so few people registered for the ACHE Congress that the thought was there won't be that many people.

Ha-ha, hello. The line was so long. The line was so long waiting to get in, just to get a drink and to meet other people, like-minded people. And then there was a guy there I'll never forget, who is a champion for his gay son. And other people who are wanting to change cultures at hospitals. It sent a powerful message.

So the next year we were blended in to the ballroom, and we were all given space and there was plenty of room for everyone to be there. So little wins. Little like, let me show you. I don't have to do anything. This is just organic. It's going to happen on its own.

I think it sent the message to the board that this is an important group that we can no longer keep invisible.

DT: Do you think that impact and that visibility has kind of filtered down from the ACHE into changing cultures within hospitals and other health-care institutions?

KEN WHITE: Absolutely. Absolutely, I think it has. My second year of being chair happened to be the year, our event happened to coincide with HRC's announcement of the top 50 hospitals in America that have the best policies and practices for LGBTQ. And so Tari Hanneman, who's in charge of that, was on our board. So Tari and I worked a deal—you've got to meet her—Tari and I worked a deal that she would hold the press conference right after our event.

So she held the press conference in a hotel in Chicago, across the street from where the Congress was being held. And of course, all of us were there because it just so happened—it does happen every year, but that year, tremendous visibility. And I was interviewed by several people, and she was interviewed, and Deborah Bowen was interviewed.

And Deborah Bowen stood up there, and she was so proud of this because she had really been the champion. You have to have a leadership champion. And a lot of things have to fall into place. So and also the hiring of Cie Armstead and having these kits, these what does it take to be a more LGBTQ friendly health-care organization, and giving talks.

And I've given a talk every year in ACHE Congress with Stephan Davis, my protégé. Stephan Davis is now MHA program director at North Texas University in Fort Worth. He also has a DNP [Doctor of Nursing Practice]. He's a nurse, he is a powerhouse. He is something else.

African-American, nurse, first person in his family going to go to college. We have very similar backgrounds. Born and raised, I believe, in Alabama or Mississippi. Got his DNP at Yale. He is a powerhouse. And we still do things together. I'll always be his mentor. So he took the reins after Bob Chaloner as the chair of the LGBTQ Forum, and he took it into a different level.

And then after that, it was Dan Gentry. And Dan Gentry is the CEO of AUPHA, which is the Association for University Programs in Health Administration. Which now we're trying to get funding, Stephan is trying to get funding for the Macy Foundation, for us to come up with curriculum-specific requirements for MHA degree programs to insert this knowledge that needs to be in the curriculum about how you're going to be an LGBTQ sensitive advocate, culture, when you get into those top positions.

So it's kind of coming full circle now. We're trying to institutionalize it in a way that it's normative. When you get to the point where it's taught in the graduate programs, that's where I feel like you can really make a difference and have a legacy going forward. And I'm writing the textbooks, so of course I've inserted it into the textbook as a requirement.

DT: But I mean to just acknowledge your how key your leadership has been on this issue, though. To be out in an organization that was homophobic. That takes a lot.

KEN WHITE: Once I came out, I came out. That door was flung wide open, and I refuse to apologize for it and I refuse to hide it. And I talked about it like it was normal. I didn't say husband until we were legally married, but I would say my partner Carl. I didn't try to hide it,

and because I didn't make a big deal about it other people would walk up to me and say the most unbelievable things.

I was visiting my stepsister, Teresa, who lives in Wimberley, Texas, which is just a couple of miles from where Barb Wall is living now. She'll always be in my life, Barb Wall. And General Rubinstein was the commanding officer of San Antonio, all that big base and the hospital and everything there.

So I was visiting my sister, and he invited me on base. He had a reception for the Trinity Health Administration faculty and for all of his ranking muckety-mucks in health care in the Army and other branches. Because in San Antonio, there's an MHA program at that base. What's it called, the Uniformed Services MHA program. And he was head of it all, and had this cocktail party for me.

And here I am, openly gay. I took my stepsister and her husband. And so people took me aside, I won't say who because I don't want to out anybody else but myself, but people took me aside and told me things like, I think I have a gay son. Would you talk to his father? You know, I think my daughter might be a lesbian, and she's really interested in health care. Would you mind if she contacted you? That kind of thing.

And of course I was always open always open to helping other people, and I was honest, too. I had gay students because of me, because I was out, outed themselves to me. And I had one student who I would always say, this is a very conservative profession, and of the 6,600 hospitals in the United States, not that many of them are in large urban places.

The majority are 100-, 200-bed hospitals in Iowa and Oklahoma and places like that. And the hospital administrator is a really big deal in the community. They are one of the leading people in the community. Just be mindful of where you live and work because my gay graduate students would say, I don't think I'm cut out for this. I won't be accepted in Iowa, and I don't want to live in Iowa.

And so I would be truthful with them and say, our profession needs you, but you need to select your administrative residencies and experiences in places where you feel welcome and safe.

And I had one student I'll never forget. He said, you know, I don't think I'm going to be very successful in this business because I'm not a hospital administrator type. And he was an innovator and entrepreneur. He got his MHA and he went to work for the Sachs Group, which was a health-care market research company in Chicago.

Yeah, you can be gay in Chicago. That's fine, you're working in a place like that, you'll find a community of support. But make sure that the company you go to work for is also supportive. So I think I helped a lot of people find their way, maybe find a path, at least, someone who was—I don't want to say sympathetic, that's the wrong term—but somebody who could give them career counseling.

We don't need people not to be gay. We need more people to be gay, so no, don't drop out of the program. Just find a place where you can thrive. So I think I was on the sidelines a lot of times, a lot of times it was quiet, a lot of times it was one-on-one conversations. But I think I did influence a lot of people. I influenced the accrediting commission.

And it's so funny how many people called me up when they were going through a coming out crisis. Some people I knew well, some people I had only met slightly. That's all slowed down because of our society. Since gay marriage is legalized and I also used to say to my students, when I was growing up, we didn't have “Will and Grace” on TV. I mean that brought a lot of things—and “Sex and the City”—into people's living rooms.

And I can't say this. I have to say this. Can I say this off-record? I said one time, we didn't have “Ellen,” we didn't have “Will and Grace.” Yeah, we had no role models. It certainly wasn't spoken. It was there, you know, confirmed bachelor.

DT: Well, I think having that being visible and out, and visible for people and a role model, and being available and open to supporting and guiding people along the way, that's just so important.

KEN WHITE: Well, thank you for saying that. It's been important to me, but it's also been important that we continue to advocate for—we’re not there. We have a long way to go. We have a long way to go, but we're so much farther down the road than Carl and I ever thought

we would see in our lifetime. We never thought we would be able to be married. We never thought that our families would accept us.

And I'm sure my family still thinks I'm going to burn in hell, although my father didn't [accept me]. He died and he wrote me off. But my mother and stepfather and my closest family, my sister, our family's divided politically. You can imagine. Only one other person voted the way I did, my stepsister Teresa.

And so there's all that now. That's an added layer of complexity and chaos that has contributed to outspokenness. And at dinner, ask Carl to tell you the story about the first time he went with me to Oklahoma. Raised in Richmond, Virginia, and my father and his wife took us to a honky-tonk. Took us to a state place. Ask Carl to tell you that story.

DT: OK, I will do. So you've also obviously had leadership roles, and you're beginning your presidency of the American Academy of Nursing—

KEN WHITE: October 9 [2021].

DT: So very soon. Can you talk about your experiences in the AAN and whether you've been able to be involved in any similar initiatives around LGBTQ issues within the Academy?

KEN WHITE: So diversity and inclusivity, as it's called at the Academy, has been a focus of our strategic plan. And it's even more of a focus with our new strategic plan that we just developed and approved as a board this past year, which begins now. And will be over the next several years.

And so I've had a voice at the table, but so I have a lot of other people. I think we have a very, very strong commitment. And in fact, we have bylaws that are going up for approval at the meeting. They have to go to ANA first and then they go to the Academy in our meeting in October.

But we're actually changing the language. It's not diversity and inclusivity. It's now called equity, diversity, and inclusivity. And many of our fellows felt like our focus has always been on social

determinants and access and equity—health equity—and that the order of those terms matters. And so we have a special committee that's now called the equity, diversity, inclusivity committee, and there's been a lot of outspoken people, with good reason.

But we're trying to focus on not individual beefs with this or that, but a more systematic way of challenging institutional and systemic racism. And with that comes everything else. And all of the intersectionalities. And we just appointed Susan Kools on that committee, and I'm delighted because she brings such a balanced perspective.

But I think that there still is going to be an upswell of voices going forward from all the invisible groups that have not had a seat at the table. And I'm very aware that I will be the president for the 50th anniversary of the Academy in 2023. And I'm also aware that in that same year, MGHIHP will celebrate their 150th anniversary of the third oldest nursing school in America.

That same year I will be the first man to head up those organizations. I thought a lot about what I want that to look like. And yes, I think our history is very important, and I think it's important to acknowledge it. But I think it's even more important to acknowledge the next 50 years, or the next 150 years, because the history that we tell is really only a white female history.

And I've learned a lot from the [Bjoring] History Center in that regard, and I've also learned a lot about the history during my time on Guam. You never hear about Chamorro nurses. Well, you are hearing now about Filipino nurses because of Ren's interest [Reynaldo Capucao, PhD, RN, who is a former student of mine at UVA in the CNL program], which is phenomenal.

And we've heard about Japanese-American nurses who didn't have a seat at the table, who were sent to the internment camps in World War II, came out of the History Center. So I think using history to inform who wasn't at the table is rewriting the history in a way because it's only part of the history, and men weren't allowed to apply.

So it's not a Black men, or white men, or Black women, or Native American, or indigenous people. Where is their history? And so I appreciate our past, but I don't want people to get the impression—because I know there's going to be a groundswell of gay men, because they're

already lobbying me. And women. Like why don't we have any men living legends, that are living?

Why don't we have a man at the table for that meeting? They can't really say that now, but I will be aware of that and I will be very sensitive about making sure that more men and more invisible groups are at the table.

DT: I think your comment earlier about the intersectionality is just so important because those intersections along gender, class, race, sexuality, ability, disability and ableism and such is so important.

KEN WHITE: Military service, veteran status. I mean, the list is growing. I also think that people with disabilities are a way underrepresented category. So I will be ultra-sensitive to that.

But I want to unite people around our common interests, rather than dividing along the things that make us different. I want to unite around our signature programs, our signature initiatives. Nursing science, innovation, and nurse leadership. And focus it around our mission, vision, values, and that strategic plan.

So I think it's going to be fun. I see a lot of overlaps with both. I learned a lot from Eileen Sullivan-Marx, who's the current president. She's the dean at NYU, and she's a very, very effective president. And I've been learning from her for two years, and she's included me on things.

And I have grown so much, I think, as a person, just as a leader, by having worked with Dorrie [Fontaine] and Eileen [Sullivan-Marx] and other people who are deans. Janie Heath, I don't know if you've heard that name. She was an associate dean at UVA, that's where I met her, now she's the dean at Kentucky.

I've been influenced by a lot of really cool people. There aren't that many men deans.

DT: Yeah, and I think as a historian thinking about the role of men in professions and occupations, it's so usual that men have been the dominant group and we usually hear about

gender discrimination against women. And so within nursing, it's obviously not the case. It is that men have been discriminated against, denied access to, marginalized. And so there's so much that needs to be told about the experiences of men in nursing, and then bringing in those intersections as well.

KEN WHITE: Tim Porter-O'Grady, I don't know if you've heard that name, Tim Porter-O'Grady, hyphenated name. He's a giant in nursing, and he should be a living legend and he should be. The nice thing about being in this role is I can honor and appoint people to serve in positions of influence.

I wrote him a letter, a cold calling a letter from Guam—and it was on my Guam stationery—saying that when I got my PhD I wanted to work for him. I said, I would like to work for you after my stint is up here as a consultant because I like what you do. I had read some of his work.

And so he wrote me a letter back. And he still remembers this, and we laugh about it now historically. I wasn't a nurse then. He said, I get hundreds of letters every month. He came across as elitist and as a very popular and highly-paid consultant who didn’t, at first, give me lot of encouragement.

Said, I get hundreds of letters from people who want to work for me, and I don't answer most of them, but yours intrigued me because I've never gotten one from Guam. So here's the advice I'd like to give you. No, I won't hire you. I only hire people who are nurses and who have a PhD.

So I wrote him back and thanked him for his letter. I stayed in touch. I'm following your advice. Dear Dr. Porter O'Grady, I'm following your advice. I'll be enrolling in a PhD program in the Medical College of Virginia. And a little bit later, I wrote him, I'm following your advice. I've just enrolled in a nursing program, following your advice. When I finished, he invited me to his home in Atlanta with his husband, Mark.

They also had lived in Richmond for a time, and they had some friends in Richmond that we had in common. And they invited me to their house and talked to me about working for them. And you know what? I didn't want to work for him then. I wanted to do my own thing. I would be suppressed by his reputation, and I wanted to do my own thing.

And so I told him that. And so he's followed my career, I've followed his career. I respect him tremendously, and people like Tim need to be recognized. And there are many others. And I think they're going to see it as an opportunity.

I think they're going to see it as the new Academy. That I'm reflective. I don't just represent men in nursing, I represent differentness than white women in nursing. And I do think it's going to go over well. I hope. I hope.

DT: It'll be great to see what the next two years bring in for your term, and obviously your leadership at MGH, too. So you've got some busy times ahead.

KEN WHITE: I know, I know. Yeah, it's exciting. It's exciting. But I feel like the time is now for me to continue to stand up for vulnerable populations and to continue to advocate for fairness and equity and healthy work environments and parity, as well. I look at nursing faculty salaries, and I look at medical school salaries, and I look at Darden Business School salaries.

And I had four joint appointments. And if I taught a 90-minute course for Darden Exec. Ed [Executive Education], I got paid $1,500. And if a nurse were teaching a 90-minute course, he or she wouldn't be making $1,500. But yet we're the most respected profession, the most trusted profession, and the most ethical profession.

So I think the time is right for us to raise the visibility of nursing. I know there's a lot of victim mentality in nursing. I don't know if you've seen that, but I'm not one who wants to buy into that or feed into that. There was two wonderful articles in the past, as a historian. If you're not familiar with them, I would encourage you to have your students read them.

One is Tim Porter-O'Grady's classic paper on “Men in Nursing: the Concrete Ceiling.” [correct title is: Tim Porter-O’Grady, “Reverse Discrimination in Nursing Leadership: Hitting the Concrete Ceiling.” *Nursing Administration Quarterly* 19, no. 2 (1995): 56-62.] I think that's a really good paper. And the other one, I think, well, you may not want to use this paper now, given where we are.

But there was a paper written in, I think, the late '70s or '80s—maybe it was late '80s—called "Oppressed Group Behavior" where nursing was compared to slavery [Susan Jo Roberts, "Oppressed Group Behavior: Implications for Nursing," *Advances in Nursing Science* 5, no. 4 (1983): 21-30]. I've cited it a lot of times.

And since you've looked at my CV, you've probably seen that there's a lot of papers there early on with Jim Begun about nursing, the profession of nursing, the future of nursing. And we used this oppressed behavior, nursing as an oppressed profession. Oppressed in that they had always been kept down by men, doctors, and men administrators.

And oppressed group behavior—what do they do? They try to legitimize the profession. They try to insulate those who are in and those who are out.

I had an associate dean at VCU who I went to see about getting my nursing degree while I was doing the PhD program, and it was a man. And he said to me, I got all of my degrees in nursing, and you could have, too. So I hit a concrete door, and that's why Janet Younger was so wonderful, because she was the one who said, I don't care. I want you in this program.

So yeah, I wrote an article which had begun about profession building. How do we build it as a profession? And I don't know if you've been able to see my correspondence with Hildegard Peplau. She got wind of the first paper that I wrote with Jim using chaos theory as an organizational theory to characterize the profession of nursing.

And she wrote a three-page handwritten letter that came across on the fax one day when I was in the mailroom, telling me what she liked about the paper, what she didn't like about the paper, what I'd left out, what I was right on about. And so Angela Vicenzi, who was the editor of *Chaos and Complexity in Nursing*. It was a short-lived journal that she edited.

She published that paper that Jim Begun and I wrote. I was still a master's student, and it was the paper that Hildegard Peplau responded to. And then Angela published our correspondence back and forth, and that's not a journal that you're going to find. I don't believe that journal is—

DT: Indexed.

KEN WHITE: Indexed. But I'd be happy to share those papers with you, and my papers with Hildegard Peplau.

DT: Definitely. I'll see if I can find it online, but I would love to see that correspondence.

KEN WHITE: And I have a picture that I'll take to Boston with me of Hildegard Peplau and Jim Begun and Angela Vicenzi and I at a restaurant in Washington D.C., where Hilda—she asked me to call her Hilda—received the American Psychiatry Association's Lifetime Achievement Award.

And Jim and I drove to D.C. to have lunch with her and to congratulate her. And we got to the restaurant, and she had her portable oxygen tank and she asked to sit in the smoking section. She turned off her oxygen for her cigarette. That was back in the '90s.

And then she continued to write to me. And then after she died, someone sent me something, a letter—a daughter or someone—that she'd found our correspondence. So I'll turn over those copies to the History Center. I think that's a story that should be told.

DT: Absolutely.

KEN WHITE: She's huge.

DT: Yeah, she's absolutely huge.

KEN WHITE: And took an interest in my career.

DT: Exactly, as a master's student.

KEN WHITE: And thought that I was asking all the right questions. But she corrected me. She said nursing is not a profession, it's a semi-profession. She said, they're still having discussions about unions, and time cards, and things like that, and professions don't do that.

And so she also said, what they're talking about in break rooms is, who's going to buy my Tupperware? And who's going to sign up for my kid's Girl Scout cookies? They're not talking best practices and evidence in a lot of places.

And so much of that has changed with Magnet [the Magnet Recognition Program through the American Nurses Credentialing Center], and we've come a long way in a very short time, really.

DT: I do wonder, you did mention, the Chamorro nurses in Guam and how no one knows anything about them. So I wondered, actually, if you might say a little more about your experiences in Guam.

KEN WHITE: So the indigenous people of Guam are the Chamorro. C-H-A-M-O-R-R-O, Chamorro, and they have their own language. And a little bit of history—this would be a wonderful story if you ever have a Guamanian student, or even if you don't—the emergence of nursing on the island of Guam.

Prior to 1898, the Spanish-American War, before 1898 Guam became a U.S. territory in '98 as an outcome of this war. Prior to that they were Spanish, and prior to that they were German. So many of the really, really, old people on Guam when I was there could speak Spanish and German.

And then of course they were occupied for four years in World War II, and English and Chamorro were forbidden to be taught in schools or spoken. And they had to speak only Japanese. And they were raped, and lots of bad things happened to them during that period of time. It's a real dark period of Chamorro history, but the history of nursing is sort of woven throughout here.

And the Chamorros are wealthy because their land is wealthy. And when it started being developed after World War II as a Japanese honeymoon destination and a tourist destination, people would sell a tiny, tiny tract of land for millions of dollars.

So it became culturally unacceptable for a Chamorro person—they don't call them castes, but it's something similar—someone of a high ranking in their culture would not become a nurse.

Because nursing had a lower value, wasn't well respected. Because wealthy people wouldn't have gone into nursing. And there's some parallels with other nursing stories.

So they've long had a relationship with the U.S., there's always been a naval base there, an Air Force base, Army base, naval air station. Big presence during the Vietnam War. And the U.S. have also always had a close relationship with the Philippines. The Philippines is three hours due west, and Japan is three hours due north.

And so because the Chamorro culture didn't respect nursing as much as the Filipino, Filipina, culture respected nursing, they imported Filipina nurses to Guam. And because of this close connection that the Philippines had and Guam had with the U.S., it was relatively easier for people from the Philippines to get a work visa on Guam.

So what developed over time was the dominant group of nurses on Guam were from the Philippines. And there were a few others, Korean, some Chinese once in a while. But it was mostly Filipina nurses. And then the University of Guam, after the Vietnam War, opened a school of nursing that later became a university.

It was a school of nursing and then became a diploma, and then it became a degree school, and then it became masters. They'd give master's degrees. And so nursing started to be more respectable. And so when I was there in the '90s, we were starting to see more Chamorro young women pursue nursing as a career. And men, not as much. There were actually more Filipino men in nursing than there were Chamorro men in nursing.

But people like Maureen Fochtman, who went there to be the dean, raised the bar about this is a profession and it's a respectable profession. So we did a lot in the hospital to promote that as well. We would go into the high schools and promote careers in nursing because we wanted to grow more local talent. Because we had shortages too.

And we were bringing in people from the States. And to bring in a traveler from the States was really expensive. And by bringing in people who had experiences in other places, we're also upgrading the whole quality of nursing and patient care for the island. And that's why we were

there. We were there to educate and to raise the standards of what the local people could expect and what they should expect for health care.

So there were a few champions of Chamorro nursing. And I don't know that history very well, but here's one book right here, Guahan *Guam: the History of Our Island* [by Pedro C. Sanchez, published by Sanchez Publishing House in 1987].

KEN WHITE: But I have a lot of documents. In fact, I was going to ask you if you wanted it. I have a notebook about all of our work on Guam during those four years.

DT: I definitely want it.

KEN WHITE: So you can have it.

DT: Yeah, no, that'll be wonderful.

KEN WHITE: It's ready for you.

DT: Yeah, that's why I wanted to make sure I asked you about it because there's so little in the American historical scholarship about Guam. About medicine and health care in Guam. At least, not that I know. There's a lot I don't know.

KEN WHITE: There's a dissertation there. There's a dissertation there, and I can give names of people to contact on the island if you ever have someone who is interested in that.

The other thing that's so interesting about Guam, because they were so wealthy because of this land, and there they were 98% Catholic. The Memorial hospital was government, but our company was Catholic. So people would listen to us because we worked for a Catholic company, even though I wasn't Catholic. But they had respect for the Sisters of Mercy. And there were Sisters of Mercy on Guam, which further helped us get cred [credibility].

But most of the education was private, they were Catholic schools. And if you had any money at all, you'd go to a Catholic school. The public school was very small. There are lots of private

Catholic schools. And because of that, they had really good education. The priests, the brothers, the nuns, they had high standards.

And because they were Pacific Islander, they were always a minority on applications. They went to the best schools on the mainland. They went to Yale, Harvard, Princeton.

To be working alongside these people who were born and raised on Guam, but who had attended Princeton [University], UCSF [University of California, San Francisco], Tulane [University]. They got in the best schools because they had such a great education on the island and they were a geographic minority. They were an ethnic minority, too.

So yeah, it's a fascinating history. I wonder if anyone from the University of Guam, School of Nursing has done that. I wonder in the dissertations. Because I think they have a PhD program.

DT: I'll see. I actually have just been reading some articles, plenty about colonialism in the early 20th century, with Cuba, Hawaii, obviously the Philippines. And Puerto Rico. So I think some may have referenced Guam, but I'll have to look back and it'll be interesting to look at the School of Nursing on Guam.

KEN WHITE: So do you have any last minute thoughts? I know we need to get—we have guests coming in five minutes.

DT: I can follow up with you about other people that you recommend that I talk to about their experiences. One of the initiatives that I do want to do oral histories with, LGBTQ nurses in particular. And if there are other folks that you think—someone that you've got to interview about their experience.

KEN WHITE: I think there's a really good history about this whole RHLA now LGBT thing, if anyone's interested in that. Or maybe you and I could write something up. But I would like for you to speak with Jerry Maki and Tari Hanneman. Because it's not just gay men, it's the whole rainbow.

And if you were to do some research on that for an article or something, I think I would give you two or three names of people to contact because I would like to get their perspective. And there were other people that were champions in our group, but we were a pretty small group.

And I would want you to speak with Stephan Davis for sure. Stephan has a really interesting story, because his complexion is light for an African American so he could pass. And he could pass as straight. And so when he speaks, he's a powerful, powerful speaker. His story is powerful, but he has a way of speaking, and educating, and commanding a room and audience that's pretty wonderful. So I'd want you to talk to him.

And I'll give that more thought. I can follow up with that. I think Ramón Lavandero might be a good person for you to speak with because he self-describes himself as straight. So I would want to hear from them as well. I would want to know how they've experienced being a nurse. That'd be important.

So I hope we can get a time for you to come back and have me give you all these things I've been saving for 40 years.

DT: Thank you.