KENNESAW STATE UNIVERSITY ORAL HISTORY PROJECT

INTERVIEW WITH GLORIA A. TAYLOR

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Monday, 18 December 2006
Location: CIE/CETL House, Kennesaw State University

TS: Gloria, let me begin with our standard question about where you were born and a little bit about your educational background and such as that. Where did you go to school, and so on?

GT: Okay. I was born—do you want to know the year—you're going to find that out anyway!

TS: If you want to give it!

GT: I was born in 1945, April 14 to be exact, and was born in Chicago, Illinois, at Provident Hospital on the South Side.

TS: Well, I'll confess I was actually born in Oak Park two years before you in 1943. My parents were from Tennessee, but they had gone up north to find jobs, so I was born in Chicago. Then they moved back south shortly after that. I don't have any memories of Chicago, but I'm from Chicago too [laughter].

GT: That's neat!

TS: So '45 you were born on the South Side of Chicago.

GT: Yes, and I lived there all of my life. I attended the Chicago public school system and graduated from Hyde Park High School near the University of Chicago. After I graduated in 1963, I then entered Loyola University, which is a Jesuit university there. That's where I majored in nursing.

TS: I think Elsa [A.] Nystrom from our faculty is a Loyola graduate.

GT: She certainly is. I know Elsa very well.

TS: Okay. So you went straight into nursing when you went to college?

GT: Yes, I did. I'm one of those traditional type students, right from high school into college.

TS: What attracted you to nursing?

GT: In part, because, fortunately or unfortunately, it just depends on how you view it, I grew up in an era where choices for women were not that broad. In those days the tendency

was you were either a school teacher or a nurse or a secretary, that kind of thing. I didn't see myself as being a schoolteacher. My mom is a schoolteacher, and I thought that I wanted to do something different. I read a lot as I grew up and read things regarding the health field, and it peaked my interest. I just innocently thought that that was something that I would like to do. I wanted to do something with my life beyond high school, so I majored in nursing.

TS: What grades did your mother teach?

GT: My mother taught primary, and typically that's first through third grade. She retired several years ago, but she retired when she was 65, and then she got bored and went back, and then she substituted for about twelve additional years. Now, she's truly retired.

TS: Wow. What's her name?

GT: My mother's name is Juanita Jones. Yes, because I'm no longer a Jones girl!

TS: We could have said Gloria Ann Jones Taylor. Okay, so you just read about it? Any mentors or role models along the way?

GT: Not a lot. It was basically just thinking about something and deciding to go do it, and that's pretty consistent with my personality. I read up on things, and I think, "This sounds interesting. I'm going to do it." But I must say that when I was in the nursing program, faculty were very nice and supportive, so in terms of the notion of mentors, I could certainly say that some of the faculty there served as mentors and role models for nursing practice.

TS: So you graduated with a BSN in '68, right?

GT: Yes.

TS: Was there a reason you went to a Jesuit school? Are you Catholic or is that why or was it just because it was convenient?

GT: Probably because it was convenient, and there weren't a lot of nursing programs that were baccalaureate based in the early '60s to choose from.

TS: The rest of them were just diplomas?

GT: Right. There were diploma programs, which were consistent with hospital-based programs, and very few associate degree programs, if any, in the Chicago area.

TS: The associate programs came later than the bachelor's programs, didn't they?

GT: Yes, they did. What happened is when the diploma schools decided to get out of the business, what they did was transition into community colleges and associate degree

programs. One of the things that was happening in nursing is nursing began to mature more and evolve as a true academic based discipline. One of the issues that hospital programs faced was the fact that they brought students in, and they got all of their training in the hospital based school of nursing. However, because it was hospital based, if the student took chemistry or English in a program like that and, for whatever reason, that individual decided to change his or her mind, they were not necessarily able to transfer those credits. So it did prove to be problematic.

TS: So you wanted a bachelor's program.

GT: Right, and in terms of answering the question about mentors, this individual was not a direct mentor for me, but she definitely influenced my choice in terms of education. I don't remember this individual's name, but it's a friend of my mother's, and she told my mother at the time as I was preparing to graduate, that if I was going to go into nursing that I really needed to get a baccalaureate degree because that was the future. In terms of where I am now, that was probably the best advice I could have gotten to go ahead and pursue that baccalaureate. So that individual was definitely influential in the decision that I made. In Illinois in the Chicago area at that time, you had basically one of two choices: either go to the University of Illinois or go to Loyola if you wanted a baccalaureate, so I opted to go to Loyola. I didn't choose them, they chose me, I should say! We had to take an entrance exam and things like that. This was well before SAT's, so I felt very privileged to be accepted there, and I feel I got a really broad-based education.

TS: Okay. We think of the '60s as a tumultuous time. Did that turmoil of the '60s affect students who were in nursing programs at that time? Did it make you want to do community service, or whatever, or did it have an impact, do you think?

GT: I'm not sure how much of an impact it had influencing community service. I think what my education did for me is there is a segment within baccalaureate education which is called community health, which is my area of concentration as a professional. All baccalaureate programs—and that makes them different from associate degrees and diploma programs—have components of their curriculum that's clearly focused on community. I was fortunate enough in my program to see a wide variety of things where I was working, along with a nurse in the health department. I worked with one of the nurses in home health care as part of my clinical. So that really changed my focus. It influenced where I ended up later because I had an opportunity to see people pretty much in their own environment. Whereas, when people are in the hospital you see only one facet of the person. If you're the nurse and you're going into someone's home, you see things a lot differently in terms of what that individual will need, but also you start to focus in on the family and see how the family is working together or, in some instances, not working together to help the person. There was a certain attraction to that in terms of being more up close to an individual and learning more about them as a person. Probably that is an underlying strain in my personality. Getting to know people as well as doing something for them.

TS: Right. It's more than just taking care of their body. It's taking care of the whole person.

GT: Exactly, to really get to know who they are and how they think and what's important to them.

TS: Right. There are a number of years before you got a master's, so I assume you went straight into community health and went to work and spent a number of years just being a nurse.

GT: I did. During that time, also, I got married, had two children. And because my children were very young, I delayed going back and getting a graduate degree. When I first graduated I worked for the Chicago Visiting Nurses Association [VNA Foundation www.vnafoundation.net/about/history.htm].

TS: Visiting in the homes?

GT: Yes. In those years, communities had visiting nurses associations, whereas now they call them home health care agencies. What's really different is that pretty much the visiting nurses associations grew up out of the communities that they served, and they were truly under that umbrella of "non-profit community based organization." I was fortunate enough that they thought I was competent enough to be hired to do that. And that really, really cemented for me that this is where I'm at my best. I had an opportunity to do a variety of work from taking care of newborn babies—and I do mean newborn babies, because in Chicago at that time they had a service called the Chicago Maternity Center. It was a place where people who did not have private healthcare insurance could go to get prenatal care.

TS: That's probably way ahead of the curve back then.

GT: Right. The interesting thing about it is that when you went into labor the doctor and the nurse came to your home, and you delivered at home and that was a very novel concept. I think with all the litigation that goes on today that is probably not still happening in Chicago. However, the nice part about that is that the Chicago Maternity Center had a relationship with the Visiting Nurses Association. They would call us every morning and they would tell us which babies were born in our area. We would go out and visit the mom to make sure that everything was going well and examine the baby. We typically would see that mother and newborn baby every day for the first five days of the baby's life. That was for me a really, really exciting time. I loved that work. I really did. It was just so much fun watching the interaction with the new addition to the family, some of the issues that the families themselves were struggling with in terms of caring for the newborn as well as economic issues, and that sort of thing.

TS: Who paid for these programs?

GT: I'm not sure who paid for that. The cost of the visiting nurses visits was something that the agency absorbed because they were free visits to the person. It was because of the

Chicago Maternity Center who did not, at that time, collect fees for their clients because the clients that they took on were considered indigent and not able to pay.

TS: So you did that for a number of years?

GT: I did that not real long. What I did was I switched. I went into school health, and I did that for about two years and then relocated to Pennsylvania in 1970. At that time I had two sons, and so with this new family relocating from the Midwest to the east coast, we had a lot to learn because my husband and I didn't have any relatives in the area.

TS: Why did you move to Philadelphia?

GT: Outside of Philadelphia, in a suburb of Philadelphia called West Chester. It has a university. It's very similar in some ways to Kennesaw, but just a little larger at that time. My husband was a college professor. That's why we moved there.

TS: Oh I see. What did he teach?

GT: Music, and he taught at a historically black college in Pennsylvania called Cheyney State College [currently, Cheyney University of Pennsylvania]. He taught there, and because this was just such a new environment I didn't work for a while. Then I got kind of antsy, and I felt that I needed to do something, so I worked at the local hospital in the emergency room at night. I did that awhile, and one day when I was out walking I saw the local health department. I couldn't believe it! I went in and asked about job opportunities, and went in for an interview and, as they say, the rest is history! I stayed with the Chester County Health Department for a number of years.

TS: Chester County, and the town is . . . .

GT: West Chester is the community and West Chester is a town in Chester County.

TS: Okay. So you did that, and then what convinced you, you needed to go back for a master's?

GT: I don't know if I'm different from—probably not so different from and very much like a lot of individuals. When I first started with the Chester County Health Department in 1971—long time ago—I worked as a staff nurse, and it was a wonderful health department to work for because we did a variety of work. The interesting thing about our county was that it was kind of a combination county in some ways like Cobb, or maybe the way Cobb used to be years ago. There was kind of a suburban section and then you had rural areas. In our county, we had some rural areas, and we provided services across the county from visiting mothers and their newborn babies, helping children with immunization, doing communicable disease follow up, and that kind of thing. During my time as a staff nurse I fell in love with infectious diseases. I don't know why, but I found that to be very fascinating. It was an opportunity to really use my microbiology and look at the evolution of microorganisms and the affect and impact on the body and disease

transmission. So I spent a lot of my professional time as a staff nurse working in tuberculosis control and in sexually transmitted diseases control. I did that for a number of years and then when an opportunity became available I was promoted to supervisor. I did that for a fair number of years, and then I just reached a point where I felt I needed more education in order to be good at what I was doing, or to be better because I felt I was effective, but I wanted to be better, and I felt a graduate education would do that for me.

TS: So you went for an MSN degree at the University of Pennsylvania, which would be in Philadelphia.

GT: Exactly. I commuted to Philadelphia and I had a really tough decision to make at that time, and this probably influenced my decision to go for the graduate degree. My older son would be finishing high school in a few years, so I thought it probably would be best if mom went to school and got her graduate degree because I foresaw with paying college tuition that there probably wouldn't be a lot of money to go around. So I decided, while my son was in high school, I needed to work on my graduate degree.

TS: What's his name, by the way?

GT: Fredrick, Jr., he was named after his father.

TS: So he graduated from high school in Chester County then?

GT: Yes, he did. Interestingly enough, he went to a Catholic high school, Bishop Shanahan [Downingtown, Pennsylvania].

TS: Why is that?

GT: Because he looked at the curriculum and he liked it. So my husband and I discussed it, and we were both proponents that if our children have an idea that they would like to pursue, then we tend to be supportive of that. That was his choice, and so that's what he did.

TS: Then he went on to college?

GT: Yes, he went to Temple University.

TS: He didn't go far from home then.

GT: No he didn't, but he had us on the ropes for awhile! He was an avid baseball player almost his entire youth, and he felt initially that he wanted to go to a college that had put out great baseball players, and he was talking about the University of Arizona in Tempe, and that was very foreign to us!

TS: They were good in baseball.

GT: Right, and that's what he wanted to do. He did get accepted, and then when the reality hit him that he was going to be on the other side of the country, he decided that maybe I'll get a little closer to home. He did look at the University of Miami, and then he decided he would just go to Temple. So he went to Temple, and he majored in radio, TV and film. So he's in the film industry, and he has a company here in the Atlanta area.

TS: That's good. Temple is an interesting place in itself. Russell [H.] Conwell, "The Acres of Diamonds" [<http://www.temple.edu/about/temples_founder.html>], the one that started Temple University in, I guess, the early 1900s. They have a basketball coach there.

GT: John Chaney.

TS: Right. He was there for ages.

GT: Yes. It's interesting that John Chaney was also the basketball coach at Cheyney University [laughter]. Temple attracted him away.

TS: Okay. So you got your master's degree in '83, and that's six years before you came to Kennesaw, so what happens in the next six years?

GT: Well, after graduate school it's always decision time. Okay, now that you've got this degree what are you going to do with the rest of your life? I'm thinking, okay, now do I want to go back to doing what it is I was doing before, or do I want to do something different? One of the components of community health is that you do a lot of teaching, both individually to your clients as well as educating community groups. People that I worked with had always said to me, "You're an excellent teacher, you're a natural teacher." So I thought, "Well, maybe I'll try that and see if they're right. I'm not sure I feel this way, but let me give it a try."

TS: Of course, all your life you've been around teachers with your mother and then your husband.

GT: Right. I thought, well all right I'll do that. And, of course, my husband was applauding on the sidelines. So I took a job at West Chester State University in their department of nursing and taught there for four years. After I did that, I decided to go back into public health, which was my very first love, because there was an administrative job that came available, and I interviewed for it and was given that job. I was just ecstatic about it. It gave me an opportunity to be able to examine my administrative skills, and being a teacher for four years certainly helped strengthen that. There are a lot of similarities between working with staff as you do with your students, and I think that was very helpful for me. I did that for two years, and that's when my husband announced we were moving to Georgia [laughter].

TS: Oh my! Did he get a job down here?

GT: Yes, and my husband is originally from Albany, Georgia. He's an only child.

TS: "All-ben'ny."

GT: Yes. I don't say it correctly [laughter]. You're right! A job at Georgia State became available in their music industry program, and he was successful in getting that appointment, so we moved. As they say, the rest is history. It's been awhile—eighteen years.

TS: So it was '87 that you came?

GT: He came in '87. I stayed back in Pennsylvania because he wanted to try it out—"Do I really want to do this?" This was a big move, and I said, "Well, I want to do this over here in public health, this administrative job. But he loved it, and it was an opportunity to come back to Georgia. With him being an only child and with his parents aging, it was the best decision.

TS: Did you have any apprehension about moving to Georgia?

GT: Yes. I didn't know very much about Georgia, and people would say to me, "Where are you moving? Where are you going to be working?" I said, "At a place called Kennesaw State University." They'd say, "What? Where's that?" I'd say, "I don't know! It's outside of Atlanta" [laughter]. My public health director said, "I know Kennesaw. He was the first commissioner of baseball."

TS: Kenesaw Mountain Landis.

GT: I said, "Oh my gosh, somebody's heard about this place." I'm not sure Kennesaw is named after him.

TS: Well, no, actually it worked the other way around. His father [Dr. Abraham L. Landis] was a physician in the Union Army at the Battle of Kennesaw Mountain, and he was from Ohio. Sherman's army was mainly a Midwestern army. Dr. Landis lost a leg at the Battle of Kennesaw Mountain. So when a son was born two years later in 1866, Dr. Landis and his wife Mary named the child Kenesaw Mountain Landis. But they didn't spell it right. They spelled it with one "n"—Kenesaw Mountain Landis. But that's the connection.

GT: Okay.

TS: But Kenesaw Mountain Landis did come down here and visit the mountain once after he was famous as baseball commissioner.

GT: Oh that is something. Now the story is complete. I've always wondered about that.

TS: So you actually had the job at Kennesaw State before you moved down here?

GT: Yes. I came down for an interview in March of 1989. They sent me a letter and said if I was still interested they would love to have me, and so that was wonderful for us. So here I am.

TS: Okay. Maybe I should ask: did you change your perception of the Atlanta area after you got here from what you had before?

GT: I didn't have a lot of preconceived ideas about what the Atlanta area was like. I think when I came for visits early on, especially during the time of my interview and then a little later when we were looking for a house, I was crazy with all the different interstates. We lived in this nice, little, slow, non-interstate community and—you know, we drove on the interstate if you had to go to Philadelphia or had to go to Wilmington, Delaware, that kind of thing, there was no aversion there. However, the way of life here was much more fast-paced.

TS: And that's opposite of the stereotype.

GT: Yes, oh, yes. I was like, how does anybody find their way around in this place? This is insane. It took me awhile to get used to all the different directions and where things are. I needed to get a part for my dryer to hook up my dryer, and I called the appliance store, and he said, "Ma'am, do you know where the Big Chicken is?" I said, "What big chicken?" I quickly learned within the first two weeks that you've got to know where the Big Chicken is to survive in Marietta [laughter]!

TS: My wife moved down from Buffalo, New York. Her family moved down when she was ten, and she had all these preconceptions that she wouldn't have to wear shoes if she came to Georgia [laughter]!

GT: I didn't think that about Atlanta from my husband's stories about Atlanta. I knew you were coming to the city.

TS: You heard from him.

GT: Yes.

TS: What was your first impression of Kennesaw in '89—we were Kennesaw State College at that time in '89—when you came here for your interview, for instance?

GT: Well, when I came, the interesting part about it is I didn't get a big tour of the campus, and it was just getting on the right interstate and off at the right exit was huge and getting to the right building.

TS: Which in '89, where was the Nursing department?

GT: Oh, I didn't tell you! We were in the library. We had offices on both sides of the second floor or the third floor of the library. We were actually in the library, if you can imagine, and that was rough. We used to have these offices that were like postage stamps. If I had to speak with a student, I would have the student step into the room so that I could close the door so that I could move that little chair that was . . . .

TS: Yes, these really were little postage-stamp offices that were built after the library, for the most part, because we didn't have enough office space.

GT: Right, and it was very tight in there.

TS: I used to have a workroom over there. I know exactly how small they were.

GT: Yes.

TS: And there actually were some on those floors, too, that were put in to be carrels for students to use.

GT: Right, the study rooms, exactly.

TS: They are still being used for offices.

GT: Oh, really? Oh, my. Yes.

TS: Some of our history faculty has been over there until this week, and now we're moving to the new Social Sciences building . . . .

GT: Oh, they're getting a grand office now.

TS: Yes, they're moving up in the world. That's right. So you didn't see the whole campus at that time?

GT: Not at that time, not on my initial interview visit. Then after we moved down here, then I got an opportunity to walk around and see things. It was a nice campus. It was small and compact, and I liked it.

TS: Who interviewed you?

GT: David [N.] Bennett and Pam [Pamela S.] Chally. The interesting part about Pam Chally is that at the time she was the acting chair when I interviewed because Dr. Judy [Julia L.] Perkins was away in Wyoming on a post-doctorate fellowship. So I was here in March, and after that the communication was primarily by letter, and when I arrived here in early August that's when I had an opportunity to meet Judy Perkins, and Pam Chally had moved on. I think at that time she had gone to Northern Illinois University [DeKalb, Illinois], I'm not sure exactly where. What happened was that David Bennett was then

the baccalaureate coordinator [for Nursing] because back in those times, remember, we had both the baccalaureate and the associate degree programs running.

TS: Right. Kennesaw started with the associate when we were a junior college and then eventually phased it out, but for a while had both.

GT: Exactly. And they had only graduated their first [baccalaureate] class or second class by the time I had arrived in the late ’80s. So for the time that I’ve spent here at Kennesaw I have grown with the program and watched it evolve over time.

TS: That’s been the neat thing about Kennesaw over the years, I think, is that a lot of us have been able to grow with programs. We’ve been in on the ground floor and had a chance to actually have some say in developing those programs.

GT: Right, exactly.

TS: So in ’89 you came here and you started teaching. It’s ’98 when you got your doctorate at the University of Alabama at Birmingham.

GT: Yes, the DSN, doctorate of science in nursing.

TS: Somewhere along the line, I guess, everybody in nursing went back and got doctorates. I guess most of the people that came here didn’t have doctorates in the old days, at least, when they arrived.

GT: You’re absolutely correct. And I was probably with that cohort of individuals that over a five or eight-year period of time typically had a master’s and then went and matriculated. I can’t think of anyone since the time that I was here that came in with the doctorate.

TS: Right. Because Judy Perkins—it was 1982 that she got her doctorate at UAB.

GT: And I remember Dr. [Vanice W.] Roberts finished in 1990, and Marie [N.] Bremner finished around that time [also in 1990].

TS: I guess David Bennett had a doctorate at that time.

GT: Yes [1987 from the University of Mississippi, the year after he joined the Kennesaw State faculty]. He taught previously at Mississippi University for Women [Columbus, Mississippi].

TS: So I guess you all were feeling a certain amount of pressure somewhere along the line that if you’re going to be in this program you need to get a doctorate.

GT: I think that was clear when I came and interviewed. Herb [Herbert L.] Davis was the dean. When I came at that time we were under Science and Math, or something.

TS: That's right. We hadn't created Health and Human Services yet.

GT: Yes, exactly. In my meeting with Dr. Davis he was mentioning the fact that nursing faculty needed to get doctorates.

TS: And you were okay with that?

GT: I was okay with that because that is what I had experienced working at West Chester State University for four years. There were a lot of faculty there teaching at the baccalaureate level with master's degrees, but it became very apparent in the '80s that nursing faculty—if nursing was truly going to be an academic based discipline—were going to need to be doctorally prepared. That was clear. There was a lot of energy where I was at West Chester State University with faculty, not all of them, but some faculty going back to get doctorates. I found a similar environment when I came to Kennesaw.

TS: How would you describe the intellectual life of Kennesaw when you came here? What was your impression in terms of students and faculty and so on? Maybe compare it to West Chester. What was your impression of students, maybe, would be a good starting question?

GT: I felt that coming to Kennesaw that we had a lot of very good students. We had students that really wanted to learn and work hard and do what needed to be done in order to meet the requirements for the degree. Because this was a commuter school at the time, it was a little bit different than West Chester State at the time because West Chester State, about 50 percent of their population represented students that came from high school right into college, which was a little bit different than the type of student that we had here at Kennesaw. The majority of our students were going to school, being mothers, maybe working a little bit on the side, having a husband. So in terms of working with that kind of student, the faculty then needed to change their expectations and get creative about the learning because people are not always necessarily free to take advantage of some learning opportunities that are scheduled at a non-class time. So I felt that I really had to be mindful of that. I had to really learn quickly that while you want to enrich your student's learning experiences, you had to get creative in how to do that within the scheduled time that you had with them.

TS: Right. So Kennesaw just didn't have very many traditional students in the nursing program?

GT: Right, at that time. Our students were a little bit older. I think when I came to Kennesaw the mean age was like twenty-six.

TS: For the whole campus.

GT: Yes. I think that's changed a little bit now since we have residential life.

TS: Have you seen that in nursing? Do you have more coming straight out of high school?

GT: More than we've had in the past, historically. Some really younger students—they have a different level of energy and curiosity about the world. They're different because this is sometimes their first opportunity with being on their own, living independently, and so the issues change. I found that in the past two to three years since we've had residential life, and some of those younger students are coming into nursing, they really have a lot of energy, or maybe I'm just old! But they really are a challenge, and they're just a delight to be around. All students are because they bring with them their life experiences, and they come, and they have that drive and willingness to succeed. Nursing is not an easy discipline, so we deal with students that don't do well, maybe having to drop out of the program, coming to talk to you about that and sharing their feelings, and that's very difficult. Sometimes I don't think students realize that it's difficult for faculty because when we encounter them in that classroom we see ourselves as being there to help them to succeed, and when they don't there's a certain sense of, what maybe could I have done differently that would have changed things for this individual? Not to say that faculty should take responsibility for a negative outcome of a student because it's certainly not necessarily faculty driven, but you still ask yourself that question and you go back and you look at the assignments and the work, and you question whether you're being realistic. That's important, and sometimes as faculty we deal in the ideal because we want the best. At least I do, I want the best from my students and I want them to grow. I want to take them beyond what's in a book because the books are so limited. They're outdated by the time you get the 2007 version on your desk. So I want them to see the latest things, and I try to bring in new information, so that when they do graduate they have some knowledge of what is currently going on related to the discipline.

TS: What was your impression of the faculty when you came here?

GT: Well, I was very impressed with the faculty. This is a hard-working faculty because a significant number of them were working on a doctorate plus carrying a full teaching load.

TS: That's impossible almost.

GT: Yes. And I lived through that as a full time faculty member trying to juggle working and living up to those responsibilities plus pursuing the degree.

TS: While you were saying that you were teaching nine months out of the year and going to school in the summertime, how many years did it take to do that?

GT: Well, it took too many! Let me think. I graduated in '98 and I took my first course, I believe, the fall of '91. I just took one course. Then in the summer of '92, I went and took two additional courses, and after that the race was on.

TS: So it was like a six or seven-year program.

GT: Yes.

TS: I did the same thing. I was here ten years before I completed my doctorate. It seems like it took forever to do that dissertation while I was trying to teach full time.

GT: Yes. People ask me how did you do that, and I say, "I don't know. I can't tell you how I did it."

TS: Desperation.

GT: Yes. I just did it because I knew what I had to do. So I just juggled my time accordingly. You discipline yourself. You do make some personal sacrifices regarding giving up certain things that you used to do that you don't have time for now. So you become very selective, and eventually if you stick to it, it just happens.

TS: It's hard to give students the time that they deserve while you're trying to go through.

GT: Right. Because I think when you're in school, especially if you're taking a course during the semesters that you're teaching, you become guarded, somewhat, of your time, and you may not be as available as you would be if you didn't have that.

TS: Right. So you were plodding along, I guess, and also learning the ropes still at Kennesaw because you started pretty early after you came here. Eventually you finally finished up in '98. What did you do your dissertation on?

GT: I designed an educational intervention for breast self-examination. What I did was I designed one and then compared it to the standard one that was currently being used, and basically it was focused at minority women, particularly African-American women. What was different about my intervention that was different from the standard intervention is that it gave women more time to be more participatory. It gave them time to talk about their feelings. We did a little skit as a part of it, and that sort of thing. So that's kind of what my research was about.

TS: Right. This is for self-examination.

GT: Right, that each month women beginning at about age twenty-one, very early on, that they should be examining their breasts monthly to locate any unusual lumps. Because there is a certain amount, even though it's low, a small amount of breast cancer among women that are under forty years of age. It's very random, and so women need to be aware that they should be examining their breasts monthly, so that they continue with that habit as they move on in life. By the time they reach forty where the incidence tends to start its steep climb upward—because with breast cancer, as with the majority of cancers, the incidence goes up with age—so the intent is to encourage women to adopt that kind of health behavior early on and continue it throughout their lifetime.

TS: Did you find a cultural difference between African-American women and Caucasian women in your research in terms of percentage that would do the self-examination or had heard about it or whatever?

GT: What I found from my research, not necessarily from my intervention, but just from the literature in general, was that [for] women across the board—and if you set aside ethnicity—breast self-exam tends to be low. Women are just not doing it, and they need to be encouraged to do it. The interesting thing is it even gets lower as women get into the more high-risk age group because when women reach forty they should at least have one baseline mammogram. The conventional thinking within the lay community is if I have a mammogram it's much more precise and able to locate a lesion I may have in my breast far better than I would be able to do.

TS: So I don't have to do anything.

GT: I don't have to do it. What women need to be mindful of is there is a phenomenon called interval tumor, meaning that you can get your mammogram today, and it is negative, and in the subsequent months you can start to develop a breast lesion.

TS: Did you come to any conclusions about why it is so low? Because it seems like it's everywhere nowadays that you hear these things and you kind of think everybody ought to know about that. Did you come to any conclusion as to why? Is it because it's something that makes them feel uncomfortable to do it or that they hadn't heard about it or what?

GT: Well, I can tell you pretty much about the women from my study, is that the percentage of women hearing and knowing about it was very high. People knew about it.

TS: They knew about it, but they didn't do it.

GT: Yes. They didn't do it. The reasons that were given—which is a very interesting phenomenon—is that a lot of women were afraid of what they would find, if that makes sense.

TS: Yes. It doesn't make sense in a way, but . . . .

GT: Right. I don't examine my breasts because if I found a lump that may indicate that I have a problem. Trying to get individuals to understand that if you have a problem it's better to find it out early on because we're more able to help you if we find it early versus late. But getting people to that point, I think, is difficult conceptually for them [because of] this fear of what they may find. And of course, a lot of women will say, "I just don't have time, I'm just so busy." And it takes less than five minutes once a month.

TS: So that's just an excuse.

GT: Yes, to a certain extent.

TS: That doesn't really explain the real reason.

GT: Right, and then some women, depending on the taboos with which they grew up, some women feel that it's inappropriate to touch your body in that way and that sort of thing. There are a variety of reasons as to why some women choose not to do it. Of course, many of them said I just don't know how, and that was the nice part because if you participated in the intervention that was one of the things that they did go home with.

TS: I had an aunt who died of breast cancer in her forties. This was back in the 1960s. She was a nurse, and she knew that the lump was there, and she didn't report it to anybody.

GT: That's not uncommon.

TS: I wondered how . . . .

GT: It's not that uncommon. It's that overriding fear that something is wrong, and I'm not sure what needs to be done to get past that barrier of fear.

TS: Is this something that you're still doing research on?

GT: No. Not right now. But it's something that I think about and I'm hoping that one day I will go back to. For the past three years I've been immersed in HIV. Now, that appears to be far from cancer, but individuals that do have HIV infection have cancers as well because no longer, at least in this country, is HIV infection, if they receive appropriate treatment, considered to be a terminal illness.

TS: No longer a terminal illness.

GT: Yes. But it's considered now to be a chronic disease. One of the issues that they're facing with individuals that do have HIV infection, whose infections have become very manageable, is that then they're just as much at risk of getting these other age related chronic diseases that other people get. Fifteen years ago if a clinician had a client, let's say that was in their early thirties, they would not necessarily talk to that individual about risk factors for heart disease, health promotion, staying well, because at that time the biggest concern was just keeping the person alive. We've been blessed in this country that we've had the availability of pharmaceuticals to be able to bridge that. So now that we're keeping people alive longer, the individuals with HIV are just like anyone else. They're at risk for getting the whole host of other things that all of us have a propensity for, just due to the sheer aging factor.

TS: Right.

GT: So there's a lot of teaching and work that needs to be done in terms of the health promotion and wellness messages that we tend to focus on for the population in general.

TS: It's really interesting that you finished your doctorate in '98, and that's also the year that you received the Preston Award [Philip Preston Community Leadership Award]. Isn't that right?

GT: Yes. Time has a way of making you forget.

TS: I guess what's maybe really interesting about this is how you found the time to do the kinds of community service that you need to do to win the Preston Award and you're doing a doctorate at the same time and so on. How did all those things tie together?

GT: Well, I'll go back to the beginning when I first came to Kennesaw. Prior to coming to Kennesaw I had always been involved with community-based agencies.

TS: Is that what you were brought in to teach was community health?

GT: Right, exactly. That's my clinical specialty within nursing. When I came in '89, along about 1990, I believe it was, I got involved with the clinic that was at MUST Ministries. I would volunteer time there once a month and continued to do that. In addition to that I got involved in the local chapter here, the 13th District Georgia Nurses Association [Marietta] and became very active in that. When I lived in Pennsylvania, I was a member of the Pennsylvania Nurses Association and was also active in that chapter, so I was just basically doing the same kind of things that I did there. As they say, life just happens. Things began to evolve, and I just became more involved in things. I don't even remember how I got to that point with doing all of these things. With MUST Ministries I continued to volunteer and then sat on the board and then was elected board chair. I don't remember what year it was, but that was all during the time that I was working on my doctorate as well. WellStar [Health System], in the summer of 1995, wanted to do something related to school health. I had been a school nurse when I was in Chicago and had provided some consultation to school nurses when I was in Pennsylvania. I had just had surgery for a major illness, for thyroid cancer myself. This is all while I'm doing the doctorate. Ask me now how I did it as I'm doing all this stuff [laughter]! Because I had my surgery and went back to school the same summer—I was just obsessed with finishing. It was a surprise diagnosis, and it was a good distracter to stay focused and work while I went through my treatment.

[L.] Annette Bairan told me about this initiative; she said, "Would you like me to tell Judy that you're interested?" And as crazy as I am, why not [laughter]? So by the time the fall semester commenced and we returned, Dr. Perkins came to me, and she said, "I was told that you're interested in this project." I said, "Well, if there's something that they feel that I would be able to help them with, I would be happy to do it." She said, "I think this could be an opportunity." I said, "Well, I'll come to the meeting." I went to the organizational meeting. At that time, WellStar, through their foundation, was very much interested in funding a school nurse program for Cobb County. However, what they lacked was definite clear data to support the implementation of such a project.

TS: What kind of data did they need?

GT: In terms of looking at which schools needed nurses, and what were some of the illnesses and issues going on in the schools that would merit the presence of a school nurse. Because at that time, back in 1995, Cobb County had what they called clinic monitors, and these individuals that sat in the clinic—not at all schools, but at selected schools—and those schools were the schools that were able to raise funds to pay someone to come in to the clinic.

TS: The wealthier schools.

GT: Yes, the more affluent, exactly. So they had these clinic monitors.

TS: The ones that probably needed it the least.

GT: Right, overall. So they wanted me to take a look at that. What I had suggested to them was—because they lacked data—that I would be willing to conduct focus groups with schools in southwest Cobb and analyze that data and write a report and make recommendations. What I did was that fall and in the spring my clinical students worked with me and as part of their clinical experience conducted focus groups and did surveys and interviews in several schools in southwest Cobb. The spring of '96, and that summer, I submitted the report—the findings, with my recommendations. The findings were that, yes, there is definitely a need, these are some of the issues, these are some of the things that are going on, and schools would benefit from having some type of consultation from a registered, professional nurse. Well, based on that information WellStar wanted to move ahead and implement this program in the fall of 1996. They decided that they would look for somebody to head that program. As it turned out, in order to meet their timeline, because they felt compelled to move ahead, they could not find someone with the acceptable background, so they spoke with Dr. Perkins, and they asked me if I would be willing to do that for them.

TS: To head the program?

GT: Right. So that fall semester, in addition to my teaching duties—what I did was the fall of '96 I designed and developed a program and interviewed five professional nurses, some having a strong background in school health and some having backgrounds in community health, so that by January of 1997 we launched the school health program in Cobb.

TS: Is this like putting a nurse full time in a high school all day long?

GT: No, one of the things that WellStar was clear about was that they could not afford to place a nurse in every school.

TS: There are a lot of schools in Cobb County.

GT: Right. We did know that there were schools that did have the clinic monitors. So the project was really designed to provide consultation to those individuals that were serving

as clinic monitors in addition to providing consultation, especially to schools that did not have anyone. What that would entail is that at least one day a week in schools that did not have anyone, that school nurse would be on the premises all day. She was available to that school on the other four days of the week by pager. If they had a situation that they felt they needed input, if the nurse could not resolve it by telephone then she would travel to that school on site to help resolve the situation. So we went live in January of '97. The first half of that year was very much a success. The school district loved it, and the families, the students, the faculty and staff in the schools, so we moved forward. What we did was we then started to look at other counties, and we then added on Douglas County, Paulding County, [and] Cherokee County. Those four counties made up that compilation. So what we did was we wrote a school manual for each of those school districts. We personalized them based on how that school district operated and the resources that it had. Then we developed a manual for them, so that they could look up information about what to do in this kind of situation in this particular school district. So we tailored four separate school health manuals over the next two years.

TS: So there's a difference in what the services you need to provide depending on what the economic and . . . .

GT: Right, and the resources that were already available. For example, in Cherokee County they were fortunate enough to already have individuals on site in their schools. They had a lead nurse in Cherokee County, but what they really needed was a school health manual, a way to facilitate and organize the help to students, so that no matter which school a student was in, the nurse that was in that school would be providing the service according to some standardized level of care that was acceptable with the school district. So that's what we did for them.

TS: What kind of things are they doing?

GT: It's from vision and hearing screening, basic first aid, management of chronic health conditions such as diabetes [and] asthma. Diabetes is on the rise and has been on the rise for a number of years, as you well know. There are more and more students coming to school who require support and help with their blood sugar monitoring, as well as insulin administration during the day. Not that the school nurses were taking over the insulin administration, but that individual was there to provide direction and guidance to the student if the student needed that. That was very important. We put in place a system for what individuals needed to do in terms of a medical emergency, especially like an allergic reaction, an anaphylactic reaction, in terms of developing the protocol for the use of the epinephrine pen. Because a lot of times people, children especially, children that have sensitivity to insects, most commonly bees, what they tend to do—a lot of times, especially during physical education, the child is out on the PE field, and the EpiPen is back in the child's locker, or in many instances locked up in the main office because of this notion of "zero tolerance" for drugs. So we were very instrumental in helping schools understand that children with this level of sensitivity need to have the responsibility for having these epinephrine pens on them at all times. It's unacceptable to have a child on the athletic field with that kind of known sensitivity and not have that

epinephrine available. As we go through doing the things that we do every day that we're not really thinking about it within that context.

TS: So you're doing a lot of education in the schools.

GT: Right, and information. Another area is in terms of epilepsy. The classroom teachers are really concerned about epilepsy. What do you do when a child has a seizure? Well, in our school health manuals, we addressed epilepsy, the different types of epilepsy, and what's the responsibility of those individuals within that environment, should a child have a seizure.

TS: What's the responsibility of the teacher in the classroom?

GT: Exactly, and putting into place protocols, or if you will, sequencing of steps to take once that's observed. Who's responsible for activating 911? Because in many instances, we're talking awhile ago, almost ten years ago—I can't believe time has passed this much—that a lot of times, in those days, teachers did not have phones in the classroom. Today everybody's got a cell phone almost—and when it is appropriate to call 911. Because one of the things that we needed to be mindful of is that if we do activate the emergency medical system that we're doing it appropriately and not utilizing a resource that we should not be utilizing at the time. So, as you say, it's a lot of education. But in order for it to be effective we had to develop these school manuals that could be placed in schools.

TS: Do we have a manual for faculty at Kennesaw State?

GT: Do you mean in terms of health?

TS: Like what's an instructor supposed to do if someone has an epileptic fit in their class?

GT: I'm not sure.

TS: I've never heard of it.

GT: Well, we're adults, I guess.

TS: I guess.

GT: I'm not quite sure.

TS: It's a scary thing for a faculty member if somebody suddenly has a stroke or a fit or something in their classroom.

GT: Right, no, it's true.

TS: Whom do you call?

GT: Right, exactly. And just what should you do to be supportive of the person if they're having a seizure because we wanted to assure as much as possible that someone was not having something placed in the mouth, which is an absolute no-no. But there is still a lot of belief in the lay community that if someone is having a seizure you have to prevent them from biting their tongue, so you need to put something in their mouth. Of course, that is still popularized in movies and that sort of thing, but we really want to get the word out to let people know that if someone is having a seizure of that magnitude in your presence the best thing you can do is move objects out of the way because the person is out of control, so you don't want to have someone falling into a table, falling into chairs or other objects in the environment that will contribute to injury.

TS: Right. And I guess what we do here on campus is call 6666 and wait for the campus police to come.

GT: Right. And a lot of times, just letting faculty know that when an individual has a seizure they feel compelled to sleep after that much electrical activity in the brain, so therefore trying to arouse someone is not necessarily the best thing because they do need that rest time. What you want to do is cover them, make sure they're kept warm, and you're calling 911. Helping faculty understand that if a student has a seizure in your classroom and they have no medical history of a seizure then that individual does need to be transported to a hospital because that individual needs to be evaluated because that's a new experience.

TS: That's a tremendous contribution to the public schools.

GT: Thank you. And it was a fun project, and we spent many, many hours in terms of assessing the needs in the various school districts. I would like to feel that we, in some part, played a role in the current school nurse system here in Cobb County that's present today. A lot of the nurses from the WellStar program, when state money became available to help fund school nurses across the state of Georgia, a lot of them were able to migrate from the program and are currently working in the Cobb County school system. They have that rich experience that they were then able to share with their colleagues. The current supervisor of the school nurses in Cobb County is one of our former project nurses. One of the lead nurses in the Douglas County system was one of our nurses. So when you've been a part of a program like that and you can still see remnants of it continue into the future then you realize that it was time well spent.

TS: Do you think this was the primary thing that led to the Preston Award in '98, your involvement with the schools?

GT: It could have been.

TS: Or what else would you be doing at that time?

GT: Around that same time, I think, maybe some of my work with the Georgia Nurses Association in terms of sitting on committees at the state level that had a direct impact on nursing and nursing practice in the state of Georgia, as well as my work as the chairperson of the board at what we called Cobb Health Partners, but it's the MUST Ministries clinic. The original clinic was at MUST Ministries on US 41, and then they developed an additional site at St. Stephen [United Methodist Church, Marietta], so I'd like to think I played a small part in that. I don't want to—because when we see something happen, it's not just one person. It's a lot of people that have contributed to making that change.

TS: Well, Janice [M.] Long said that you were a major mentor for her.

GT: She's very kind. When I was working with WellStar she was one of the liaison individuals that we worked with at WellStar. She did share that with me because she came to my office, and she said, "I just wanted to tell you how much of a mentor you were for me, and you really are one of the reasons that I went on to pursue my doctorate." I said, "Well, when you knew me, with all that was going on, I didn't know that that was impetus to take on more work!"

TS: Well, it really is incredible that you were doing all that you were doing and working on a doctorate and teaching a full load.

GT: Well, one of the things, when I was working with WellStar, I was released from my teaching. Yes, let me be clear on that. I mean, I can do a lot of things, but I can't do all that!

TS: Well, you were still doing quite a bit.

GT: Yes, I was. There were many hours that my husband went to bed, and I was at the computer, and when he would get up I would be at the computer. It takes a little more sleep for him than it does for me. When I'm in the middle of something it's very difficult for me to sleep!

TS: I've always envied people who can do with a limited amount of sleep.

GT: I wouldn't try it now! It won't work!

TS: Are you still working with the schools?

GT: No, not at all. Basically what I do with the schools is I try to maintain the relationships with individuals that I have worked with over time because that serves as an opportunity for my students. So I tend to contact people and try to negotiate clinical placements for the students and that sort of thing.

TS: Right. I noticed that your official title now is WellStar Distinguished Scholar in African American Health, as well as being Professor of Nursing. When did that come about, and

the increased research emphasis come about? WellStar put some money in, didn't they, to encourage scholarship in the department?

GT: Right. And because of my past activities with some grant writing. I wrote two NIH grants that were related to breast cancer—neither was funded, but I did get some good feedback on them. At the time that this opportunity became available, the dean approached me, and he said, "Because of your track record and initiative, I would like to give you one of these appointments." So I'd been getting some release time to do research, and that's probably how I ended up focusing on HIV because the African American community is disproportionately affected by HIV. It's been very interesting in terms of my involvement with HIV disease. I've learned a lot and have met some very wonderful people. I've been involved in, I can't remember how many projects, but the two that are the most memorable for me is that I was involved with the state project with a team of researchers, Dr. Timothy Akers and Barbara [J.] Blake and Annette Bairan and Dr. [Richard L.] Sowell when we, for the state of Georgia, did an HIV/AIDS community services assessment and their HIV/AIDS comprehensive plan. I was very much involved in that. I got to travel around the state a lot and meet some interesting individuals that provide care and services to people affected by HIV and help put together those two documents that were then presented to the state. In addition to that I've been working for the past two years in the African-American Outreach Initiative. It's not an organization, but it's a community effort that's comprised of professionals within the metropolitan Atlanta area that provide HIV services. Because African Americans are disproportionately affected, for the past seven years they have been putting on an event in Atlanta called the African-American Outreach Initiative, where it's a two-day event that provides education to African Americans about HIV disease. It covers a wide gambit of topics from holistic health, how to manage your HIV disease, how to advocate for yourself, what are some of the legal issues related to people affected by HIV disease, and issues related to housing discrimination.

TS: Discrimination against people who are HIV positive?

GT: Exactly. Because if it was known that I was HIV positive sometimes a landlord may not want to rent to me. I just learned two weeks ago from a gentleman from the Civil Rights Commission, who represents the southeastern United States, who is now doing a survey of all the nursing homes in the state of South Carolina regarding admission discrimination for persons with HIV, meaning that these individuals are denied admission to certain nursing homes because of their HIV status. At the conclusion of his work he is hoping that this will then become a model for the southeast in terms of advocating for individuals that need nursing home care and that they are admitted to the appropriate facilities because of their need, not necessarily because they are HIV infected.

TS: I wouldn't think that anybody would go to a nursing home if they didn't need it!

GT: Right. And some nursing homes will say, "We're not equipped to take care of somebody." The bottom line on that is that's really a smoke screen because they are. Within the practice of healthcare we all work under a mandate that's called "universal

precautions." That means that any time you potentially anticipate coming in contact with blood or bodily fluids from any individual—this is across healthcare; this is standard practice—

TS: That's the issue. They don't want to . . . .

GT: Right. Some of these nursing homes may feel that it would increase the risk to their employees. But what these nursing homes don't understand, or probably I shouldn't say it's not a lack of understanding, it's probably a bias towards people with HIV disease—you can't look at someone and determine their HIV status. Therefore, an individual that you may not even suspect to be HIV positive could very well be HIV positive. So it's really important that when we provide health care in any setting or in any environment, if there's a potential for exposure to blood or body fluids from any individual, then the provider should take the appropriate precautions in terms of using a barrier, and in most instances it would be gloves.

TS: I was going to say, what's the chance of becoming HIV positive from somebody's blood if you're wearing your gloves?

GT: Almost remote, yes, it just doesn't happen.

TS: So what you're saying is they know better, but somehow or other their mind is closed.

GT: Exactly.

TS: Fear.

GT: Yes, the typical discrimination that we've seen throughout history in terms of healthcare—because if you go back fifty years or even longer, people were terrified of individuals that had tuberculosis.

TS: Right, and isolated them in a special pest house.

GT: Right. And they used to put quarantine signs in the '40s, and even into the early '50s on people's doors. Somehow we have forgotten that while we all have the potential to be exposed to certain infectious organisms that for most diseases casual contact is not how you become infected in terms of just the day to day routine activities.

TS: My wife's mother had ALS and it's amazing how people didn't want to touch somebody with ALS. I guess they didn't know enough to know how you got it, I guess.

GT: Right. And I think some of this is just, as you said earlier, a closed mind to how diseases are really transmitted. That gets me back to something I said earlier in the interview about my fascination with infectious disease. I've always found it extremely interesting, and once you study how diseases are really transmitted person to person you really realize that you have to do something that's a little bit different to get exposed.

TS: Why do you think that African Americans would be disproportionately affected by HIV?

GT: That's a question that a lot of people are still trying to uncover the answer to. There are a lot of hypothesis that have been proposed for it. One is access to care, not enough information about the disease, behavior—some people propose that it's sexual behavior. But it's my understanding that most Homo sapiens have sexual contact, so it's not really clear as to why they tend to be disproportionately affected. I just completed an article with Dr. Blake in terms of going back to the beginning of the epidemic, and tracing . . . .

TS: Which is really not that many years back.

GT: No, twenty-five years, to look at HIV infection among men. Once we went back to the published data, it was very clear that probably the infection was going on at a significant level within the African American community, but—how can I say this?

TS: Before they knew what it was?

GT: Right. If you don't look for it, you're not going to find it, and if you don't document it then it doesn't exist. Most people know that at the beginning of the HIV infection, it was considered a white, gay male disease, and that's part of the problem. What has happened with HIV disease in terms of how the general public, or even we as healthcare providers see disease—this is probably no different than some of the other things. We tend to categorize and pigeonhole certain groups or populations.

TS: If white, gay men were the first to be identified as having AIDS, are you were suggesting that maybe it existed long before 1981 among African Americans and since nobody was looking for it, a lot of people were probably getting sick and dying while it was diagnosed as something else?

GT: Right. Because we have to remember that no one at the beginning of the epidemic knew what it really was. It was white, gay male disease. But then as we became more informed, as we uncovered the underlying organism—and that's always important in infectious disease, what is the causative organism—we began to learn what it was. However, there was this bias towards white males, and so we tended to gather most of our data and because of the sheer prejudice that was going on at that time—and I do applaud white, gay males for standing up for their rights—we had issues for the first time, as far as I know, in terms of a known infectious disease not necessarily being reported. Most people don't know that within only the last two years name reporting finally came to Georgia. Whereas if I'm infected or you're infected with HIV disease and it's identified then our name is reported to the state—by name—they know who is infected.

TS: In other words, the doctor who finds it out reports, or the nurse who discovers it reports it, or whatever.

GT: Right, and now the laboratories have to report it. They have always been mandated to report it.

TS: What do people do with these names once the state has them?

GT: See, that's the concern that was at the very beginning of the epidemic. They felt that people would be penalized in some way, or there would be some type of retribution for being known that you are HIV positive. We do need to keep in mind that because we knew so little in the healthcare profession there was a lot of bias out there.

TS: Do you think there's less bias today?

GT: There's probably a little less bias, and I do emphasize "little!" And insurance companies have been notorious for discrimination and not necessarily about HIV disease, for individuals that have been affected by other diseases. It is only in the past decade that it really is against the law for insurance companies to deny somebody coverage. Let's say that my husband had a debilitating disease like multiple sclerosis, and I moved and changed jobs. Well, when I take my family to go sign up for the family plan, and he comes into the insurance plan with a pre-existing diagnosis, some insurance plans won't cover them at all. However, the law is clear that most insurance plans will take you, but for the first year you're on your own. When you think about it, that's a bias. So you can imagine how that may be multiplied when it comes to something like HIV disease. So still within the profession and in the general public there's a lot of bias out there. But getting back, one of the things that we noted in our article is that the incidence was there because what do you tend to do from an epidemiological perspective is you look at each population—African Americans represent only between 12 and 14 percent of the U.S. population. So if you just look at the total number of cases, yes, there may be more white cases than black cases, but percentage-wise the distortion was there early on. The white males tended to get most of the attention. Today we're at a place where we're looking at those numbers now and trying to look at what we might do to reduce these numbers. One of the things that we do know, setting race aside, is that typically we're still getting about 40,000 new cases of HIV infection each year.

TS: Forty thousand where?

GT: Across the country, in the U.S. AIDS, outside of this country, especially on the continent of Africa and in Asia is off the scale. We're talking small number of cases in this country compared to some other parts of the world.

TS: Because of lack of access to health care, lack of education, why do you think?

GT: Do you mean globally?

TS: Yes.

GT: A lot of it has to do with a lot of things that go on culturally. Typically, if you look at where the infection is now, it tends to be rampant in cultures where there's—and I'm not sexist or a women's libber or whatever—but I describe what is being manifested in the community where in these communities—and I don't have any bias against it—but it's a male-dominated culture meaning that women are subservient to males. I think that exists in America, but it exists in a kind of different way. When you have a culture that's male dominated and women don't question what males do, then that sets the stage for women being infected and not knowing that they have infections, and then they pass that infection along to their children, their newborns. Here in the United Sates, our rates of transference of HIV disease from the pregnant moms to their newborn babies are almost negligible. And it has to do with access to care.

TS: Prenatal care.

GT: Right, because when it's found that the mother has HIV infection she's usually offered treatment, and that typically minimizes the transmission to that baby. So that's really important.

TS: It's almost a vicious cycle in a way because those areas where HIV is off the scale are often in very poor countries, and because they're poor they can't afford or haven't put the money into prenatal care, perhaps.

GT: Right, and also have people that live in remote areas—getting the medications to them. We have to keep in mind that in some of these parts of the world there's a lot of internal strife, so transporting goods—sometimes medications that are earmarked for a certain destination may not make it.

TS: Because medicine is still very, very expensive, isn't it?

GT: Extremely expensive. And that is an issue from a global perspective that the World Health Organization is addressing in terms of getting pharmaceutical companies to lower their prices and also allow generic products into the market place. This patent trademark notion has been an inhibitory factor in terms of getting medication to the people that need it.

TS: Do you see yourself continuing to do research on HIV?

GT: For now, yes, just due to the number of projects that I have going right now. Dr. Blake and I are in the middle of data analysis for the African-American Outreach Initiative because what they would like to look at is to see if their particular education and intervention, which occurs once a year, is making a difference in the community. We're also involved in the HIV/AIDS TAKE project for the state of Georgia that is addressing HIV/AIDS in African American populations. We've just starting working with them as program evaluators for that particular initiative, which is in its second year.

TS: Is HIV a problem greater in Georgia than in other states, do you think?

GT: It is. The southeast has a higher percentage of HIV cases. Getting back to the article that Dr. Blake and I just finished, which just came out this month in the *Journal of the Association of Nurses in AIDS Care*, we were able to see within the last decade of how certain regions of the country . . . we're not sure as to why we're seeing as much HIV in the southeastern United States, but a lot of our cases are coming out of this region of the country [B.J. Blake and G.A.J. Taylor, "A Portrait of HIV Infection Among Men in the United States," *Journal of the Association of Nurses in AIDS Care* 17 (November 2006): 3-13; www.janacnet.org]. We typically associate numbers in HIV cases with densely populated areas because when we look back, historically that's where it started, in New York and San Francisco.

TS: So it's worse in metro Atlanta than it is out in the smaller counties?

GT: Only because the numbers are here because of the density in population. However, from my work throughout the state and talking to individual providers, it is a problem. They face a lot of different issues. In the metro area you have access to services. For example, there's one public health district that's comprised of thirteen counties, and they only have one clinic in a thirteen county area that provides the care. So that means that some of their clients are traveling two and a half to three hours to come in for their care. That's definitely an access issue. That access is related to economics. There's only so much money available to run these clinics that are in close proximity to a number of individuals. So the rural areas, while they may not have these same numbers, they're struggling in their own right.

TS: What do you see as the future for the Nursing program at Kennesaw?

GT: I think Kennesaw has a bright future. I am very privileged to work with some very creative and innovative faculty members. I see us within the next five years having a doctoral program.

TS: I wondered how long it was going to be.

GT: Yes, I would think in the next five years maximum.

TS: Once you get your new building.

GT: Right. In terms of the caliber of faculty that we're attracting to our school and the emphasis in terms of research—not that our research emphasis precludes our teaching because our teaching is our first responsibility—however, due to our research endeavors I think we will be attracting some very quality people that will help us grow our current programs and solidly establish additional programs in the future.

TS: Well, it seems to me that all the research you do in the School of Nursing is directly related to community needs and that you are involving students in different ways in what you're doing.

GT: Yes, I do. And as much as possible because now that I'm involved in HIV I've had two RN to BSN students work with me on my African-American Outreach Initiative project, and both of these individuals were very much interested in learning more about HIV and taking their career in that direction. One of those students is now a graduate student in our nurse practitioner program.

TS: What's her name?

GT: Laura A. Dirico. She just started this past fall, so she's thrilled. It's nice if you feel that maybe you have influenced somebody to continue with their education. That's always a good thing to see.

TS: What are you proudest of in your career at Kennesaw?

GT: Oh, that's tough. I think if I had to choose right now, what I would say I'm proudest of is my work with the school health project because I think that we did make a difference in our local communities. I would like to think that the work that we did for those few years helped influence school nursing across the state.

TS: Well, I think I'm about out of questions. Have I missed anything that we should talk about, do you think?

GT: I don't think so.

TS: Well, I certainly enjoyed the interview and I appreciate your coming in.

GT: Well, thank you. This has been fun.

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