



D. Kirk Oglesby, Jr.
In First Person: An Oral History

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D. Kirk Oglesby, Jr.

In First Person: An Oral History

**Interviewed by Larry Walker
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EDITED TRANSCRIPT
Interviewed in Anderson, South Carolina

LARRY WALKER: My name is Larry Walker and I'm here at AnMed Health in Anderson, South Carolina talking with Kirk Oglesby, the former president and CEO of AnMed Health. We're here to discuss his life and leadership during a health care career that spanned over 45 years. Kirk has been recognized as a thoughtful, forward-thinking, dynamic, and results-oriented executive. As Anderson Area Medical Center and AnMed Health's longest-serving President and CEO, Kirk retired in 1997, after 30 years at the helm. Welcome, Kirk.

KIRK OGLESBY: Thank you.

WALKER: You were born in Gastonia, North Carolina, in 1930 and grew up in Rock Hill, South Carolina. What stands out as an experience or a life lesson from childhood that defines who you are and what you tried to be?

OGLESBY: It's fun to think back to the 1930s. I have memories of the very distinct differences in lifestyle in the 1930s compared to today's world. My father grew up on a small 80-acre farm in South Carolina. That farm was essentially self-sufficient. They grew what they needed to eat for the most part. They had to buy sugar and coffee and salt, but everything else came from their efforts.

There was no electricity, no running water, no indoor plumbing. I can remember going with my two cousins to a spring some 200 or 300 yards from their house and bringing home buckets of water that supplied the water needs for that family. There was no central heat, of course. The heat was supplied by fireplace or occasionally a stove. I can remember winter visits when it was so cold that we had to use so many blankets and quilts that, once you got under them, you couldn't move. You had to stay in the bed because you couldn't get out! This was very different than today's style of life. Having never forgotten that and recognizing the comforts that I enjoy and the blessings that have been shared with me, there is a real lesson there. You don't take anything for granted.

The next thing that I would say about the 1930s had to do with my parents. Neither of my folks went to college. Neither finished high school. But they, like most people back then, knew how to work and they knew about responsibility, to work and to care for their family, and they did that. I'm an only child. We were a close-knit group, called each other "The Three Musketeers." I think I would have enjoyed having brothers and sisters. Single children tend to get spoiled, and I was spoiled by my parents – not with material things, because they didn't have them, but with their concern, their care, their love for me.

My mother and dad were very religious. The church played a major part in our family life. I grew up thinking that when the Bible was read, you listened. It was quite normal and natural to think about God. It was not a strange word. You were accepting of the things you had and didn't worry about the things you didn't have – this was a major influence on me as a child.

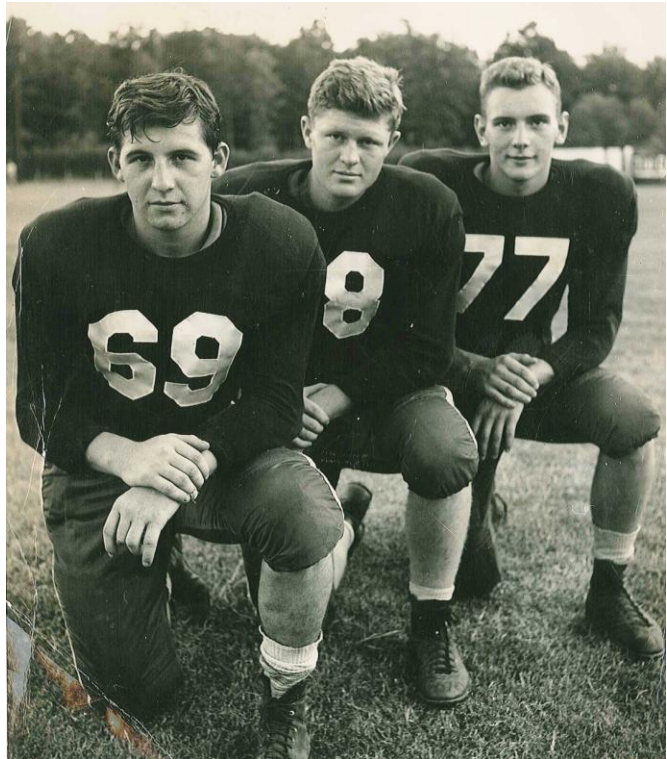
Then the '40s came along, the World War II era. I remember clearly where I was on Sunday morning, December 7, 1941.¹ The first question I asked my folks was, "Are they coming here, to

¹ On December 7, 1941, the Japanese launched a surprise attack on the U.S. naval base at Pearl Harbor.

bomb us?” This was in Rock Hill, South Carolina. At that time, the armed forces of our country did a lot of training in South Carolina. Around our town, there were military exercises, war games. It wasn’t unusual for us to see military vehicles, even tanks and armored cars, roll through our streets. It made a big impression on this little boy who was growing up back then. I remember following the war news in the paper and at the movie theater – no TV, of course – and we had the radio. The war years made their mark. It gave me great pride in the United States of America, the land in which we live. It’s never left. In fact, I find myself often still kind of resenting the folks that did those things to us, knowing full well that the people who live today had nothing to do with that. But, still, back then you wanted to strike back.

Those were the three things from childhood – family, church, and a major world war experience – not that I was in it, but that I watched it with great interest. As I moved into high school years, the next influencing factor that I would describe is participating in team sports. Being an only child, kind of spoiled, a little introverted, and quiet, what did team sports teach me? They taught me to recognize groups and be a part of groups that had goals, not just a person who wanted to do his own thing, like me as an only child. If I wanted to play with my toys, there was nobody else around to bother me. But when I got on the team, it was the team, it was other young fellows. We had a goal, and that was to win games. That stuck.

All through my working years, I tried to think in those terms. Leaders can lead, of course. Somebody has to start something. Somebody has to present an idea or a plan. But then it leaves the leader and becomes a team effort. Goals are rarely accomplished by a single individual. Most of the time, they’re accomplished by groups of people who do their jobs, as guards and tackles don’t do the same thing as running backs on football teams.



Kirk Oglesby is Number 77

I also learned from sports the thrill of winning. When I was in high school, our team was undefeated for two and a half years. Then came the agony of defeat. It was my senior year. I had become captain of the team, and you can imagine what that meant to a teenage boy. We lost our sixth game of the season by one point. It broke my heart, and I felt more sorrow than some of the other guys because I felt responsible. It was my team. But we lost. The thing I learned was that the sun came up the next day. I still got my supper. I was not run out of town. The world didn’t come to an end because we lost a football game. That carried forward with me through work life. You can try something. If it doesn’t work, that doesn’t mean the end has come. You just find something else to try and move on from there. Mistakes create more opportunities than anything else. Those are the things I would suggest that were meaningful to me as a child and as a young man.

WALKER: You earned your Bachelor's degree in Economics from Davidson College in 1952. You earned a Certificate from the Duke University program in hospital administration in 1954. How did that education prepare you for work as a hospital executive?

OGLESBY: When I went off to school in 1948, Davidson College² was a very small, 800-student, all-male, Presbyterian school. I went there on a scholarship to play football. Davidson's never been known for their football teams. They don't compete with the Alabamas and the Oklahomas, and so on. But it gave me a chance to get an education, something that my family had never had. It was a new experience. My mother and dad had never been able to tell me about their college years. Everything I came across was new. It was an adventure for me. After I got over the homesickness, it was truly a wonderful experience, and I would take nothing for the four years that I spent there.

Davidson is a liberal arts school, and we took Bible courses and things that are generally not required of students now. But then, that was part of our life, an extension of my exposure to the church side of things. I didn't escape it by going off to college. It was still there. I learned to have a great respect for all the new things that were opened up to me that I had not seen, heard, or talked about before. It was a great opportunity.

After I got through my first two years and it was time to select a major area of study, I learned that the sciences were not for me. I had thought about being a physician. But it didn't last long. Biology and chemistry – no, thanks. But, I did get a kick out of economics and related courses that had an impact on management and business and what made the country work in terms things financial. For those things, I was grateful and still am.

I didn't mention to you that I was seriously thinking about the ministry as a vocation. I finally went to see my pastor, a wise man. After we talked for a while, he said, "Young fellow, don't do it if there is anything else you can do." I said, "That's a strange answer." I thought about it, and the more that I thought, the more I understood, that this was not one of those undeniable callings to go into the ministry. So I did not, and I've always been grateful to him because I think I was a better hospital person than I would have been a minister.

By the time I got to Davidson, I was still committed to the idea of trying to live my life in such a way that it would be of some help to other people, be of some service to other people. I realized from my Davidson experience that I, though not a physician or a minister, could perhaps make a difference in the world of business and management.

The Duke program, in which I became interested when I was probably a junior at Davidson, was not a master's program in 1950s. Certificates were awarded since you were really learning-on-the-job. We had some classes and we had roundtable discussions among the group, which was very small. They took from two to four people a year, and they were essentially administrative interns for two years. We worked in all aspects of Duke University Hospital. We did everything. We observed the operating rooms and the private medical clinics. We made rounds at night when you had administrative call. This included checking the morgue, which you did very quickly, looked in there and said, "That's got to be okay," closed the door and left. You learned health care from the

² Davidson College (Davidson, NC), was established in 1837. Today this Division 1 school is co-ed and has about 1,700 students.

hospital point of view, strictly from walking the walk. You were there and you did the work.

Now was this a good approach? We interns probably needed more theory and historical background experience. We didn't get a lot of that. It was like, what do you need to do today and what do you have to plan for tomorrow? But, this experience provided opportunity in the South, because in the 1950s, there weren't many people specifically trained by any method in hospital management. When you had that tag to hang on your name, it was a great assistance to getting a job and getting into the field. It worked so well that I became a hospital administrator, as they were called then – chief executive officer – when I was 25 years old. It was too soon and I was too dumb, but nevertheless, it happened. My two years at Duke provided a great beginning for me.

WALKER: Your first position in health care was as assistant administrator at Blount Memorial Hospital in Maryville, Tennessee. You were there for a couple of years. From there you became administrator at Union Memorial Hospital in Monroe, North Carolina from 1955 to 1959. Then you spent eight years at Scotland Memorial Hospital in Laurinburg, North Carolina. Were hospitals in the South at that time segregated or where there any major disparities in the way minorities were treated?

OGLESBY: Being a Southerner, having grown up in the South in the '30s, '40s, '50s, the way the South was, was what I knew. The word "segregation" – I never heard that word when I was a little boy. It was just the way things were.

In the '50s when I got started and went out into the field to work, in East Tennessee, for example, the minority population was pretty small. Segregation was never an issue in terms of large numbers of people. In Monroe, North Carolina, which is a suburb of Charlotte, it was pretty much the same kind of picture. By the mid-'50s, I think segregation was on its way out, although it was a mixed bag. There were still hospitals that had Negro wings or units, where only black people were treated, and then there were units where only whites were treated.

Laurinburg, which was "down east," as we said in North Carolina, about halfway between Charlotte and Wilmington – was a rural area, with flat land. I told folks the highest spot in town, was the pitcher's mound on the baseball field. It was a great place to live, good solid Presbyterian Scotsmen. When I got to Laurinburg, I realized that a lot of my Davidson College colleagues were natives of Laurinburg, so we reaffirmed our friendship, and it was great.

If I can take you a step forward to Anderson in 1967 – my predecessor as CEO of Anderson had a cross burned on his yard in the 1960s. It never happened to me. Never heard of it before or since. By the time I came, the mix of races in the hospital was done. Segregation had been kicked out the door, but perhaps not fully accepted by everyone at that point in time.

In all my years of work in hospitals, I have never had the sense that all patients did not get the same care, the same concern, the same treatment. Physicians also worked along this line. We didn't have the official programs that said you must take care of all the needy and the poor and the elderly. But if someone needed medical care, they got it. It might have taken a little longer and they might not have gotten all the specialty care that's now available because it wasn't even there in those years. It was in some things a slow, but steady, change, and in others, a very dramatic swing. In my experience in health care starting in the 1950s, in terms of what was done for people, it was the same.

WALKER: Another thing that you were certainly witness to in the 1960s was change in payment systems. With the establishment of Medicare and Medicaid – what do you recall about the leadership challenges that you faced with the establishment of those new social programs?

OGLESBY: First of all, how to spend the money! I'm not kidding. Medicare and Medicaid programs ushered in "the golden years of hospital finance." When you were paid cost-plus, how could you not be happy? There was a lot of money that moved from Washington to the states, and then was translated into buildings and equipment and services that were never there before. The leadership in Washington found out pretty quickly they couldn't afford Medicare and Medicaid to be paid for on that basis. So we went from cost-plus, to cost-less. Then things changed, and you had to start looking for different ways to do your job, different ways to provide service.

I would comment about the problem of providing all services to all people. In the early days of my life in health care, technology was very basic stuff. When I went to Monroe and Laurinburg, there was one x-ray machine in each hospital and a very small room for the lab. Think of what we have now. If you walked into AnMed Health and asked to have a tour of all the radiology areas and all the laboratory areas, they're bigger than the hospital was back then. Now you have all of these options. But technology is expensive so how do we make it available to all no matter what their ability to pay or their true needs? Also, how do we maintain the human touch in health care? This means so much. Our patients want and deserve time with their caregivers, but time is money and what is our answer to be?

WALKER: Let's move on to when you were running Anderson Area Medical Center, which later became AnMed Health. You spent 30-plus years as president and CEO here. What did you see as some of the striking changes that occurred?

OGLESBY: The first thing that always comes to my mind is technology with such a dramatic addition of things – machines, tools, medications. I remember my first penicillin shot. I was playing football in Rock Hill, broke my leg in summer camp, and had to have it surgically fixed in Charlotte. Penicillin had come back to the States from the war. We didn't have it as long as the war was going on because they needed it for the military. But it had come home, and I was getting a shot. The nurse came in and said, "I've got some penicillin for you. Do you want it in your shoulder or in your buttocks?" As a teenager, I wasn't about to pull my pants down and let her shoot me in the fanny. I just wasn't going to do that. So I said, "Put it in my shoulder." That was the first and only shot that ever went in my shoulder. When they came back then, I just rolled over and said, "Have at it." You know, penicillin in its early days was very thick and going in the muscle was a painful experience. Then they fixed it so that it didn't hurt so much.

That's just an example of the change, but it goes far beyond that. There was one x-ray machine in the small-town hospitals that I served, as compared to CTs and MRIs and all the other things that have come along, and we just keep adding. I've heard it said that more than half of all the significant advances in medicine and technology occurred after World War II, in the last half of the 20th century, and into the 21st. You'd have to exclude the public health advances like providing clean water and vaccinations for disease which came earlier. But in terms of hospitals, that statement's probably true. The advances in technology and all the bells and whistles have been good, but in some respects not good because human beings have a tendency not to want to throw anything away. We're hoarders. You get a new technology and so you try all the old stuff first, and

then add the new one on top of that. It just gets more and more costly. I think this is still happening.

Another thing that has happened, not so much before 1997 here in Anderson, but certainly since then, and not just here but all across the country, is the change in the relationship between physicians and hospitals or health system organizations. During the early years of my work in the Carolinas, the Duke Endowment was a prominent player in health matters. They held meetings and group discussions about finance, organization, medical affairs, etc. One of the first definitions I heard in one of those meetings was that the structure of the community hospital was a three-legged stool. All the legs support the seat, but they were separate legs – the board, the medical staff, and the administration.³ In my early years, that’s exactly the way it was. I’ve been to meetings of medical staffs where doctors wouldn’t sit next to the administrator. These people came from different tribes. Today you have a significantly growing number of physicians who are either under contract to health systems or hospitals or are employees of these organizations.

Now I understand the reasons for that, and many of them are very good reasons. My concern is, will it last? Physicians are trained to be individuals. They’re trained to make decisions – tough decisions, with some good and some not. But that’s their training. They’re expected to do that. They’re expected to be the boss of patient care. Now increasingly, yes, they still make those kinds of decisions, but in total, they’re not the boss anymore in the same sense. How that’s going to play out still remains unknown. I hope it’ll work well, and I think it fits into the concept of a national health care system. If you’re going to have one, somehow you’ve got to involve the doctors appropriately. I still believe, after all these years, that the physician is the centerpiece in health care delivery. You can’t separate the physician from his patient and you can’t take away all of his options and you can’t tell him you can have only so many minutes with each patient – at least in my opinion.

WALKER: You have had experience in the 1990s with the purchases of physician practices, HMOs and gatekeepers and all of those attempts to try to create a lower-cost, more functional system. None of that worked because the American people didn’t want it. It will be interesting to see in the next few years whether this new iteration is what the American people want. What changes *haven’t* yet occurred in health care as you continue on as now as president emeritus of AnMed Health? Even though you’ve been retired for many years, I’m sure you retain a significant interest in health care and what’s happening. What changes haven’t occurred that you believe should occur?

OGLESBY: If I were a dictator and had sole power to make decisions? I think I would probably start with the fact that we must create a system of health care delivery that’s tailored for the United States – not Britain, not Canada, not Germany, not Japan, not China. We’ve never had an overall system that says, “These are the components of our plan and this is the way we’re going to deliver them.” Probably the reason we don’t have is because it’s so complex and so involved, that when you try to attack it all at one time, it’s overwhelming. Forget about the cost – that’s another major factor. I think we’re going to have to somehow develop a system, maybe piecemeal, but

³ “The three-legged stool has traditionally been used in the health care context to symbolize the power relationship among trustees, administrators, and physicians in a hospital. Ideally, the legs are of equal length (equal power), and the seat of the stool is flat. Over the years, much debate, oral and in writing, has concerned whether the balance of power should be equal and what to do when one leg of the stool is longer or shorter than the others.” Jaeger, B.J., editor. *Revisiting the Three-Legged Stool: Striking a New Balance Among Trustees, Administrators, and Physicians*. Durham, NC: Duke University, 1991, p. v.

we've got to get there.

The second thing that I'd do is set in place in public education – beginning as early as kindergarten, or even preschoolers, and all the way through high school – efforts to generate in students an awareness of personal responsibility for their own health. It's never been done. We've had health courses. We've offered some instruction but very little in our public schools. But that's not what I'm saying. Look at the problems that we have. Look at the difficulties that Americans have – obesity and heart problems that are caused by personal habits as much as anything else. Americans like to make their own decisions. Good or bad, they're still “my” decisions, like the attitude that bikers who don't think it's necessary to wear helmets, and get hurt, that's okay, it's their call. We've never emphasized personal responsibility for that, that your actions ultimately can influence and affect others, and in very direct ways.

Those two things – system and education, I would tackle, along with backing away from this idea of tying the health care delivery system to the corporate image – big business. It is big business, of course, but it must be flexible and caring. It seems to me that with health care, you've got to have it in such a form as to cover all the folks that you can, but you don't want to exclude the unusual.

It's like my doctor tells me, the average patient is one thing, but as individuals none of us is average. We're all different, and those differences can be significant. The corporate model, which leads to fierce competition, which leads to everybody having to have all the latest gear and technology, we can't afford. There was a piece in one of our papers about small rural hospitals in South Carolina being in deep trouble financially because they can't do all this. The hospitals can't provide all the services that people in their communities want, so they go off to some other place. But, the little hospital is who they still depend on for E.R. care and maybe a delivery. Those are the kind of things we've got to find an answer to and a system could do that.

WALKER: What was the most difficult decision that you made while you were CEO at AnMed Health?

OGLESBY: When it came to the real toughies, it was my goal to include others in that decision-making process, particularly trustees. You teach them, you give them the opportunity to learn what the factors are in the issue, what are the options and what are the risks. Then you bring the group together and make a decision. It's not something that the CEO takes in, lays it on the table and says, “Gentlemen and ladies, this is what we're going to do.” A lot of the tough ones are like that, or could be. The CEO is a leader, but he is on the team.

But there was one. I have the memory of having to go to my board and say, “Folks, the AGS effort is not going to work. We're not going to be able to create an upstate regional delivery system.” That was not easy because I believed that it could do wonderful things – still do, as a matter of fact. But it was not its time, and because of that, it didn't develop. The AGS exercise was to bring together AnMed, which was then Anderson Area Medical Center, the Greenville Hospital System and Spartanburg Regional System – the three major communities in the upstate of South Carolina.

WALKER: When was that?

OGLESBY: This was in the 1990s. The idea was to bring us together. We all had some

involvement in post-graduate medical education. You could do a lot of backroom stuff with computers and financial stuff, and decide where the young residents were going to be trained and the best place for them to get the best experience. It wouldn't have to be just one place. It could be a combination.

Decisions could be made about technology. Make it available to all the people in the area, a regional system, but it didn't have to be in every place as long as it was within reasonable access and distance. Those were just some of the basic concepts. We thought it could save money and improve patient care. You didn't have to have so much duplication of services. You wouldn't have to have the competition that I've already talked about, where you go out and you spend money on TV and newspapers to advertise, "Look at all the things we do for you." It becomes a different game.

But local control was a major issue, and people just couldn't see giving up the possibility of deciding their own future for their health system in their county. It was a disappointment for me personally because, at that stage of my life and career, I would not be involved much longer. I had hoped that we could do this together, and that it would turn out to be in the long run a positive example for others to consider. We weren't the only ones who were looking at that kind of step forward – or step sideways or backwards, as some would call it. It was kind of popular back then, to create systems. Some people were more successful. Some hospitals did come together into a unified system. But we were talking about more than just the hospitals. We were talking about a lot of things, and that's what got me energized about it, and I hoped it would work. It didn't, and I had to say to our folks that it's not going to work, and what we're going to do now is do the best we can for this organization and this community, for which we have ultimate responsibility.

WALKER: In the 1990s, you were talking about doing things that hospitals and health systems today are talking about to reduce cost, eliminate duplication, reduce competition, streamline services, do all the things that patients and consumers want. At that time, it was an issue of people being concerned about losing –

OGLESBY: – control.

WALKER: Do you think that, with the increase in health care costs, more communities may look at that issue differently and say, "Local control is nice, but lower costs and more efficient services and higher quality will trump local control?"

OGLESBY: I think there's a chance that can happen now because of what's happened in our country and, as you said – and double-underline it – the cost. The health care cost – we can't go on with it the way it is now.

WALKER: I want to come back to faith. Your colleagues describe you as a strong, faith-based person. I'm told that at Anderson Area Medical Center and AnMed Health, there was always a prayer that was said before meetings, and that a book of prayers that you wrote was assembled, and that that is oftentimes referred to today here at AnMed Health. How did your faith guide and influence you throughout your career?

OGLESBY: You have to be careful when talking about faith because most of us are often failures in our faith life. We don't live up to the standards that we set for ourselves and that have

been set for us in organized religion. But there are some basic things that I don't believe you can escape when you start to think about faith issues. If it's true that you have to be concerned about your fellow man, that maybe you have to be your brother's keeper, then you have to be aware of what you're doing and you've got to try to do the right thing every time, even though the right thing may not be in your best interest. That's very difficult to make a decision to do something you know may be uncomfortable for you.

I hope that here in this place that means so much to me, over the years that I was directly involved, I was able to convey to our staff that our purpose and commitment should be – that we are going to do the right thing. If we make a mistake, we're going to take responsibility for it and do our best and correct it, even though it might not be comfortable for us. I hope that we've been able to do that. I look at this place now as compared to what it was 40 years ago when I first saw it. These guys have done a yeoman's job of conveying that concept through community involvement and community service. It was not this way in the 1960s when I first came. The community's attitude toward its health facility was not the same as it is today. I think now you'll find that the majority of people in the Anderson area have respect for AnMed and they know that AnMed works not just to put people in beds and take care of them, but that AnMed believes in personal health, believes in doing things that will encourage people to take care of themselves and to have a better life.

Faith-based beliefs, a commitment to morals and to values has a place anywhere. I don't care what the activity is. It's not to say that we're successful in doing that all the time, and certainly I don't claim that at all. The prayer book was a little pamphlet that my wife and daughters and secretary put together in the 1980s. Back then when I was doing some traveling and involved in some other organizations, it was not uncommon that I'd be asked to ask the blessing or give the invocation. Perhaps one of the most flattering and pleasing things that I've ever had happen to me was that after doing that at a meeting, I'd have someone call or write and say, "Could you give me a copy of what you said?" Most of the time, I remembered it well enough to do that.

But you know, Larry, I'm a realist, and I understand that I have not changed the world in my life. I hope that I've done some good things. If I have touched one other human being in such a way that it made a difference in that person's life, then, my friend, when the bugle calls on the other side of the river, I'm going to answer it.

WALKER: What were the ethics and values that you tried to model?

OGLESBY: Perhaps I could summarize a lot of things into three points. In talking to young people about health care, in talking to folks in the field, I've tried to emphasize what I call "The Three Cs." The first one is, you have to care about what you're doing. If it's just a job, you're in the wrong place. You have to care about what you're doing. You have to care about the people with whom you do it. You have to respect those people. There is no such thing as an unnecessary or second-class job as long as it's done well. You have to respect your people. You have to listen to them. You have to ask them for their opinion and you have to talk to them in their language.

People will tell you that I listen more than I talk. I never have learned anything while I talk. You learn when you listen to other people. You have to ask them, because often they won't tell you what they're thinking. I've been around too many board tables, where there are always some people who are silent unless you make them tell you what's on their mind by putting them on the spot and

say, “Joe, what do you think?” You have to care about what you do and the people with whom you do it, and you have to remember that every day.

The second C is, you have to make a commitment, and that commitment is to something bigger than you are as an individual. This place is a lot bigger than I was, or am. You couldn’t find anybody more proud of what it’s done than I am. Doing that takes you outside your own ego, and you’re working for something else, not just yourself.

The third C is consistency. You have to be the same person every day. Your staff can’t wonder what your position is going to be. They’ve got to be able to say, “I’ll bet you that’s what that guy will do.” You have to be dependable. If you’re not, they’ll never know what to expect.

Back when I was on the speaking circuit, particularly with the College⁴ and talking about management, I had identified articles and theories of management that had been postulated by some expert. There must have been dozens of the “latest management theory” pieces all implying that this is the way that you’ll be successful. I’m sure there are elements of them that probably helped. But, there was never one that was the ultimate answer. You’ve got to keep learning. That’s not a “C,” but it’s an absolute necessity. Let me leave it at that.

WALKER: You spent almost your entire career in South Carolina at Anderson Area Medical Center and then at AnMed. That’s a longevity and a commitment to one organization that isn’t seen a lot today with average tenures of CEOs being somewhere in the 5 to 7 year range. You said in an interview that you had many opportunities to go elsewhere, but you never got to the point where you had what you called, “such an itch to move,” that you did it. What was it that motivated you to stay at Anderson?

OGLESBY: I have a warm place in my heart for this community because they took me in, me and my family, when I was 37 years old, a little older, a little smarter than when I first started. They took us in and made this home for us.

The way I grew up, as an only child, makes a difference in lots of things that I do, that I’ve learned in watching others. I don’t quite know how to put this – maybe for me it was better to be a big fish in a little pond than a little fish in a big pond. After coming here and seeing Anderson and seeing this organization, recognizing what I thought was its potential, I didn’t really need to look at something else. When you’re building something, there’s a new day every day. Boredom comes with status quo. That’s when you get tired and start looking for something to do, and that’s when you need to move. But when it’s a new day, a new adventure, new opportunities to make good changes, to do good things, there’s nothing more exciting. I don’t care what the activity is. It could be hospitals. It could be business. It could be religion. It could be anything else. But I do think that you get bored if you’re satisfied with the way things are. That’s never been the case here in Anderson – never in my tenure here as a retired citizen or as an active executive in the organization. So, that’s the main thing.

The other thing was, my children threatened me that if I moved, I could go by myself. This was home to them.

WALKER: Were they old enough to threaten you?

⁴ American College of Healthcare Executives

OGLESBY: Absolutely, they were, and I heard them. There were multiple good reasons, and I've never been sorry – never been sorry.

WALKER: Let's move on to the topic of leadership. When I spoke with people in preparation for this interview, one word that came up was "wisdom." They also described you as humble, quiet, stoic, passionate, committed, under spoken and dignified, and with an understated leadership style. They say you are a consensus builder. Dick Davidson⁵ called you a "true Southern gentleman." You are described as someone who always put community first when you made decisions for Anderson Area Medical Center and AnMed Health. You mentioned earlier that you do a lot more listening than talking. People mentioned that you're sometimes to the point of being stingy with your words, but when you do talk, people take notice of what you have to say. Are those traits a part of Kirk Oglesby's DNA, or were those habits that you honed over the course of your career as being a style that worked for you?

OGLESBY: DNA – to some degree. My dad is my hero. He would be labeled as a common man. He was a retail furniture salesman most of his life. He worked on the railroad briefly, but during the '30s, the years of the Depression, we were lucky in that my dad always had a job. He didn't bring much money home, but we always had something to eat and we had a place to live and a roof over our heads. But that's not what made him my hero. What made him my hero was his absolute patience and dependability. I never saw my father angry but once in his entire life, and that's when somebody said something to me that he didn't like, and he jumped on him. He was protecting his child.

My mother was a bulldog. She'd protect her son no matter what. But she also had an approach to things that you had to keep trying to do better. I'd bring home a report card at the end of the year, and I'd say, "Look, Mom, I finished the third grade and I made A's! Now I can kind of take it easy." She said, "No, you can't. You've got to do better." Maybe that adds some pressure that you really don't want to have, but that was her. She wanted things for her son that she never was able to have. Even today, parents want for their children more than they were able to have, and our worry is that it looks like it's getting harder and harder for that to happen.

People are very kind about saying those nice things. I would be the last one to claim to be wise. I do have sense enough to know that other people are smarter most of the time than I am. Not in everything necessarily, but in some things. I think that's what has made this organization successful. I picked some people for key slots that didn't work, like any executive. But most of the time, I had great success.

Let me tell you about John Miller.⁶ I knew John's wife, Julie, when she was a little girl because her father worked for the Duke Endowment. He was one of the guys who talked to me about health care management when I went to their office in Charlotte. This young couple came to Anderson and John has spent 20-plus years as a key member of the executive team, and now for the past 15 has served as the CEO. What he's done that has continued to build this place is just

⁵ Richard J. Davidson (b. 1936) was CEO of the American Hospital Association from 1991 to 2007. His oral history, Garber, K.M., editor. *Richard J. Davidson in First Person: An Oral History*. Chicago, IL: American Hospital Association and the Health Research & Educational Trust, 2010, can be viewed here: <http://www.aha.org/research/rc/chhab/oral-histories.shtml>

⁶ John A. Miller, Jr. (b. 1947) started as an assistant administrator at Anderson Memorial Hospital (SC) in 1973. Since 1998, he has been President & CEO of AnMed Health.

outstanding. All you have to do is look around. Just drive around and talk to people.

We're not perfect. But it's so different than it was. I can remember the board telling me when I first came here, "Look, we want a balanced budget. We don't want you showing profits. That's not what the community wants, for the hospital to make money." So, one of the things that I saw happen while I've been here – and I remember it clearly – was a motion that, "Gentlemen, we're going to establish an active program to have a positive operating margin. It can change, but no more balanced budgets. We're going to tell the community that with the funds we generate through our services, we're going to reinvest in this community, because this is our home." That was a great step.

The other was when the board decided that we are going to be something more than a place to put people in beds. We're going to be more than an acute care hospital. We're going to be a community-oriented overall personal health advocate. We've tried to do that, not always successfully, but I think there's been progress. As you know, changing people's habits takes years. It doesn't happen overnight. We knew that it would take time, but the decision was made to try, and that much I do respect.

My part in this was to recognize talent, and to say, "This is your job." I hope I made some good decisions about who and "this is your job," and then let them do it. Because I wasn't smart enough to do all these things. I couldn't do it and knew that was the case. You put your trust in people and then you ask them what's going on, and they'll get to the point where they'll tell you openly, and then you move forward.

Some of that, very little of it, I deserve in terms of accolades. But I do take some pride in having helped to build a system and helped to build a team that was so good that when I walked out the door December 31, 1997, the lights didn't blink. There was no problem, no change. If I had to pick a single accomplishment, maybe that's the only one that really matters.

WALKER: You also have been described as ethical. I know that you've written and spoken during your career about ethical issues. Why was the issue of ethics important to you, and do you see that as an issue today in health care?

OGLESBY: It was an issue with me because of my background. My folks expected me to do the right thing and they would not accept less. They knew I would make mistakes and sometimes needed to be punished. My mother could do it well. My father wasn't much at it. Maybe that's why he's my hero! But at any rate, that's what I grew up with, doing the right thing. It's something that stayed with me. I claim no credit for it, except if you put things together like family and faith and friends and colleagues who support good behavior, it's not all that hard to do. I'll just leave it that if someone thinks that ethics were important to me, they were.

Is it an issue today? I've been away from things so long now that it's hard for me to really have a good sense of it. I think unless you're in the trenches and watch it day in and day out and see what's happening and see how folks respond, it's difficult to know at what level that response is placed. Because Anderson was home and because my wife and I planned to stay here and not move away to some retirement place, I felt that the one thing I owed John Miller was to stay out of his hair and not be involved in hospital activities. There couldn't be any question about who was running things, who was responsible.

Competition can be ugly sometimes and can bring up ethical questions. When I read some of the stuff in magazines about health care providers, if they can do all they've said they can do, why do we have any problems anymore? You know that it's not all true. Truth is too important to ignore as a part of your ethical makeup. You have to get used to telling the truth and you have to insist that others tell you the truth. When you get to the point where you trust each other, things happen.

WALKER: Your nickname among your friends and colleagues was "Straight Arrow." Of all the descriptors they could pick, why did they pick that one?

OGLESBY: Probably because I could never beat them playing golf, and I didn't cheat to do so! So you suddenly become a straight arrow in that sense. I'm joking about that. It is a nickname that I've heard for a long, long time. I don't feel like I deserve that. If you look at the nickname as meaning you are always on target, you never make mistakes, you never veer to the side or go back, you're focused always in front and you do the right thing, I wish I could say that that has been true all my life. It obviously hasn't. I don't know of a human being that could say that. But maybe – well, I don't want to tell you that story.



WALKER: Please!

Kirk Oglesby (left) with Ben Latimer in 2001

OGLESBY: When I first came to Anderson, the administrator in Greenwood, you talk about "Southern gentlemen" as a term – that's who I would have labeled as a Southern gentleman.⁷ He was certainly that. He was always considerate of everybody. He took me in as a much younger guy. He was a Duke program graduate as well. He always said that I would never amount to anything because I didn't drink enough. So maybe things like that created the "Straight Arrow" image that you refer to. But I accept it and deal with it and keep it on the shelf.

WALKER: You've been known as someone who is committed to serving the community. You talked years ago in an article about the importance of community benefit. How do you define community benefit?

OGLESBY: What you define or label as a "community benefit" can be anything that enhances or improves or makes better the ingredients of that community. What kind of family life do you have in your community? What's the business environment, the economy of the community? What's the educational status of your community? Are your children well educated? Are you pleased with the results? What's your high school dropout rate? Anything that enhances the overall value of your community is just that. It's a community service.

⁷ A. Preston Nisbet (b. 1917) was head of Self Memorial Hospital in Greenwood, SC, from 1955 to 1983.

For so many years, and certainly in my early days, we didn't even think about outpatient care. You had an E.R. where people came if they had a cut or they broke their leg or they had some kind of injury or an illness that was serious. But in terms of trying to get people treated in a different environment than an inpatient care facility, it was not on the horizon. Certainly in some places, I'm sure it was. But in the small towns where I grew up and in Anderson, we didn't have that concept. I think you have to understand that that was a major change.

When we got into it in the '80s here, we had a speaker who gave a great talk at one of our annual meetings. His concept was outreach, moving outside the hospital walls and giving back to the community. Even using a religious term "tithing," if you have a surplus, give part of it back. It doesn't have to be for health. If it's a community need, then make a contribution to it.

This organization has done that. This board agreed that we would do that kind of thing. You can begin to see my admiration for the leadership at the board level in this community over the years. Over time, those kinds of things will change a community's outlook toward their health system, which I'm pleased to be able to say that we have here now. But it didn't happen overnight and it happened because of a lot of people's involvement. Community service – we're part of that as a hospital, as a health care provider, because health is such a vital part of any community. If we can improve the overall health of our citizens, then we've done our job.

WALKER: In 1992, when you were the chair of the American Hospital Association, what do you recall as some of the critical challenges that the hospital field was facing?

OGLESBY: The number one challenge that AHA had then was this idea of developing health care as a system, creating a system for providing health care services to people all across the country – young, old, rich, poor. It was not something that everybody understood because we had never done that. You had some models to go by, like the English system and Canada and places like that.

Harry Truman had talked about it, and others have promoted the idea of a health system. Bill Clinton came along and he pushed it hard, put his wife in charge, which was probably a mistake politically. We just weren't ready and still struggle with it. I remember sitting in the gallery of the House of Representatives the night Bill Clinton presented the concept at his State of the Union talk about building the health system. I was sitting next to Franklin Delano Roosevelt's grandson, and I was so impressed with the historical touch of that moment. Here was a President of the United States talking about something that I had great interest in, and I was sitting next to a grandson of FDR, whom I remember speaking on the radio in his Fireside Chats in the 1930s and '40s. It was a great experience for me.

The Clinton plan didn't work because it tried to deal with the entire problem in one big bite. When you do that, you can't chew it. It's immense and the financial part of it has become so problematic that it's like trying to chew a bite you can't handle along with hot sauce that's on it and you can't get rid of it. It didn't work. Out of it may have come some things, and out of all this that we've been talking about comes Obamacare, as it's now being called. It's a little different approach, but it still tries, over time, to attack the whole problem.

Maybe what we're going to do in dealing with this system question is put together the outline structure of an American system, and then say, what's the first piece we have to deal with? Then fix

that and make it work, and then say, all right, now the next piece, and then the next piece. It will take longer, but maybe it'll be doable. I truly hope so. I think it can be. I think it can happen. We'll see whether it does or not.

In 1992, at the AHA, we had a change in leadership. Dick Davidson had been selected as the new president of AHA and my role as board chair was to get my file out and smooth off any rough edges that might be there with regards to that kind of change. Regardless of the people involved, it's inevitable that you will have some uneasiness, and you have to work at it very carefully. With Dick's acumen and his smarts, he made it an easy job.

WALKER: The AHA at that time was headquartered in Chicago. When Dick Davidson came in as president, he began a transformation of the AHA away from an organization that was primarily focused on providing services to hospitals, and instead be one that took on a strong advocacy role in Washington. How problematic was that shift in focus for you as the AHA chair? That was a substantial change in mission and direction for the association.

OGLESBY: It was, and giving Dick Davidson the credit, he sold that concept so well that the problematic period really didn't last all that long. But for a time it was there. My role was to make sure that we didn't let anybody stew about it. If they had a question, if they had a problem, get it out there on the table and let's all talk about it together as a board. My job as chair was to bring that board together – and you know, any board is a very diverse group – although at the AHA, they were all hospital people by and large. When I moved over to the Joint Commission,⁸ it was a different world because you had folks from medicine, you had folks from hospitals, you had folks from nursing, you had folks from business and industry. It was a very diverse group. But what you have to do as a chair is to try your best to bring them together and not let anybody get a free pass as to what their opinion is. They've got to share it.

WALKER: Let's talk for a minute about bringing people together. Right after your term as AHA chair, you chaired the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). At that time, JCAHO and the American Hospital Association were in disagreement over the role of accreditation, and how accreditation was being carried out. What was happening behind the scenes? How were you able to bridge the differences, having just come off as chair of the AHA, between Dick Davidson and Dr. O'Leary⁹ and any number of other personalities involved at that time?

OGLESBY: I'm not sure that I did. It was a nervous time. There were a lot of people in the hospital field who said accreditation was not worth it anymore. It's too much routine and rote, and so what? There are other ways. We can get Medicare to accredit us. Then there was the new

⁸The idea of developing a set of standards for hospitals originated around the time of World War I and was managed for over three decades by the American College of Surgeons. In the early 1950s, four other associations, including the American College of Physicians, the American Hospital Association, the American Medical Association, and the Canadian Medical Association, joined with ACS to establish an independent hospital accreditation organization. This organization, known originally as the Joint Commission on Accreditation of Hospitals (JCAH), began to accredit hospitals in 1953. By the late 1980s, because accreditation programs were added for other types of provider organizations, the name was changed to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). More recently, the name has been shortened to The Joint Commission. More history can be found here: http://www.jointcommission.org/about_us/history.aspx

⁹Dennis S. O'Leary, M.D., was president of JCAHO for 21 years, becoming president emeritus in 2008. He went on to become the chief strategy officer of Awarepoint Corporation.

strategy that the Joint Commission was trying to develop, and that was how to measure performance, how to put standards on medical activities. That was scary for a lot of people. First of all, we didn't know how to do it, and secondly, we didn't know what it would mean to us, what the impact would be. There were other things, I'm sure, but those two points I do recall as being issues. There were folks who were adamant about it, and they were ready to argue it down to the last penny.

My concern was if I accepted the role as chair of the Joint Commission, then I had to be responsible for the Joint Commission. I was no longer just a hospital person and I had to take that into account. I couldn't argue the hospital's position against other positions, because that would be prejudiced, or viewed as prejudiced, and it would have been. The only option I had was to try to keep conversations open between the leaders of the groups, and let's say, "Okay, this is an argument. This is a problem. This is something we need to work on. How do we do it?" If you look back historically, over the next year or so, it settled down and the Joint Commission moved on. It changed its stripes to a significant degree. I don't really know how the field views the Joint Commission in 2011, but I hope that it's at least a healthy environment and one that can be lived with by all parties. It was perhaps the most demanding chairman's role that I ever experienced.

WALKER: I want to take you back to the mid-1980s. I read an interview in which you identified challenges and problems that were facing the health care field, many of which remain today. You talked about the need to increase efficiency and productivity and to do better with less. You talked about the importance of coping with rising costs, taking responsibility for the medically needy, defining and delivering value and community benefit, and the ethical dilemmas that are surrounding care at the end of life. Why do you think that we haven't made more progress?

OGLESBY: Those are serious problems and change is uncomfortable. We all know that change is constant. It's with us every day. We have to deal with that. Here's a quick example about people at the end of their lives. In the late '70s, the Duke Endowment sponsored a group of people (the board chair, the president of the medical staff and the CEO of the hospital and our wives) to go to England for a couple weeks to look at the British health system.

One of the things we did was visit a hospice in London. I came away from that trip saying that the British system had two things better than ours – their emergency system, which was up and ready and available all the time, consistent throughout the country. The other was hospice and dealing with the people at death's door. We've since caught them on both. In fact, we probably do better. But the hospice we went to was run by Catholic nuns. Those women made me ashamed that I had no good interpretation of where death stood in the expanse of life, that death indeed was just a part of life. You don't get all down in the mouth about it. It's going to happen to all of us. It's just a matter of when and from what cause. We walked into that place and we didn't see a sour face among staff or patients. We left there, all of us, just overwhelmed with what they were doing.

We tend, in America, to want to make it a dollar-and-cents thing. How much are we going to spend on this, rather than how are we going to deal with it individually and humanly, person to person. I think sometimes, we haven't made more progress because we make it a business decision. Can we afford it? If not, what else do we do? Often we ignore it for a while, saying, "Maybe the problem will go away." These problems won't ever go away. They're going to stay with us until we get something to help make them better. Maybe we'll never solve some of them completely. I do think they'll get better, and I wish I could say that it will happen by 2015, but I don't know. I don't know that that will be the case. Am I disappointed that we haven't made more progress? Yes, that's

true, but I think there has been progress. It's just not as dramatic as we would like it to be.

WALKER: You mentioned your board of trustees earlier. What was your philosophy in working with your board?

OGLESBY: Boards are important because they represent the community. You have to build that responsibility into them sometimes. It's not just an honor to sit on another board. Health care is too critical for that.

You never let your board get surprised. You keep them informed about what's going on. Now you may miss something, and if you do, then you may not be able to prevent somebody else from missing a bomb explosion. But insofar as you can, you stay on top of things to the point that your board is never surprised. That means you keep them aware of what's going on. You let them know the issues. You may not get into the entire depth of it immediately, but they must know that it's on the table or it's on the horizon and be aware of it.

The next thing you have to understand about boards is that boards meet mostly once a month, or sometimes less often, for an hour or two. What do they do between meetings? What do they think about between meetings? Being a realist, I don't think they think about AnMed, for example, every minute of every day between meetings. You have to be aware of that and don't load them up on things that you don't have to. Give them what they really need and make sure they understand the basis on which you are working together.

You have to try to get them to become representatives of the community, to accept that as their primary responsibility. Yes, legally, they're responsible and have duties to the organization as a director or a trustee, but in health care, they represent the community's needs. Because they make decisions about what's going to happen in that regard, they must understand both sides of the equation.

We had a trustee here once who lived in a little house right behind the hospital. I won't use his name because he was a pain in the neck to me. He believed that the hospital did nothing right, and that all we wanted to do was to get his house so we could expand. Finally, we closed a street that ran between the hospital property and his property and bought his house for a price that was more than it was worth, but it was like getting rid of a pain. He later was put on our board by our county council, who at that point had the right to appoint a certain number of board members. He served for two or three years, and every meeting, he'd go through the same procedure. He'd bring up something that he didn't like, and we'd have to listen and then talk about it. After about the second year, he finally came in my office one day and he said, "I'm resigning from this board. I don't fit here." Instead of jumping up and down and yelling, "Happy days!" I said, "Oh, okay, we'll deal with it." He didn't fit. You have that occasionally when you work with the public members of a board. But mostly they are great people who come here with the intent of doing good work, and for the most part do.

WALKER: You were honored by your alma mater, Davidson College, in 1992 with an Honorary Doctor of Laws, some 40 years after you graduated from there. What did that award signify for you?

OGLESBY: Since it had been so long, I told them that I guess they were just down to the



At Davidson College in 1992, for the award of the honorary doctorate of laws. From left to right, front row: grandson Josh, granddaughter Anna. Middle row: daughter Kathie, mother Bettie, daughter Lynn, wife Bobbie. Back row: father Dan, and Kirk Oglesby.

“O’s.” It meant a great deal to me, and it has a special place in my book of memories simply because my four years there had such a powerful meaning for me and an influence on me in my later life. I think it happened because there were some folks who felt like a number of years of service to the health field were worthy of some recognition, and suggested that to the college, and the college agreed with it. At least that’s the story as I know it. In any case, it occupies a special place for me in my memories.

Care Hall of Fame.¹⁰ Those kinds of awards are oftentimes as important or more important to the organization you’ve been involved with than they are to the actual recipient. What do you think that award meant to your AnMed Health family?

WALKER: In

2006, you were named to *Modern Healthcare’s* Health

OGLESBY: I think your statement is correct. I think it meant more to AnMed, to Anderson, South Carolina, and to the people who have been a part of this. People who have been here on this team made that recognition possible. When the phone call came from the publisher of *Modern Healthcare* magazine to tell me that that action had been taken, I said, “Who are you kidding?” I know enough people who are not above pulling a joke like that. That’s exactly what I thought it was. But he said, “It’s true. Whether you like it or not, it’s true.”

Obviously, it’s an honor for me to have that kind of recognition. Let me draw a parallel to how I feel about it. Recently there have been several awards to military people for the Congressional Medal of Honor. The common theme of those recipients is, “It’s not for me. It is not for me. I really don’t want it for me. But I’ll accept it on behalf of the people who were in this with me, who gave everything, even their lives.” I think of it in the same way about health care. All the people in this organization who, day in and day out, week in and week out, month after month, year after year, provide good service and health care to the people in this area – they’re Hall of Famers. As far as I’m concerned, they are. I don’t care what it is they do. They deserve that recognition. If having one person be called on to stand in the spotlight for a moment and receive it, that’s okay as long as you understand the basis on which it’s accepted, and that is, it’s in honor of all these other folks.

¹⁰ *Modern Healthcare* Hall of Fame: <http://www.modernhealthcare.com/section/halloffame>

WALKER: What are your hopes for what health care can become that it isn't today?

OGLESBY: I won't say health care can be "anything it wants to be," because that probably is not true when you consider the cost of health care and where do you find the resources to provide that. There are only limited ways to do that. We've got to figure out a better way. We, as in nature, must come to grips with the idea that Americans must take a greater responsibility for themselves with regards to their health. Only then are we going to begin to chip away, over time, at the increasing number of people who require all this expensive care and treatment. You're going to have to have personal responsibility. That's why I said something earlier about education. Start almost before the children can understand what you're saying and begin to teach them that they have a responsibility. It's not just what you eat and what you don't, and drink and so forth. It's how you live that makes an informed mind.

Earlier we talked about building an American system where competition doesn't force us into trying to reinvent the wheel in every little community across this entire country. We can't do that. We can build systems and ways to get people with health needs to caregivers, for tests, treatments and services that are overwhelming. It's not like my having to go to California to have an operation. It can be done so that it's workable. We've got to accept that and begin to deal with it. If it means changing names and putting different signs up – banks do it all the time – they put a different sign up, but they do the same thing. What is it they do? They do all the routine stuff in one place and they have branches, or as they call them now, "stores." What they do is try to make it convenient for their customer. Health care can do that kind of thing. We can make it convenient. Signs shouldn't bother us that much. That's an issue of personal pride for the local community, and we've already talked about that.

We also have to continue along the road to develop ways to measure performance. I think that's going to be required. We've got to know, do people get better care in Anderson than they do in Any Town, USA? I don't know and they don't know. We've got to be able to get some way to point us in the right direction to look at that.

We've got to never fail to use what will be an increasing pace of technological and medical innovation. Genetics is a perfect example. I had a chance to be on a genetics board for a few years, and the things that they're doing are just amazing. There is going to be a time when we will be able to eliminate a lot of the problems that we have now. I believe that, and I think it will come, and I'm excited about it. We've got to learn to live with the pace of change. We've got to be ready for it. We can't ever accept the status quo.

I'm an optimist about the future. I don't think it's all dismal. It's not easy, but we've got lots of smart people if we can just sit down and focus on the really important things. Maybe that goes back to basic ethics and basic values and basic morality. I don't know. I don't want to preach that sermon, but it can't hurt to think like that, rather than just focus on what I want.

WALKER: What advice would you give to young people who are considering a career in health care?

OGLESBY: It's like my decision about the ministry. Don't do it unless you have no other choice! No, it's not quite that bad. Health care management has changed in the years that I've known it, but it's still a challenge. There are problems, but as we've said, problems present

opportunities. I would tell folks to build their own philosophy as they move into the field of health care, to recognize where they will be and what they'll be doing and their relationships with others.

I've talked about caring and commitment and consistency. Young people need to know those things and deal with them, too, because they're going to be evaluated on how they perform. They're going to move if they want to move, up or out or whatever, to the degree that they're able to produce results. That's the kind of world we live in. I'm optimistic about it. Health care is going to be around. It's going to be different. My experiences in the last half of the 20th century are memories. They are gone. The world of the 21st century is now with us and there will be more change than ever before. It has been a privilege to serve ever so briefly in the evolution of the field of health care. For those who want to make their own contribution, I would encourage it.



**Kirk and Bobbie Oglesby in 1986,
when he was ACHE chairman**

I've been truly blessed in having spent my life with Bobbie. She is a lady. She is as tough as boiled owl, as Charlie Boone used to say. She started volunteering for our free medical clinic here the day it opened 25 or 26 years ago, and she's still at it. She's now going up there three days because it keeps her active. She's a wonderful human being. She has been the wind beneath my wings for all these years.

I've been blessed with family and I've been blessed with super friends like Charlie Boone,¹¹ who I met in 1952 when I went to Duke from Davidson, and we've been close ever since. Charlie is one of the most intellectually curious people I've ever known, and because of that, there is no one

WALKER: Tell a little bit more about your family.

OGLESBY: Bobbie and I started the first grade together in Rock Hill. Her family moved away because her dad worked with Metropolitan Life Insurance and they moved a lot. In the mid-'40s, they moved back to Rock Hill, and Bobbie and I met again in high school. We've been together since that time. We've been married for 58 years.

We have three lovely daughters, Lynn and Kathie and Lee. They're grown, mature, wonderful women now. Each is as different as night and day, but talk about commitment, they're committed to doing what they do. They each have families. I'm glad to say that they'll always be my little girls, but we're still good friends, too. We had a gathering the other day as I celebrated my 81st birthday, and my children came and we sat around and we talked about all kind of things. It is good that we can do that.

¹¹ Charles C. Boone (b. 1927) was president of Spartanburg General Hospital, and later of Spartanburg Hospital System (SC) for 30 years.

I'd rather talk to than Charlie because he's always got something to tell you.

Bill Yates,¹² who died at age 65, and was president of the South Carolina Hospital Association when I came here, was one who used people well. He would see something that looked interesting and he'd turn around and find a person to check it out. In 1968, one year after I got to South Carolina, Yates talked me into going to California to interview some people who were doing some project on enhancing performance – kind of like the clipboard kind of thing back then. I was in Los Angeles the night that Bobby Kennedy was assassinated. Bill Yates never knew anybody who wasn't a friend. He was so supportive of me throughout all the years.

Ben Latimer¹³ I should mention because we shared many years working for hospitals through organizations like Carolinas Hospital and Health Services, SunAlliance and SunHealth Corporation. Ben knew how to build activities to support others and how to get good people to help him. I've been blessed with friends like that.

I've been blessed also with staff here that I think so much of and really enjoy seeing.

I've been through a lot of causes and a lot of organizations. But my number one cause right now is my faith. I want to live the last years of my life in such a way that they will mirror my background and Christian status. If I do that, the preacher won't have to lie at my funeral, and that's important.

WALKER: Thank you for sharing your insights, and your personal and professional observations.

OGLESBY: Thank you. I appreciate it.

¹² William L. Yates (b. 1931) became president of the South Carolina Hospital Association in 1979.

¹³ Ben W. Latimer (b. 1940) was head of SunHealth Corporation (Charlotte, NC).

CHRONOLOGY

- 1930 Born September 15, Gastonia, NC
- 1952 Davidson College, Davidson, NC
Bachelor's Degree, Economics
- 1952-1954 Duke University Hospital, Durham, NC
Administrative Residency
- 1953 Married April 4 to Bobbie Owen of Rock Hill, SC
Children: Lynn, Kathie, Lee
- 1954 Duke University, Durham, NC
Certificate, Health Services Administration
- 1954-1955 Blount Memorial Hospital, Maryville, TN
Assistant Administrator
- 1955-1959 Union Memorial Hospital, Monroe, NC
Administrator
- 1959-1967 Scotland Memorial Hospital, Laurinburg, NC
Administrator
- 1967-1997 Anderson Area Medical Center (f.k.a. Anderson Memorial Hospital), Anderson, SC
1967-1976 Administrator
1976-1997 President
- 1992 Davidson College, Davidson, NC
Doctorate, hon. caus.

MEMBERSHIPS AND AFFILIATIONS

American College of Healthcare Executives

Chair, Board of Trustees

Fellow

Governor, District 4

Regent, South Carolina

American Hospital Association

Chair, Board of Trustees

Delegate

Trustee

Carolinas Hospital and Health Services

Chair, Board of Trustees

Trustee

Greenwood Genetic Center

Member, Board

Joint Commission on Accreditation of Healthcare Organizations

Chair, Board of Trustees

North Carolina Hospital Association

Member, Board

Partners for a Healthy Community

Member, Board

Chair, Board

South Carolina Hospital Association

President

Member, Board

Southeastern Hospital Conference

Chair, Board of Trustees

Sun Alliance

Member, Board

Sun Health Corporation

Chairman, Board

Director, Board

United Way

Member, Board

Chair, Board

AWARDS AND HONORS

- 2006 Hall of Fame, *Modern Healthcare*
- 2006 Pointing the Way [leadership award], *Anderson Independent Mail*
- 2006 Communitarian of the Year Award, Anderson County United Way
- 1997 AnMed Health North Campus (Out Patient & Professional Offices building) named D.K. Oglesby Center
- 1997 Distinguished Service Award, American Hospital Association
- 1993 Gold Medal Award, American College of Healthcare Executives
- 1993 S.C. Order of the Palmetto
- 1983 Distinguished Service Award, South Carolina Hospital Association
- 1952 Phi Beta Kappa, Davidson College



Photo taken in 2006 at the induction into the *Modern Healthcare* Hall of Fame



Left to right: Charlie Boone (Spartanburg Regional Medical Center), daughter Lee, Kirk Oglesby, daughter Lynn, and Bill Yates (South Carolina Hospital Association) in 1997 for the AHA Distinguished Service Award presentation.

Photo courtesy Twin Lens Photo, Silver Spring, MD

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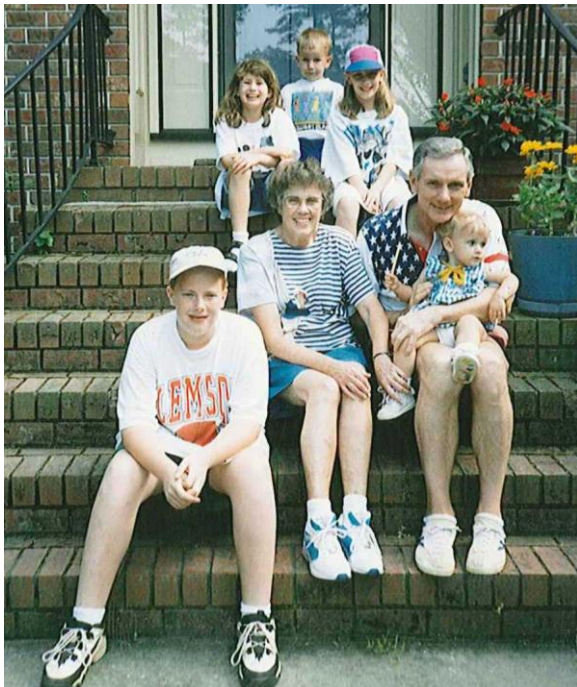
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Family Photos



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