



Dr. Guilford Hartley: An Oral History

Bariatric Programs

and Communication Evolution

at Hennepin County Medical Center

HENNEPIN MEDICAL HISTORY CENTER

2023

Hennepin Healthcare, Minneapolis, MN

Hennepin Medical History Center - ORAL HISTORY PROJECT

Dr. Guilford Hartley: An Oral History

Bariatric Programs

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Interviewed by Mary Ellen Bennett, RN, MPH

October 4, 2023

At Hennepin County Medical Center, Minneapolis, Minnesota

Edited and redacted by Mary Ellen Bennett and Michele Hagen

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Coordinated by

Hennepin Medical History Center

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Minneapolis, MN 55415

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Direct quotations are based on recollection. The entire text has been edited for length and clarity. Portions of the text are redacted as noted due to privacy, confidentiality, or sensitivity of the content.

Mary Ellen Bennett: The following interview was conducted with Dr. Gil Hartley on behalf of the Hennepin Medical History Center, for the History Center's oral history project. It took place on October 4th, 2023, at Hennepin Healthcare. The interviewer is Mary Ellen Bennett. Dr. Hartley, thank you for coming in to speak to us today to tell your story and the story of your career here at Hennepin County Medical Center. Can you tell us a bit about your personal history, where you grew up and where you went to school and medical school?

Dr. Guilford Hartley: Yes, and thank you for asking me. You and I go way back at work, at Hennepin.

I got a BA from Kalamazoo College in 1971. Didn't know what I wanted to do with myself. Puttered around for quite a while, two or three years of various things, and decided to go to medical school. Applied to medical school, didn't get in anywhere. Worked for a year at the Physiology Department in the University of Minnesota, Duluth. I applied for a second time, got into the University of Minnesota, Twin Cities Medical School the second time around, and graduated in 1979. I was looking all around for a residency, but ended up, very fortunately for me, at Hennepin.

I was a medicine resident from '79 to '83. I did a fourth year, chief year, and that was four months that year of being a chief resident. But then, the rest of the year was spent on electives, which was a great opportunity for me to concentrate in a particular area. And what I picked was hematology and oncology. I worked in the lab here with Dr. Loann Peterson of hematopathology. And I worked with Dr. Mick Belzer, and Dr. Athanasios Theologides, and Dr. Brian Rank here. And Dr. Bert Schwartz at Mount Sinai, who is a wonderful oncologist.

Finished up in '83 and then went to work as a primary care internist in Owatonna at the Owatonna Clinic, which is about 75 miles south of here. Worked there for three years. Really loved it. It's a beautiful town. Wonderful colleagues, great patients. But, at the end of those three years, my wife who was a medical technologist and who had taken time off because our son was born right at the time we arrived in Owatonna, was thinking, 'I can't really work in Owatonna because of anti-nepotism concerns and I don't want to drive 40 miles west to Mankato or 40 miles east to Rochester.' So, when I got a call from Hennepin, from Dr. Kath Whitley, who was the director of General Medicine at that time, that she and Dr. Alvin Schultz, who was the Chief of Medicine, wanted to open a private practice setting, primary care internal medicine clinic,¹ my wife and I decided to come back.

And one thing that I left out in our earlier conversations is, and this is probably the most appropriate place to put it, is that my whole medical career and adult life have been made so much better by the support I've gotten from my wife. Who has just been there constantly and working really hard and giving me an opportunity to do what I have done. So, love you Kathy!

Owatonna, 1986, Kath Whitley called. They wanted to set up this new clinic. I agreed to come back to Minneapolis and join the Internal Medicine Staff at Hennepin.

Bennett: Good. We're glad you did. You started off in primary care when you returned to HCMC, then moved into obesity medicine. Can you discuss the obesity medicine program and your role in this program.

¹ Hennepin Faculty Associates or HFA was the physicians practice group that was started in 1982.

Hartley: I very much love doing primary care. But I was in a position in which I was doing primary care but also working on internal medicine aspects of the care of bariatric surgery patients. And also trying to find non-surgical approaches; effective, safe approaches to weight control. And it just got to be two jobs where there was enough space for one. I eventually had to decide, was I going to just do primary care or was I going to do obesity medicine. Because it was pretty unusual at that point, especially, for anybody to be interested in obesity medicine. There were lots of primary care providers, but nobody else who had my particular interest in that area. I decided to go with obesity medicine.

I worked with the bariatric surgery program here, but I also had a number of abortive forays into non-surgical management of obesity, including the placement of an inflatable gastric balloon. The history of medicine, as with the history of all of humanity, is full of things that seemed like a great idea and turned out not to be great ideas. But the inflatable gastric balloon, in retrospect, there was never any reason to think that it was going to be a permanent solution. And it turned out in fact, that they would deflate spontaneously, pass into the small intestine and cause small bowel obstruction. There are at least a couple of deaths around the country. FDA [Food and Drug Administration] revoked its approval, and before Hennepin had ever put one in at all, they were off the market.

I was also involved in a liquid protein diet, kind of like an Optifast.² It was a different brand called Medifast,³ but a liquid protein diet program. Very effective while people were on the liquid protein diet. But just like the Garren-Edwards gastric balloon, nobody thought you could continue it indefinitely. And when people would go off of the liquid protein diet, it was with the expectation that they had learned things in an educational process that would allow them to continue eating a healthy calorie appropriate diet. Only it never worked.

And that was the downfall of pretty much everything. There were a number of things that could help with weight, but nobody ever came up with a behavioral program that would help people to keep it off once they had gotten it off. And so, I was also involved in an intensive outpatient group therapy program with Dr. Anna Hampton, who was a wonderful clinical psychologist and eating disorder specialist. There the focus was on psychotherapy for eating control, weight control, but that ended up a disappointment as well.

Throughout this entire time, the one thing that wasn't a disappointment was the amazing effectiveness of weight loss surgery, bariatric surgery. And in the early days at Hennepin, it was restricted just to Roux-en-Y gastric bypass.⁴ And of course, that surgery has been dramatically refined over the years. But even back then, it was the only effective treatment for severe obesity that was safe compared to the danger of being severely obese. It was not perfectly safe; it was just a lot safer than not doing it.

² OPTIFAST is a program designed to help persons lose weight. It combines lifestyle education, medical monitoring and a liquid meal replacement diet.

³ Medifast is a weight loss program similar to OPTIFAST.

⁴ Roux-en-Y (roo-en-wy) gastric bypass, is a type of weight-loss surgery that involves creating a small pouch from the stomach and connecting the newly created pouch directly to the small intestine. After gastric bypass, swallowed food will go into this small pouch of stomach and then directly into the small intestine, thereby bypassing most of your stomach and the first section of your small intestine. Gastric bypass is one of the most commonly performed types of bariatric surgery.

Bennett: Can you discuss the drug Fen-Phen⁵ in your program?

Hartley: Well, that was another one of those, it seemed like a great idea, but didn't pan out. Michael Weintraub, I think he was in New York, was a researcher on endocrinology and obesity and pharmacology. And a couple of drugs had been identified as having helpful effects for people who were overweight. One of them was phentermine, which is mildly addicting. Phentermine is a congener of amphetamine which explains some of its addicting properties. The other one was fenfluramine, which is related to the other serotonin reuptake inhibitors⁶ like Prozac and Zoloft. And both of them had at least modest good effects on weight and so he [Weintraub] thought that they probably have different mechanisms of action. Maybe if we put them together in a medium dose of each, instead of a maximum dose of either one, they would work synergistically to help people control their weight better. That got a lot of press and there was a lot of enthusiasm about it.

Dr. Mehmood (Mohamed) Khan, who was the director of Endocrinology here at the time, and I designed an open label, not randomized, not blinded, just an open label study of Fen-Phen, as it was called, phentermine and fenfluramine. We recruited just short of 200 people to participate in the study. The longest duration of treatment of any of those, the ones who were recruited earliest, was just about three years. We had some people who had been treated for three years. At that point, a very observant echocardiography tech in Fargo, ND, discovered that people were telling her that they were all enthusiastic about the wonderful results they had had with Fen-Phen. But noticing also that people who were mentioning Fen-Phen were often showing an unusual, rare abnormality on the echocardiogram of their mitral valves.⁷ And so brought those two facts together. Is this just a chance association? Is the medication causing the heart valve problem or what?

It ended up at the Mayo Clinic, and they came to the conclusion that either phentermine or fenfluramine, and probably fenfluramine, was causing this. There was a precedent, because it's a serotonin reuptake inhibitor. And serotonin, naturally occurring serotonin, in people that have tumors that secrete too much serotonin, was known to cause mitral valve abnormality. So perhaps, the fenfluramine was causing elevated levels of serotonin in the blood of people taking it, and that was causing the heart valve problem. It wasn't at all clear initially whether that was a real thing. Again, the fact that two things are associated with each other doesn't mean that one or the other of them is causing the other one.

Dr. Khan and I, and he was the prime mover on this, got funding from NIH and CDC both, to do a case-control study,⁸ in which we would recruit people from our own patient population on Fen-Phen, and then recruit people from the community who had never been on Fen-Phen. And we would match them according to gender, age, height, weight, body mass index, smoking status, diabetes, and a whole

⁵ Fen-Phen is a drug combination of fenfluramine/phentermine, usually called fen-phen, was an anti-obesity treatment in the early 1990s.

⁶ Serotonin reuptake inhibitors are the most commonly prescribed antidepressants. They can ease symptoms of moderate to severe depression.

⁷ Mitral valve is the valve in the heart between the two left heart chambers.

⁸ Case-control study is a type of observational study used to look at factors associated with diseases or outcomes. This type of study starts with a group of people with a disease and matches them to a similar group of people who do not have the disease. If the exposure is found more commonly in the cases than in the controls, the researcher can hypothesize that the exposure may be linked to the outcome of interest.

variety of other factors. We would match them one to one. One a person who is taking Fen-Phen, one a person who is not. And it very clearly showed that there was a very strong association between taking Fen-Phen and heart valve abnormalities. The people who were not taking Fen-Phen had an almost nonexistent prevalence of these heart valve abnormalities. I've forgotten the exact number. It might have been 30%, might have been even as much as 50% of the people who had been taking Fen-Phen had some abnormality in their mitral valve.⁹ I don't think there was any question.

There was another group elsewhere in the country who was doing a similar study. Both those studies got published in the *New England Journal of Medicine*.¹⁰ That was my only appearance ever in the *New England Journal* as an author of an article, and that was very exciting. We were front page of that issue. It was concluded, based on people who had been taking phentermine alone or fenfluramine alone or the combination, that it was not phentermine. So fenfluramine was taken off the market by the FDA. But the people that we had did really well on Fen-Phen. They were euphoric about the weight they had lost. But interestingly by the end of the first year, people had lost pretty much all of the weight they were going to lose, regardless of how long they stayed on the whole program. And then their weight began to creep back up again. By the end of the third year, those few patients that we had that were on it for three years, had regained maybe one-third of the weight that they lost between starting and the end of the first year. It had crept back up about one-third by the end of the third year, and it didn't appear to be plateauing. It was looking as though even if they continued in treatment, they would probably continue regaining weight. So seemed like a good idea, but for more than one reason, it wasn't.

And that was, by the way, typical of the last fifty years of medical obesity practice. There has been this struggle to find pharmacological treatments for obesity that are safe and effective and that would allow us to get away without having to do surgery to help people with severe obesity. And only in the last five to ten years has that begun to bear fruit, after probably hundreds of billions of dollars of research in the pharmaceutical industry trying to find something. We are now in the Semaglutide, Ozempic, Wegovy¹¹ era and the Tirzepatide, Mounjaro¹² era. And so, things are really moving along now. You never know till the treatment has been on the market for ten years or so, that it's really safe because things tend to crop up late. But at this point, pharmacological treatment for severe obesity appears to have a new lease on life and is likely to be very safe and very effective.

Bennett: Does the obesity program still carry on today after you're retired?

¹⁰ Khan MA, Herzog CA, St. Peter JV, Hartley GG, Madlon-Kay R, Dick CD, Asinger RW, Vessey JT. The prevalence of cardiac valvular insufficiency assessed by transthoracic echocardiography in obese patients treated with appetite-suppressant drugs. *N Engl J Med*. 1998;339:713-718.

¹¹ Semaglutide (Wegovy, Ozempic, Rybelsus) is a drug used for weight loss and to lower blood sugar levels and reduce the risk of major cardiovascular events such as heart attack or stroke in type two diabetes patients. Semaglutide is a GLP-1 agonist and works by increasing insulin release, lowering the amount of glucagon released, delaying gastric emptying and reducing appetite.

¹² Tirzepatide (Zepbound, Mounjaro) is used for weight loss and type 2 diabetes in adults. Tirzepatide is a GIP and GLP-1 receptor agonist and works for weight loss by decreasing appetite and slowing the movement of food from the stomach into the small intestine, which makes a person feel full more quickly and for a longer period of time. Tirzepatide also decreases blood sugar levels by increasing insulin production and lowering the amount of sugar the liver makes.

Hartley: Yes. It's the Comprehensive Weight Management Center¹³ at Hennepin, which encompasses both nutrition education, behavior modification, and pharmacological treatment for obesity. All included in the same program along with the bariatric surgery program. There are a couple of wonderful bariatric surgeons here still doing surgery and primarily now vertical sleeve gastrectomy is the operation of choice. I'm still a big advocate for Roux-en-Y gastric bypass, but the surgeons basically get to say.

Dr. Ilesha Galloway-Gilliam is the internist who is in charge of medical obesity treatment in the Comprehensive Weight Management Program. Dr. Jon Krook is the full-time surgeon at Hennepin and Dr. Munyaradzi Chimukangara has an outside practice but also does bariatric surgery here.

Bennett: That's good. You made quite an impact and started something that was very needed for the Community.

Hartley: I think so, and I think that there were a number, and still are a number of bariatric surgery programs in the Twin Cities. It's really been a center for development of new techniques. The University of Minnesota and Methodist Hospital and Abbott Northwestern all have made major contributions to where bariatric surgery is right now.

But our major contribution was, A) having phenomenal surgeons and B) taking people that would never be let in the door at any of the other programs. Either because they had, heaven forbid I should say it, negative wallet biopsies, or because perhaps they had chemical use disorder issues that scared other people off justifiably. Or, other mental health issues, schizophrenia, bipolar disorder. We had a very careful program of evaluating and following people through treatment and being sure that they were chemically and psychologically stable. And that we could get them on medical assistance and get adequate financial support for them. We would take years getting people ready for surgery, but we never gave up. And it took patients years to get ready for surgery. Partly because some of those questions, partly because it's a huge step. There's been a lot of prejudice against people who suffer from weight problems and a big prejudice in society and in medicine against bariatric surgery. So, getting an individual person to the point where they believe that it's the right thing for them, irrespective of whether they have other complications, either medical or psychological or financial. Just being sure that it's the right thing for them can take a long, long time and we would take the time.

Bennett: That's wonderful. You mentioned technology as something that had tremendous changes in your career. Can you tell us about your memories of communications and pager evolution during your years here?

Hartley: When I arrived as an intern in June of 1979, there were no pagers. Pretty much all of communication technology was hardwired landline. And so, when I got here, if you needed to get hold of somebody in the hospital who was not sitting at a desk with a telephone and you knew what the phone number was, you call the operator and ask them to page overhead.

There was an overhead paging system and throughout the day there was a constant din of overhead pages, 'Dr. Hartley call 2660,' or whatever. And then finally late in the evening they would shut that off and only do emergency pages at night, so that the patients get some kind of rest. During that first year,

¹³ Comprehensive Weight Management Center at Hennepin Health Care is a Hospital Based Clinic that provides weight loss programs to improve life style. [Weight Loss - Hennepin Healthcare](#)

or a few months into the first year, we got our first pagers. They were Motorola and they were quite sophisticated for the time, but relatively crude by modern standards. And of course, nobody even talks about pagers anymore. That's one of those generations of technology that came up and went away over the course of those decades.

Pagers got more sophisticated with time, and they would display the phone number, they would display messages and so on. The next step was to liberate people from landline telephones. My first cell phone was one of those, again Motorola, Motorola Brick, which was good as a doorstop or a cell phone or whatever you wanted to use it for. And obviously those have become many orders of magnitude more sophisticated and powerful than they were.

When I would be on call with no cell phone, I had to know where every pay phone along the road between work and home was. And I had a favorite payphone at the Burger King on I-35 and County Road C, and I always kept quarters in my car. So wonderful having a cell phone.

When I started, and this is another one where I'm really feel old because I've been through a number of generations of wonderful innovations that don't even exist anymore, but that made a huge difference in our lives at the time. When I started, all medical records were on paper, and I believe the lab had a computer or had some computers in the lab connected to their individual analysis machines. But there was no laboratory wide information system in which the laboratory even could look up both chemistries and hematology and anatomic pathology and immunology and microbiology results. Each individual department had its own computer. Eventually, the lab got a lab-wide computer, and then eventually the lab put workstations out in maybe a dozen places around the hospital. A total of a dozen workstations in the hospital where you could, using complicated DOS commands, look up lab results for your patients. Up until then, all of the laboratory tests on inpatients and outpatients were recorded on paper and put into the charts on paper.

All of the charts, the narrative notes, the X-ray reports, the lab reports, the correspondence, and everything was paper, bound in charts. And people who had complicated medical histories and have been around at Hennepin for years and years and years, might have twenty charts. They might have a shopping cart full of charts. You can imagine taking care of an inpatient service of twenty patients and having to get their old information out of paper charts. And the other disadvantage, other than the fact that they were just bulky, is that they could only be in one place at once. If you had a person in the emergency room and you needed their chart, but their chart was locked in one of the medical staff offices upstairs, and whoever had it, had forgotten to check it out, and Medical Records [department] didn't know where to look for it, you were just out of luck. Initially HCMC created its own homebrew medical record system. It was read only. You couldn't document anything new in it. But at least you could look up lab and X-ray results and transcribed dictations, narrative notes. IRIS, it was called the *Integrated Realtime Information System*.

That got to the point where everybody absolutely depended on it, and it was wonderful. But everybody recognized that we needed to take the next step, to a record in which we could actually document new information. We could put new narrative notes into it directly rather than having to have to dictate a note with a Dictaphone, have it go to transcription, have them type it up and have them put it into IRIS. And the hospital made the perfectly appropriate conclusion that that was beyond local capability.

That's when they had a huge search for what the correct provider of an electronic medical record should be. And to make a long story short, it was *Epic*,¹⁴ and it is *Epic* today. It was a wonderful thing to do, and it was a huge trauma to everybody in the system. It was a terribly steep learning curve and a lot of things about it didn't work well at all at the beginning and had to be fixed on the fly. But having a medical record where you can just walk up to a terminal, scan your fingerprint, and have access to every facet of the patient's medical record, including with the patient's permission, using *Care Everywhere*,¹⁵ get access to their personal records at other institutions that use *Epic*. When, otherwise, you'd have to fax a release of information. And if they were very bulky, they'd make photocopies and mail them to you, which would get here two weeks from now. Or they could fax you limited numbers of documents.

The fact that you could create formatted documents that you could use to create your own narrative notes and you could mix drop down menus with longer sections of free text, which you could still dictate and have embedded in a note, and all kinds of flexibility that really helped. Along with the fact that *Epic* was also being used on the inpatient units. In ICU, all of the heart rate, rhythm, blood pressure, and oxygenation monitoring would feed into *Epic*, and would keep real time track of all of these data. It's just phenomenal, but it hasn't been cheap and it hasn't been easy. And it's just been very frustrating at times, but it's not as though there was really any alternative.

Bennett: And it transformed care. People had to learn their jobs over and integrate *Epic* into it, but it had so many advantages.

Hartley: Well, it did. But one of the features that made the medical staff maddest was that it was very expensive and the hospital didn't want to keep paying transcriptionists and so the medical staff, and this was to a certain extent true of the nursing staff too I'm sure, there was a much greater burden on the medical and nursing staff to create notes and to create input and to do purely clerical duties that had nothing to do with medicine, in order to get the information into *Epic*. I'm not sure how much of an issue that remains, but it was certainly a cause of great resentment in the early days.

Bennett: I'm sure, over time, it became easier for everybody.

Hartley: And not only over time, easier for the people that never knew *Epic*, but the new generation of providers and nurses coming and who have never known anything other than *Epic*, are so used to it, that it's not clear that there ever was another way.

Bennett: Right. They don't remember the big clipboards and spreadsheets.

Hartley: The ICU clipboards were like four and 8.5 by 11 sheets. I mean, that size paper and they would tri-fold. The nurses would hand enter systolic blood pressure, diastolic blood pressure, heart rate, O2 saturation, medication list and IV's, all handwritten in this flow sheet.

Bennett: You worked here for many years, and you stayed for many years. Can you talk about why you stayed and the culture here at HCMC?

Hartley: Yes, and one thing that isn't going to reflect particularly well on me or on HCMC is that I'm sort of a stick-in-the-mud and so I really am pretty much change averse. And so, once I get into a

¹⁴ Epic is the electronic medical health record system that was initiated at Hennepin Healthcare in 2007.

¹⁵ Care Everywhere is a feature of Epic that allows healthcare providers, with permission of the patient, to electronically access Epic medical records from other healthcare organizations.

place that seems to be working reasonably well, I'm pretty unlikely to jump ship. And there are a lot of people who say, 'oh, I'm kind of tired of this house. We've lived here for five years. Let's buy a new house' or 'I've worked at this job for five years. It's time for something new. I've gotten kind of bored.' And that's never been me.

So, part of the reason that I stayed here for thirty-some years, was that I tend to get into a spot and stay there. I sort of touched tangentially on the satisfaction of working with people who really need help and from whom I can learn a lot, and from whom I get a great deal of satisfaction in my personal relationships with them and in the things that they can teach me. But in a situation where I can be helping them in a way that it would be really hard for them to get that help anywhere else. And that meant that I got to work in a place where there were a lot of other people, like the other medical staff, and like you and the nursing staff who felt the same way. And so, it was a community of people who really loved working in a place where there were people that needed our care and who appreciated our care.

Bennett: I was interviewing another person, another employee earlier, and she talked about the community too. I think that is a big part of it. And yes, we were a community.

Hartley: Yeah, and of course I always think about things like this. But I'm sure there are great communities at Abbott Northwestern, or Methodist, or Mercy. It's just that I never worked at any of them. So, I don't know, and I have no idea really how comparable the situation here is or how different it is from other hospitals. And how things are different between nonprofit hospitals and for-profit hospitals. I just don't know.

Bennett: Do you have anything else that you would like to share regarding your work here at HCMC? Anything you forgot to mention, or you think is important?

Hartley: Only to reiterate that I really loved working with the nurses and the other medical staff and usually with the administration, although that was sometimes a process.

I think I do want to mention one other thing about when I was an intern and the idea that doctors are doctors and that doctor is the Latin word for teacher. And that if I'm a doctor, I should be a teacher. But that it ought to be teacher/student or something like that. Because the whole time here, not just as an intern or a medical student, but right up to the end, I was learning from the patients and learning from the other people who work here. My first ward rotation as an intern, we had responsibility for both floor patients and critical care patients. We would have patients in medical ICU, and in coronary care, and out on the wards. And I remember Betty, a nurse in the ICU, a wonderful lady. I was taking care of a gentleman with a huge anterior MI [myocardial infarction] and cardiogenic shock and she was there. And she was just very diplomatically and calmly, saying, 'had you thought about a little lidocaine, or do you think dopamine would have anything to offer this gentleman?' Being very helpful and diplomatic and helping me and helping the patient at the same time. I think that's been my experience of the nurses here and of the rest of the medical staff as well.

Bennett: We helped each other. We taught each other. And there was never a dull day here and never a day where learning wasn't occurring.

It has been a great honor to speak with you today Dr. Hartley. You have had a wonderful career here at Hennepin County Medical Center and it was very interesting to hear about your work and your experience, especially with your bariatric medicine programs.

On behalf of Hennepin Medical History Center, I want to thank you for the years spent at Hennepin and all the many contributions you have made to the institution and the patients you have served.

CURRICULUM VITAE

NAME Guilford G. Hartley, MD

EDUCATION

University of Minnesota Medical School, Minneapolis, Minnesota, MD
Kalamazoo College, Kalamazoo, Michigan, BA-Physics

POSTDOCTORAL TRAINING

1979-1983 Categorical Internal Medicine Residency, Hennepin County Medical Center, Minneapolis, Minnesota

ACADEMIC APPOINTMENTS

2012-2020 Adjunct (Clinical) Associate Professor of Medicine, University of Minnesota Medical School, Minneapolis, Minnesota
1995-2012 Adjunct Assistant Professor of Medicine, University of Minnesota Medical School, Minneapolis, Minnesota
1986-1995 Clinical Instructor of Medicine, University of Minnesota Medical School, Minneapolis, Minnesota

CLINICAL/HOSPITAL APPOINTMENTS

1986-2020 Attending Physician, Hennepin County Medical Center, Minneapolis, Minnesota
1986-1991 Attending Physician, Metropolitan-Mount Sinai Medical Center, Minneapolis, Minnesota
1985 President, Medical Staff, Health Central of Owatonna, Owatonna, Minnesota
1984 Vice-President, Medical Staff, Health Central of Owatonna, Owatonna, Minnesota
1983-1986 Attending Physician, Health Central of Owatonna, Owatonna, Minnesota

CERTIFICATION AND LICENSURE

1982-Present American Board of Internal Medicine, Certification #085084
1980-2021 Minnesota Medical License #0258580

HONORS AND AWARDS

2011-2012 "Best Doctors in America", *Minneapolis/St. Paul Business Journal*
2008 "Best Doctors for Women" for Weight Management Care, *Minnesota Monthly*, March
1978 Alpha Omega Alpha Honor Medical Society

MEMBERSHIPS AND OFFICES IN PROFESSIONAL SOCIETIES

Member, American College of Physicians
Member, North American Association for the Study of Obesity (The Obesity Society)
Member, Obesity Society program committee for annual scientific meetings 2016-2018
Member, American Society for Metabolic & Bariatric Surgery

TEACHING ACTIVITIES

1986-2020 Hennepin County Medical Center, Department of Medicine
Ward Attending with medical students and medical residents 4-6 weeks per year

INTERNAL PRESENTATIONS

1986-2019 Update on Bariatric Surgery and Diabetes, Department of Medicine Grand Rounds (CME) and Core Curriculum, Hennepin County Medical Center, Minneapolis, Minnesota. Annual presentation to the faculty, residents, fellows, and medical students

EXTRAMURAL INVITED PRESENTATIONS

1. Behavior modification, pharmacotherapy, and weight loss surgery and the patient with diabetes mellitus 2. Continuing Medical Education lecture sponsored by Minnesota Medical Association at Essentia Saint Mary's Medical Center, Duluth, Minnesota. February 3, 2012
2. Care of the post weight loss surgery patient. Continuing Medical Education lecture sponsored by American College of Physicians-Minnesota Chapter. November 4, 2011
3. Behavior modification, pharmacotherapy, and weight loss surgery and the patient with diabetes mellitus 2. Continuing Medical Education lecture sponsored by Minnesota Medical Association at Regina Medical Center, Hastings, Minnesota. October 26, 2011
4. It's an Epidemic--Diabetes, obesity, and hypertension. Presentations and panel discussion (presenter and moderated panel). Best of Hennepin: Partnerships in Primary Care. Engaging Patients, Specialists, and Care Teams in Delivering Primary Care. October 20, 2011 (Continuing Medical Education course sponsored by Hennepin County Medical Center October 20-22, 2011)
5. Treatments for obesity. American College of Physicians Minnesota Chapter Scientific Meeting. November 6, 2004
6. Gastric bypass surgery for obesity & the patient with diabetes mellitus, Type 2. Minneapolis/Saint Paul Diabetes Educators Chapter Meeting. November 5, 2002
7. The Phen-Fen Problem: Its Origin and the Future of Obesity Control. North Memorial Medical Center continuing medical education program presentation. April 14, 1998
8. Diet pills, pulmonary hypertension, and respiratory health: Recognizing and responding to risks. Current Concepts in Respiratory Care, University of Minnesota, Twin Cities: University College and the School of Nursing and the American Lung Association, Hennepin County and Minnesota affiliates. November 11, 1997
9. Epidemiology of obesity. Citizen Ambassador Program delegation concerning obesity to western and traditional Chinese hospitals, Beijing, China. November 6, 1996
10. Pharmacological treatment of obesity. The Spang Memorial Lecture at Saint Mary's Medical Center, Duluth, Minnesota. October 16, 1996
11. Pharmacological treatment of obesity. Minnesota Dietetic Association Annual Meeting, Brooklyn Center, Minnesota. May 2, 1996

OTHER PRESENTATIONS

WCCO-4 News reporter Jason DeRusha's segment "A good question: Where does lost weight go?" The segment was featured on the 10 pm news cast, July 3, 2008

COMMITTEE AND ADMINISTRATIVE SERVICE

Hennepin County Medical Center

2010 Member, Medical Staff Quality Committee
1997-1998 Member, Information Technology Taskforce
1996 Member, Information Technologies Committee
1994-1996 Member, Task Force on the Identification of the Primary Physician
1994-1995 Member, Search Committee for Medical Director of Medical Informatics
1993-1994 Member, Quality Improvement Team, Medication Allergies
1990 Medicine Practice Committee

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1989-1990 Infection Control Committee

Hennepin Faculty Associates

1993-1996 Chairman, HFA Internal Medicine Clinic, Quality Management Committee

1990 Marketing Committee

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