It would be an understatement to say these past few months have been busy. We’ve been hit by a bus full of information, ran over by the wheels of adjustment, and expected to survive. With the boatload of information that we’re expected to jam into our heads, it’s a miracle we haven’t forgotten the essentials to life: bathing, eating, clipping our toenails (better check on those talons).

It’s easy, for me at least, to lose sight of why we signed up for this lifestyle. With the cornucopia of cell cycles, cardiac anomalies, etc., how could you not help but feel you signed up for a Bachelor’s of Science on steroids? Aside from the IPE exams, longitudinal clinics for M2s, our lack of actual medical interaction (in my opinion) clouds the real reason I wanted to be a doctor in the first place; to serve.

Recently, I sat through a speech with Nhu-Nguyen Le, and Jon Campbell given by Dr. Jill Brown from the Creighton Commitment to Service department. During Dr. Brown’s speech, I listened to some insight I had been struggling to put into words for quite sometime. I wanted to share the feelings I connected with, as I found them to clarify my purpose, my intent, why I’m here.

For the weeks prior, I questioned my commitment to this craft as the realm of possibility for attaining the most-sought out MD seemed like a rainbow; you can see it, but if you can’t reach it, is it really there? When going through these conundrums, I find some clarity through volunteering. After all, our career paths are just that; we will serve others. Regardless if you decide to dedicate your lives to a community (PMD), or make it rain as an orthopaedic surgeon in Miami, your profession will require you to serve.

Why do we serve? This is the question Dr. Brown brought up. For years, I found the answer to be as simple as “it makes me feel better.” But the reality is, a lot of things may do the exact same thing: coffee, relationships, that extra spread of cookie-butter on your toast. So what is the exact reason?

I find myself analyzing the course of my life a lot. Weeding out several life events, I question if I had changed my decision, taken a different route, what type of person would I be? I am a firm believer that life is a serendipitous confluence of events, tragic, happy, mixed. While this discussion could lead to some deep, existential conversations, the fact I want to stress is our paths in life are created by a myriad, random-at-that course of decisions.

So, going back to the question: why do we serve? Perhaps, in those we serve, we see some reflection of ourselves. We envision the decisions we made in life, and hypothesize that you, a medical student, could have been your patient had you chosen another path. That you might have understood the pain of those you help because you might have been them in another life. Whether or not reincarnation is something you carry as a religious tenant, decisions that brought you to medical school were made, and just as easily, could have not been made for another. So I serve because I could have easily been that woman waiting for 3 hrs to be seen, rather than on the other side.

So stay inspired while flipping through Robbins (aka Micro’s version of War and Peace). Breathe life into the passion that will sacrifice your youth, your life. Just ask yourself...

Decisions. Did you make the right one today?
Four Myths of a Feminist, Disproved

Alyssa Hickert
M2

Proclaiming myself a feminist in front of distant acquaintances is always an adventure—usually because the person to whom I am speaking has either: 1) no earthly clue what that means, or 2) thinks he/she knows EXACTLY what that means and has now just imagined me wearing war paint and burning bras at an anti-men rally. But, really, identifying as a feminist is very important to me, and not actually all that radical. In fact, after reading this article, you may find that you land somewhere on the spectrum of feminism too.

Myth 1: Feminists Can Only Be Women

In reality, both men and women can be feminists; defined loosely (as I have come to understand it), to be a feminist is to be someone who recognizes—or continuously tries to recognize—social gender-based stereotypes and inequalities. Simply by being critical of these fabricated, often subtle and damaging messages, we take one more step towards correcting or eliminating them altogether. But the same gendered stereotypes that demean/objectify/subvert women are the same sorts of social stereotypes that demand men be hyper-masculine, or work outside the home, or watch only movies involving Bruce Willis. It is my firm belief that we simply use the term “feminist” and not “masculist” because, historically, women have suffered more from these stereotypes, and were forced to create an organized movement in response.

So, men, you don’t have to go so far as taking your wife’s last name or buying “The Holiday” blueray/DVD combo just yet (unless you would like to), in order to call yourself a feminist; by simply appreciating the utter artificiality of the gendered stereotypes under which our society currently labors, you place yourself some-

Myth 2: Feminists Hate Men

If you believe this, you skipped Myth #1 and I recommend—for this and all other reading assignments—you go back and begin at the beginning. Having said that, this myth deserves a clarification: feminists hate sexist men. But we also hate sexist women. And we hate sexist camels, those jerks ... However, this does not mean all feminists have to join “spermdonation.com” and start dating each other. I’ll sheepishly admit there was a time in my life when I imagined aging alone with pride; muttering “I don’t need a man” as I searched cat adoption websites and registered for LifeAlert, I envisioned myself a pillar of the individualistic, feminist community. But, inevitably, taking out my own garbage grew tiresome, so I revised my plans. I do need a man. I need a man the same way that any human being with the desire for a meaningful, romantic relationship needs a member of the sex to which they are attracted. If I were a lesbian, then no, I would not “need” a man to satisfy the romantic aspect of my personal relationships. And this cuts both ways—heterosexual men “need” women as well, to fulfill their personal desires. And finding or not finding that “special someone” has literally no bearing on the degree to which you are a feminist; it might have a bearing on the degree to which you are a bitter feminist, but that is a separate matter entirely.

Myth 3: Feminists Hate Bras, and Burn Them

This literally never happened. I mean, since the invention of women’s undergarments there has most likely been some unfortunate dryer accidents or candle incidents (birthday cakes are more of a hazard than you may realize...) but there was not actually a historical rally involving burned bras. In 1968,
organized feminists protested a Miss America beauty pageant by throwing a number of articles that represented female oppression into a trash can (including bras and girdles); a poorly-interpreted press article led to one very pervasive misunderstanding. Frankly, I think most feminists, like most members of society, appreciate the benefits of bras.

**Myth 4: Feminists Don’t Have Fun**

Ok, so I don’t do drugs and I never go out on Tuesdays. I think haunted houses are too stressful to be really enjoyable, and those spinning teacups at Disneyworld make me nauseous. But unless the haunted house is full of restricted voting slips, or *Alice In Wonderland* was a metaphor for patriarchal domination, feminism actually has very little effect on my aforementioned characteristics. Sure, once you start to be sensitive to social stereotypes or images, it can be hard to “turn off” and enjoy certain songs or movies (and dear Lord don’t even get me started on *Twilight* and *50 Shades of Grey*), but that is simply the curse that comes with education and awareness. And, personally, I think it’s more than worthwhile.

I still get all “dolled up” to go out with friends, I love a good pair of high-heeled shoes, and yes I enjoy wine more than beer. But these are not things I do because I am a woman, or for the benefit of a man, or for any other such reason. I do these things because I enjoy them! Even still, I acknowledge that my appreciation for these things can be misunderstood as a fulfillment of female stereotypes. To which I say, just remember there are plenty of women in the world who hate wine and love beer; plenty of women who would rather go hunting than dancing; and plenty of men who would rather wear high heels if people would stop being so gosh-darn sensitive about it, and if they could find them in the right size.

Well, there you go—four myths (hopefully) dispelled. I could go on and on about feminism’s history, current battles, and future prospects, but there are plenty of well-respected articles for that sort of information. At the very least, I hope I have helped a few people fear feminism a little less… and if you still despise feminism, hopefully you can now do it with an angry but well-informed mind.

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**The Learning Cycle**

*Linda Pappas*
Academic Success Specialist

The cycle that our brains go through to learn information is not something that most of us ever give much thought. Years of being in academic situations has put us in our own special zone. However, we can discover how to be more effective as learners if we do pause to reflect on what happens. How do we grow those dendrites and create the massive neural networks that help us to answer that exam question correctly?

I recently reread “The Art of Changing the Brain” by James Zull, (2000, Stylus). In that book Zull describes David Kolb’s Learning Cycle. That cycle is described as a four step process which Zull explains happens in four different parts of the brain: (1) **Concrete Experience**—take in information though the senses (lecture, panopto, labs, videos). That is happening in the parietal lobes. (2) **Reflective Observation**—compares information with stored knowledge to determine if it is new or already known (taking and reviewing notes). That is happening in the temporal lobes. (3) **Generalizations and Abstract Concepts**—connect the new information with what is known; find new possibilities; ask questions about significance; decide on probability (small group discussions, looking up supporting materials, referring to old notes) That is happening in the prefrontal lobes. (4) **Active Testing of Generalizations**—do something with the new information (explain it to someone, solve a problems with it, draw a concept map or a table, re-write it in condensed form, do practice questions). That takes place in your frontal lobes. This four step process never stops because all active testing becomes new input to remember.

The problem is that the cycle is usually short-circuited in students who only memorize. What do you do to “make the information your own”? A concept map, a flow chart, a summary sheet, answer practice questions, discussion with peers or faculty, not just making note cards but practice by grouping them, looking up information that you don’t understand in greater detail, breaking up detail memorization into shorter bursts of time.

Dr. John Pelley, professor at Texas Tech University Health Sciences and author of *Success Types for Medical Students*, states that you are passive if you are looking “at” or listening “to” and active if you are looking “for” or listening “for.” There is not one right way to be active with or own the information; finding the way(s) that work for you is the key. Dr. Michele Millard and I would be glad to assist you in “brainstorming” about your own individual learning cycle.
Huh? Okay, we have all been asked to write about our summer vacation. The required essay that many teachers have asked us to write as a way to slowly coax us back into a focused study mode following a wonderful, or sometimes, not so wonderful, summer vacation. Oh, the memories! I thought that as you wind down the fall semester – and for many of you your first semester of medical school - I want you to consider planning for and then to visualizing how you see yourself answering the question: "What I Did on My Winter Vacation?" – as a way to ensure that you get out of it what you want and come back feeling recharged and refreshed.

Yes, it is still a little early, but my hunch is that many of you have made or in the process of making plans for your holiday break. Now some of you may say, “The heck with plans – I’m going to mom’s house to sit on the couch and demand, ‘Mom, more meatloaf!’” much like Will Ferrell’s character Chazz Reinhold in the Wedding Crashers.” And, yes, to some that may sound like a pretty darn good way to spend a winter break. However, to others…not so much.

As you consider how your essay will read as you return January 6th, I ask that you begin planning now on how best to maximize your Christmas break in order to make your break and your essay more meaningful. Here are some suggestions on how you may do this:

- First, consider your expectations about the holiday seasons. Studies suggest that many people feel worse after the holidays due to the fact that their pre-holiday expectations were unrealistic to begin with. Going home to a loving family where everyone gets along and sits around drinking hot chocolate and eating Christmas cookies in front of a roaring fire while singing Christmas carols as the snow gently falls outside just may not be in the cards for everyone this year. Don’t get me wrong, it’s great to have positive expectations and to do your best to fulfill these, but keep them realistic. Holidays are wonderful, but they can be stressful, especially when you mix family and friends who may not have seen each other or the new independent you for a while and who possess their own expectations on how you should be spending your break. Yeah, you get the picture. So, look forward to good things, but be realistic and flexible – sometimes going with the flow is not all bad.

- Second, go into your break with the idea that being with and doing things with family and friends is great, so, enjoy them, but also take care of your own needs and feelings as well. You have worked hard over the past semester and you want to make sure that you engage in activities that you enjoy and find relaxing. Read a good book, go see that movie you have been waiting to see, visit family and friends you want to visit, and volunteer - possibly at a homeless shelter serving a meal; a great way to feel good about yourself and your impact on others. These are the activities that can re-center you and recharge your batteries for the spring semester.

- Third, as you enjoy the holidays, remember everything in moderation. There will be lots of great food and alcohol around and it’s certainly okay to enjoy it all, but also to keep in mind the importance of drinking and eating in moderation. This is not the time to get a DUI, so, please be smart and careful out there. And, don’t forget to keep up with or to crank up your exercise routine. This is a great time to stay active and to truly enjoy that walk or run. Finally, holidays can be stressful, so, make sure you incorporate effective stress management techniques into your daily routine. In addition to moderating food and alcoholic drinks, make sure that you remember to stay calm, take deep breaths at times of stress, challenge irrational self-talk, relax with music or a hot bath, and, as mentioned previously, keep up with your exercise program.

So, when you come back January 6th and your professor asks you to write your essay on “What I Did on My Winter Vacation?” – will you be happy with the final product? I hope so, and I hope everyone has a wonderful and peace-filled holiday. Have fun, be safe, and I look forward to seeing everyone back in 2014!
Many times during a medical school career, your head is plunged under the surface of medical studies. As your life gets distorted by your own panicked waves, you, the student, flank yourself with blinders to block out distractions – to narrow your gaze so that you can effectively navigate the obstacles lying directly in your path. In doing so, you sacrifice perspective for the sake of overcoming challenges facing you in the short term. Occasionally, however, we are offered brief respite, over holiday breaks or on mental vacations away from the route that runs between the hospital, apartment, and library. These respite provide us perspective; a reflection on what the medical student is trying to achieve. Students of medicine are charged with task of learning the science of the human body, and fusing it with the art of caregiving. In doing so, we are to become healers for the sick – a resource for those whose own resources have been outrun. This is a great responsibility, an admirable undertaking, a weight that justifies the heavy lifting we do during our training. Still there is more – a commitment that extends further than formulas for alleviating ailments. Outside our blinders, above the surface of our studies, the influence of the physician reaches beyond the hospital.

Where holiday breaks and mental vacays provide the medical student ‘outside looking-in’ perspectives on their own life, these letups also provide a feel for what the rest of the world perceives, and understands, about our schooling and field. This understanding, I have found, is limited. Relatives, friends, even students in other professional fields, rarely seem to grasp fully the mental and financial commitment it takes to perform well in our vocation – or why we are motivated as much out of fear as by a dedication to our principles. When we are shuffling our schedules to create delicate “balance”, friends and family wonder, bemused, why we cannot make it to the bar on a Sunday afternoon to watch the football game – why we bring a book to that bar. Why we can’t “Just take a break!” or, “Take the night off...” These questions reflect a loving attempt to understand, and a falling-short, by those to whom we are closest. Still, the depth of understanding of our profession contracts further as the medical student interacts with societal rings that radiate at distance from our cohort centric universes. Our patient populations represent the breath of radiations from center. Many times have I had patients with detailed knowledge of my schooling, the health care profession, and disease processes. Many times have I had patients with little to none. Not uncommonly, patients have asked me if I am still in school, if I am in medical school, or if I want to go to medical school. I respond, “yes, I am in medical school.” They congratulate me and remark about how medicine is an excellent profession, how much work it takes, how much dedication and compassion I must possess. And then, with surprising consistency, those same patients follow with questions, “So, is that a two year program?” or, “So, are you going to be a nurse, or doctor, after medical school?”

The beautiful (and precarious) significance of this sometimes gulf of understanding that separates care provider from care receiver - physician from lay public, even us from our families and friends - is found in how that gulf shapes the patient-doctor relationship, and the mold it places to the physician’s consequence in society. The knowledge gap that exists cultivates beauty in the bonds of the patient-doctor relationship; a beauty found in the form of an enormous amount of trust, of which physicians are the beneficiary, handed over by patients out of respect for what an M and a D, placed together, represent. Relationships with patients are shaped from patient trust in the rigorous training we undergo; trust in the oaths we take to provide the best care we are able; trust in our best intentions and values. This trust, shaped in the doctor’s office, also translates beyond the walls of the hospital to the physician’s role in society.

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Health Care

Cont’d from page 5
It is trusted that the moral values, and ethical commitments made in patient rooms, are embodied by our values, and our commitments to society in general. Simply earning the title of ‘Doctor’ makes one a leader in one’s community, a person whose voice is heard and always considered – a token of the confidence placed in us by our patients. Perhaps no longer the auditorium wielding god-surgeons of old, today’s physicians nonetheless bear a weighty consequence in society. The trust and respect given to physicians persists and is palpable. I saw glimpses of it on my rural rotation as a third year student. I was humbled many times when patients would rise and remove their hats upon the doctor entering the room; when parents would dress their kids in Sunday clothes and farmers would don sport coats and button down shirts for doctor’s visits. War vets refer to you as sir or ma’am, and patients ask your advice on matters far from medically related. So, what does all this mean? What is the point of this pontification? The point is, physicians bear responsibility for both the medical knowledge gap that separates us from our patients, and the respect our voices receive on issues outside of medical diagnosis and treatment. Over four years of school and countless more in residency, we are to become authorities in the realm of medicine, but also, authorities on countless other topics. Among those topics are the happenings concerning our own industry, Health Care.

For the physician, knowledge of the political, financial, and social aspect of Health Care is of comparable importance to knowing well the art of diagnosis and treatment. Though difficult to appreciate through our medical student blinders, taking the title of ‘Doctor’ implies an obligation to become educated on the issues and challenges that concern the broader field of Health Care. For, much like we are trusted to fill in the knowledge gap on disease and treatment, we too are trusted to fill in the knowledge gap on matters of importance to our field. If we do not take up this responsibility, we forfeit this trust to lawmakers and others, who do not have the privileged perspective that we have. In essence, we forfeit the opportunity to be advocates for our patients at a political and social level – the opportunity to redeem the respect shown us by society.

As I prepare to enter the real world, as a resident, I am peeling the medical student blinders from my face. Emerging above the panicked waves of my studies, I am beginning to realize the implications of the choice I made, over four years ago, to enter medical school. While my first responsibility is to care for patients, being a physician means much more. To me, it means holding in my hands the respect handed to me, feeling the weight of it, and finding ways for it to be redeemed within, and without, the hospital’s walls. To me it means being informed on what is going on in my field, that I may be ready to respond intelligibly when my opinion is asked. It means being informed on a gamut of other issues, that when my counsel is called upon, I offer thoughtfulness and wisdom. It means being prepared to take up the mantle of leadership in my community, that I may earn the trust that is so humbly offered to me out of a simple respect for my profession. Approaching Christmas break, we are soon to be afforded a respite, a time to consider the implications of what being a physician means.

As you field questions from your family and friends regarding issues ranging from the Affordable Care Act, to diagnosis and disease, to a range of other non-medically related topics, I invite you to consider the weight your words carry. I invite you to consider the fact that that weight will grow as your career progresses. Soon, you will be an esteemed voice for your profession, and for your patients, in a broader context than the Doctor’s office. Consider this, and consider how you might make good on this responsibility.

You can find information about the Affordable Care Act at the AMA homepage, under “Advocacy Topics.”
It’s easy when you are in the middle of an intense experience to lose perspective. The only thing you see is right in front of you and you miss seeing the bigger picture. Here are some hints that as a med student, you may have lost perspective:

- When you go out with non-medical students, you’re abnormally quiet, because you don’t know what to talk about besides med school.
- You know countless mnemonics for parts of the body, but couldn’t tell anyone what the front-page headline is today.
- You refer to the semesters you took organic chemistry as “The Good Old Days.”
- You know that, in theory, you have a family and friends, but you can’t place the last time you saw them.
- You constantly find yourself saying things like “I just have to get to spring break” or “I just have to get through Step 1.”
- People assume you know something when you tell them you’re in med school, but you know that you haven’t learned anything.
- You assess beverages for amount of caffeine before buying only those with more caffeine than coffee. Then you explain to the cashier how caffeine works for you.
- Grey’s Anatomy, House, and Scrubs, are your favorite shows, but you point out all the wrong things in them all the time.

Perspective is an elusive thing and hard to maintain because the demands in front of you are so great. It’s easy to get lost in the cycle of just getting beyond the next quiz or test and lose sight of the bigger picture. An opportunity that you have to gain back some semblance of perspective before buying at the moment and faculty mentors have been around the block. A short conversation with one of these people can remind you of the bigger picture with moments filled with “Oh yeah, now I remember why I want to do this!” or “They have made it; I can make it.”

When I asked M3s and M4s what they “wished they would have known”, here are a few of the things they shared:
- I wish I would have had a better idea of how much time to spend studying. Throughout medical school I learned how to study smart (which doesn’t mean study every waking moment).
- What to expect at the next level. A lot of times it seemed as though we were always in the dark until just before something happened. I found myself asking upperclassmen a lot of questions regarding the next step.
- I wish I would’ve figured out sooner not to believe everything you hear. I think there were times that I defeated myself before I tried because people from the class above said how hard or impossible something was. I wish I would’ve been aware of the tendency to over exaggerate some things.
- What 3rd and 4th years are like. I honestly knew nothing about what to expect when I entered my third year.
- I wished I would have known that these four years go SO fast, and that you should enjoy any and all time with the people important to you.
- I wish I would have known earlier how approachable and accessible most of the residents and faculty are. Most of them are glad to answer any question you might have and willingly offer advice if needed.
- Don’t be afraid of being wrong.
- I wish I would have known more about how to get involved in research projects/poster presentations.
- I wish I would have known that until you see it, do it, and are immersed in a specialty area of medicine, you really cannot completely understand or appreciate it. I think people get too closed minded on what they want to go into early, and that can be detrimental to choosing the specialty that truly fits you as person best.

A mentoring conversation could help you learn from your mentors—what do they now know that you need to know? Instead of saying “I wish I had known”, you could be saying “I’m so glad they told me….” You might think that the mentoring requirement is onerous—just another thing to do. But au contraire. . . try the perspective that it is an opportunity to meet a variety of people who may help you along the way. These are people that you may not have met or a conversation you may have choices—just take the mentoring moments for what they offer. Don’t forget the list of alumni mentors (there are over 250 of them) found in Blueline/Vital Signs that are willing to be contacted via phone or e-mail for questions about the profession, their experiences, their specialty, or region of the country. Have a conversation and gain some perspective!
Dean’s Quarterly Update

This issue, M2 Class President Chris Lensing asked Associate Dean Dr. White to answer some questions regarding changes in the school:

1) What is the overall impression from administration with moving the teaching hospital from CUMC to Bergan? Medical education has been part of Creighton University for more than 100 years and continues to be an integral part of the experience. Over that time, the clinical education has been completed in various locations in the community. Moving the teaching hospital from CUMC to the current Bergan campus is the most recent evolution. It is believed that this will allow more educational opportunities and greater training experiences. There will be tremendous excitement and growth potential.

2. How will this move effect students in particular? Also, what is the timeline for move to start and be finished? This move will allow students to learn in a different location and space. The education and curriculum will continue with expected improvements. The faculty are committed to continue to provide a high quality educational experience no matter the location. The timeline has not been established, but will not occur overnight. This will take a considerable planning effort and there are construction needs at the current Bergan campus which will need to be completed in order to accommodate our needs. Once this timeline has been created, this will be shared with the entire community.

3. Will students be able to give input on how the new hospital and classrooms will be constructed? Absolutely. Once the planning process is initiated, representatives from the student body will be invited to be a key partner to make this transition successful.

Clubs Profile: Family Medicine Interest Group

Elizabeth Wooster
M4

Family Medicine Interest Group is for anyone interested in going into family medicine—a specialty focused on taking care of patients from womb to tomb. We hope to increase interest in and knowledge about a career in primary care medicine. Throughout the year we will be hosting speakers, planning procedure nights, and spending some time in community service. We hope to see you there!

Ariel Postone, Sarah Grauman, Cody King, Susanne Alcudia, and Elizabeth Wooster attended the American Academy of Family Physicians National Conference for Students and Residents in Kansas City, MO August 1-3, 2013. The conference focused on family physicians being at the forefront of healthcare reform. There were a variety of sessions from improving clinical skills to learning how to apply to family medicine to the numerous options of practice in the field of family medicine.

In the exhibits room, attendees were able to meet with representatives from 300+ family residency programs throughout the country as well as various health care agencies recruiting residents for employment.
Attention Creighton Medical Students! Medical students report that the demands of medical education increase burnout and decrease the ability to connect with patients (JAMA 2010). Are you looking for a high yield way to keep your empathy limber while relieving stress, increasing happiness, and gaining a bit of psychological (and physical) flexibility?

Enter Mind-Body Education and Development Yoga (MEDYoga). This program was started at Boston University Medical School by Heather Mason and was chaperoned to Creighton University School of Medicine by our very own Dan Janiczak (M2 Wellness Chair). What is MedYoga? It is a program that is spreading like wildfire across med school campuses because it is an outlet to cultivate mindfulness and a vehicle to maintain resiliency and release stress. Research shows mind-body practices like yoga with emphasis on exercise, breath control, and mindfulness are effective in curbing stress. Dan Janiczak writes, “The MedYoga program will provide a special platform for stress coping strategies, enhancing self-awareness, and sophisticated understanding of the neuro-physiological effects of yoga.”

Between 10 and 14 sessions are planned for next semester. One session a week, likely on Wednesday afternoons. A yoga session will include at least 50 minutes of yoga postures with emphasis on breath. The practice is enhanced by slow, deliberate movements that aim to soften and relax the nervous system response to stimuli. Finally, students will learn how to explore the habits and feelings that arise in the body and mind through a mindfulness activity. Richard Saper, professor of family medicine and director of integrative medicine at Boston University, also helped develop the program and states a session “targets the unique challenges and stressors medical students face as well as offers a fairly advanced level of intellectual content appropriate for the medical students.”

Dan Janiczak and the rest of the M2 class has brought MedYoga to life here at Creighton and proved how beneficial it can be to cope with the inherent stressors of medical education. So why not join your fellow classmates in gaining a skill that can help you tune out the noise and focus on becoming “centered” in times when concentration is key? Now, it is up to us, M1’s, to help Creighton continue to be a leader in wellness and progress in medical education.

As your M1 Wellness Chair, I checked out MedYoga to see what all the fuss was about. I was blown away by the quality of the class and particularly by the knowledgeable instructor - Libba who had 20 or so of the M2s hopping up into crow pose in no time. If you don’t know what that means, not to worry - I didn’t either. But it was impressive. The instructor does a great job tailoring the class to all levels and she avoids using some the typical yoga jargon you might otherwise tune out in other yoga classes.

High yield points: MedYoga is the real deal. All the cool M2s are doing it. It’s way more fun than reading Robbins and Cotran and we don’t have anatomy lab as an excuse! I will be sending out a notification to our class with a google sign-up sheet during break to gain a sense of who is interested in joining. After that, I will start an email chain with more info about cost (probably about $20 for the entire semester, its a steal) and possible meeting dates. Please email me if you have any questions, comments, or concerns.

Stay well, friends.
“It’s So Cute When They Think They’re Doctors.”

Gordon Chien
M2

“Gordon, why don’t you go and see Mr. M on your own and then we can discuss his case?”

Oh, thank you mystical powers above. It’s finally happening. My longitudinal clinic preceptor is throwing me the reins. I get to stroll in to a patient room with my white coat and my notebook and pretend I’m actually a somebody. I get to try my hand at diagnosing something real. I’m the boss. This must be how the NCAA men’s basketball national championship team feels when “One Shining Moment” blares as the players try to not choke on confetti.

Then came sweaty palms, a lurch in my stomach, and mind-numbing terror. Oh my God. How stupid will I sound if I stumble all over myself? What if the patient realizes that I actually have no idea what I’m doing? Will the university cover my legal expenses when I accidentally poke the otoscope right through Mr. M’s eardrum?

Dr. L saw the hesitation in my eyes, gave me a motherly pat on the back, and said, “Stop worrying. It’s not like you’re going to do anything that can accidentally kill him.” Wanna bet?

“Hey Mr. M! My name’s Gordon, and I’m the medical student working with Dr. L today. It’s a pleasure to meet you.” My eager hand shot out toward his, following the familiar script that I had rehearsed so many times in standardized patient interviews.

Mr. M, a mildly obese man in his 50s who was on several medications for hypertension and arrhythmias, came in with concerns regarding some mild, intermittent chest pain that had started three weeks prior. Immediately, my mind flipped to everything I knew about cardiac and respiratory conditions, which at the time was pitifully little. I ran through the standard interview protocol—chief complaint, review of systems, medical, family, and social histories—without a hiccup. My self-esteem up, I stood convinced that the school should’ve just handed me my diploma right then and there because I was just so dang GOOD AT THIS.

As I was about to give my little scripted wrap-up Oscar speech, Mr. M chimed in hesitantly. “Oh, and there’s something else...do you know much about ED?”

ED...ED...oh right, Ehlers-Danlos. Crap, I know it’s a congenital connective tissue disorder, but not much else. Oh well, I’ll just ask him about his family history of connective tissue problems and wing it from there. Two minutes into my line of questioning, my patient’s quick evolution from gentle smile to angry demands for why I was asking him how far back his parents’ fingers can bend made me realize that I was completely on the wrong path. Embarrassed, I hurriedly excused myself from the room and presented the case to Dr. L.

Now, most people with any common sense would have figured out that he was, of course, asking about erectile dysfunction, a problem already difficult enough for most men to discuss without being questioned about “places on your body where you’re stretchier.” I, defying all laws of logic and statistics, managed to ignore the mainstream assumption entirely and made myself look really foolish. Despite my best efforts, I had fulfilled those pre-interview fears.

As medical students, we learn about numerous fascinating diseases that have all sorts of fun buzzword descriptors that “show up on the boards all the time” but, funnily enough, never in real life. Our mental Rolodexes like to jump to those far, dusty corners, believing that we’ve found that one-in-eight-hundred-thousand case so we can show off to the attendings. The designation of these uncommon conditions—“zebras”—takes root in the idiom “When you hear hoof beats, think horses, not zebras.” Common things are common; you’re far more likely to see an atypical presentation of a common disease than textbook symptoms of a rare one.

Yet, we spend so many classroom hours learning about the zebras that eventually we train our minds to go on wild safaris by default, always searching for our next white whale. This, of course, is where experience comes in. This is why we swallow our fears and see patient after patient, hoping to come out each time with a little more diagnostic know-how so that we make fewer mistakes in the future. Let’s not lie to ourselves—at the end of the day, the major driver for doing all the learning we do is simply the fear of sounding completely stupid to strangers and superiors. We all might as well have “fake it ‘til you make it” tattooed to our foreheads.
Penne with Roasted Asparagus and Balsamic Butter
Adapted from Food and Wine, Total Time 25-30 minutes

INGREDIENTS
1 bundle asparagus
1 tbsp olive oil
¾ tsp salt
½ tsp freshly ground black pepper
½ cup balsamic vinegar
1 Tbsp light or dark brown sugar
1 box pasta
4 tablespoons butter, cut into pieces
1/3 cup freshly grated Parmesan cheese, plus more for serving

DIRECTIONS
1. Heat the oven to 400 degrees. Cut off the tough ends off the asparagus and discard them.
2. Cut the asparagus spears into 1-inch pieces. Put the asparagus on a rimmed baking sheet and toss with the oil and ¼ teaspoon of the salt and ¼ of the pepper. Roast until tender, about 10 minutes. Remove from the oven and set aside.
3. Cook the penne in a large pot of boiling salted water until just done, 11-13 minutes. Drain the pasta and return to the pot.
4. In a small saucepan, put the balsamic and simmer over medium heat until the vinegar is reduced to about 3 tablespoons, about 5-10 minutes. Stir in the brown sugar and the remaining 1/3 teaspoon salt. Toss the cooked pasta into the vinegar-butter mixture. Add in the asparagus, Parmesan, and the remaining 1/2 teaspoon salt. Serve immediately with additional Parmesan cheese for serving.

Chicken Parmesan Sandwiches
Prep time 5 mins, Cook time 10 mins

INGREDIENTS
2 ciabatta rolls
4-6 chicken tenderloins*
red onion, sliced
deli mozzarella
1/2 cup marinara tomato sauce* [warm up in microwave]
1/3 cup freshly grated Parmesan cheese for topping

INSTRUCTIONS
1. Turn oven on low broil and heat a skillet over medium heat.
2. Brown chicken on both sides and season with salt and pepper.
3. Split ciabatta in half. Then, top each with one slice of mozzarella and toast in preheated oven for about 5 minutes or until lightly brown.
4. Remove ciabatta from oven, top with chicken, red onion slices, marinara and parmesan cheese.
5. Serve warm with extra marinara for dipping.

NOTES
*Sub grilled or sautéed eggplant for a vegetarian option.
*Sub Cooked Frozen Chicken Fingers if that’s all you’ve got!
*Sub pesto for marinara if you prefer.
*Ciabatta rolls can be bought individually at Baker’s (they also freeze very well!)
*Serve with Roasted Broccoli (since you have the oven on to toast the ciabatta) or with side salad for a complete easy meal!
Big News

Amanda Wellnitz (M4) and Chad Wenzel (M4)

Engaged: August 25, 2012
Wedding: May 24, 2014 in Fond du Lac, WI

Erik Frandsen (M4) and Megan Frandsen

Married: August 3rd, 2013 in Portland, Oregon