

## What do YOU want to be when you grow up?



Photo Credit: <http://www.dignityhealth.org/>

Lauren Kurtz  
M4

It would never happen to me. The wonder and excitement I initially felt about being a medical student would last through my entire career. My respect for the miracle of life and fragile human state would keep me invested and engaged each step of my journey. I would forever maintain a deep sense of gratitude and privilege for the opportunity to study medicine.

Even before the end of my first year of clinical experience as an M3, it indeed happened. Despite everything I promised myself, I had become both disengaged and disenchanted with healthcare as a whole and with my medical education in particular. As ERAS deadlines approached, I wrestled with the decision of what to be when I grew up, becoming less optimistic by the day that I could be satisfied as a physician in any of the

current medical specialties. And since I perceived my future success and happiness as primarily dependent on the type of physician I chose to become, I continued my clinical rotations with the desperate hope I would regain my excitement about medicine once I interacted with physicians in the field I was meant to pursue.

Ironically, it was instead a rotation in the specialty I decided *not* to pursue which taught me what type of physician I truly want to be when I grow up. I spent four weeks amidst a collection of nurses and physicians who intentionally held their patients' families at a distance, fearing the emotional impact of become too close to families of patients who had undesirable outcomes. However, I noticed how readily these same staff bonded with the families of patients who came back to show off their children as success stories. Witnessing this emotional paradox reminded me of Brené Brown's famous Ted Talk *The*

What do YOU want to be when you grow up?	Pages 1-2
Dying and Living Well: "The Asymptote of Perfection"	Page 3-4
Life as a Medical Student	Page 4
Shrink Rap: Balance!	Pages 5-6
Salient Psychiatry	Page 7
The Power of the Mindset	Pages 8-9
Silence	Page 10
Meet the SOM Staff	Page 11
Big News	Page 12

### In This Issue



**LIFE AS A FIRST YEAR  
MEDICAL STUDENT**  
Page 4



**SHRINK RAP  
BALANCE!**  
PAGES 5-6

*Power of Vulnerability* in which she remarks how we as humans cannot expect to experience the highest peaks of joy if we close ourselves off to our own vulnerabilities, including those that lead us into the deepest troughs of pain and sorrow. The staff I met during my brief rotation may have needed to protect themselves in order to survive their jobs, but my entire struggle in choosing a specialty reflected my desire to thrive, not just to survive, in my career. I realized I needed to re-open myself to as much of my own vulnerability as possible if I were going to reclaim any semblance of my beginner's elation about studying medicine for the rest of my life.

One night on this particular rotation I held an hours-old newborn tightly in my arms as the cardiothoracic team prepared to conduct an open-heart surgery on this tiny human whose mother had prenatally decided on "comfort measures only" for his devastating congenital defects. He was transported without accompanying family members to our receiving hospital when his mother changed her mind and requested the team "do everything" shortly after her son's birth. As inappropriate as it seemed to me to rip apart this little boy's chest in a likely-futile attempt to prolong his life, I was overwhelmingly concerned this

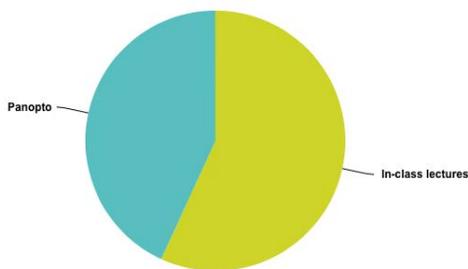
newborn might be without the warmth and comfort of human touch during his few hours on Earth. The time this baby spent in my arms was insignificant to his medical outcome and it may not have registered in the newborn's consciousness, but it was crucial for our shared humanity in this situation. It was also immensely rewarding in my personal search for vulnerability as I contemplated committing to the type of physician I was going to be.

I finally came to realize my residency specialty is not synonymous with the type of physician I will be; it is only a determinant of the type of work I will do. The essential decision I must make, time and again, is how I will approach my work. I can make the choice to experience satisfaction with my professional trajectory as a physician if I allow myself to be vulnerable. Recognizing my own vulnerability, I am again able to care about patients' vulnerabilities. When I feel committed to patients in this way I am much more enthusiastic about my future in medicine, regardless of the type of work I choose. Now when I am asked, "What do you want to be when you grow up?" I can answer confidently. I want to be vulnerable.

## SCHOOL OF MEDICINE RESULTS ARE IN!!

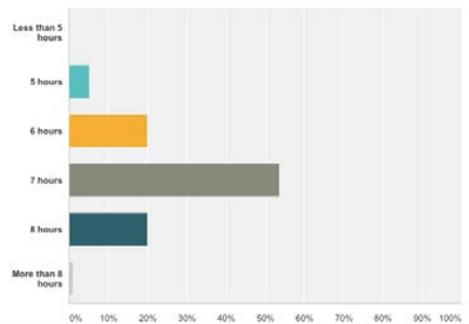
In-class lectures vs. Panopto: Which one do you prefer?

Answered: 95 Skipped: 0



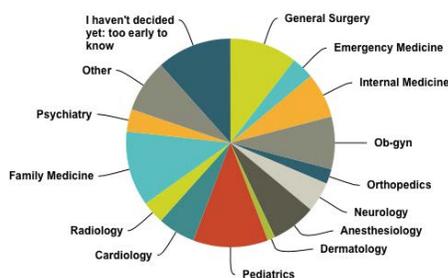
How many hours of sleep do you get each night on weekdays?

Answered: 95 Skipped: 0



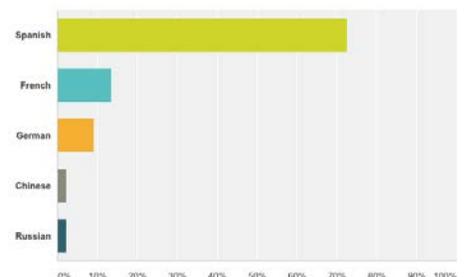
What medical specialty are you interested in?

Answered: 86 Skipped: 9



What languages do you speak besides English?

Answered: 44 Skipped: 51



## **DYING AND LIVING WELL: THE "ASYMPTOTE OF PERFECTION"**

The following is an entry I wrote in my journal during my hospice elective:

"Yesterday on a house visit, we had a patient pass away while we were visiting with the family. Through inpatient medicine, anatomy lab, and funerals of friends and family, I have experienced death. Yesterday, though, was the first time that I have truly experienced the moment of someone's passing. Breathing one moment and gone the next.

One of the patients that Nancy, the hospice nurse, and I were scheduled to visit that day was a gentleman named Robert. He was a new patient to the service, having just been diagnosed with bladder cancer a few days previously. Nancy and I entered the room, and immediately saw that Robert was very clearly actively dying. I had been on the hospice service only about three weeks, but even I recognized this instantly. Robert was demonstrating agonal breathing, sometimes sardonically referred to as "guppy breathing" because the patient resembles a fish out of water. He also had cold, discolored extremities, and was satting at 57%. I felt for a radial pulse and found one, though it was noticeably thready. (One of the hospice nurses had shared with me earlier in the week that a feeble radial pulse was often prognostic of imminent death.) Nancy and I exited the room to meet Robert's family

We met Robert's wife and two daughters, and sat on the carpeted floor because all of the chairs were being used. For about ten or fifteen minutes, we discussed what "hospice" entails, how Robert's care would be provided, and attempted to answer any questions or concerns. They also told us a little about Robert, how he had begun an industrial business in his basement, which quickly became successful in three states. At one point, one of Robert's daughters left the room to check on him, and returned ashen. She quietly whispered, "I think he's gone." Wordlessly we rose from the ground, and walked quickly to Robert's room. I embarrassingly must admit that I felt some sensation of importance, proud of myself to be viewed as an expert in a critical moment.

It was at that moment that I learned to be pronounced dead, a patient has to be without a heartbeat for sixty seconds. This is an uncomfortable truth, one that I have struggled to rationalize during my clinical years, that as medical students we often learn through human lives as examples. What a long minute that was for everyone in the room. One unfortunate twist was that towards the end of Nancy's assessment, Robert's wife asked her a couple questions. Of course you can't understand anything that's said to you while your stethoscope earpieces are in, but patients don't know this. One of these questions, though, was "Is he gone?" Nancy gently, ambiguously moved her head side to side. Whether it was in a spirit of sympathy or misunderstanding, I do not know, but it made my heart drop. Shortly thereafter she looked up stated, "On the death certificate

it will say 3:56 PM." A look of understanding and grief flashed upon the face of Robert's wife, and I quickly everted my eyes. There was such a sense of presence in the room at that time, the silence deafening, save the now useless oxygen compressor optimistically delivering air through Robert's nasal cannula.

I always thought that death occurs instantly: In a flash the patient, family member, or loved one is removed from the world. Of course, for some, this unfortunately is true (e.g., trauma, MI's, CVA's, massive PE's, etc.). But so called "natural death" is truly a progression. Hospice staff like to use the metaphor of standing on the shore of a great body of water, watching a boat gently move away. When the large white sails move over the horizon, they begin to be visible by someone standing on the opposite shore. Breathing slows and becomes progressively less efficient, temperature regulators begin to fail, and heart rate becomes increasingly irregular. These physiological phenomena slow and slow, until they finally cease altogether.

Of course, what does or does not happen to us after death is highly subjective. We physicians (I find I have now begun to subconsciously include myself in this group), are obsessed with facts and data, but here lies a truth which we cannot know absolutely. For me, personally, I was surprised by my sense of peace after Robert passed. I think that nearly all physicians would agree that there is something intangible and expansive that lies within all of us. Call it a spirit, a soul, or a desire to live, it is something that makes us distinctly human. In medicine we guard and

support this force, protect and defend it. Perhaps at times we project our own sense of its importance on our patients, or become “burnt out” when our greatest efforts appear to have zero effect on (or worse, harm!) our patients’ essential humanness. However, in that bedroom and during that hour, I was struck by how Robert’s body now seemed to be an empty vessel, a peaceful testament to a life well-lived. He rested peacefully, surrounded by an emotional, but very loving and proud family. His family left the room, and Nancy and I wordlessly bathed, shaved, and clothed Robert’s body in an outfit selected by his family.

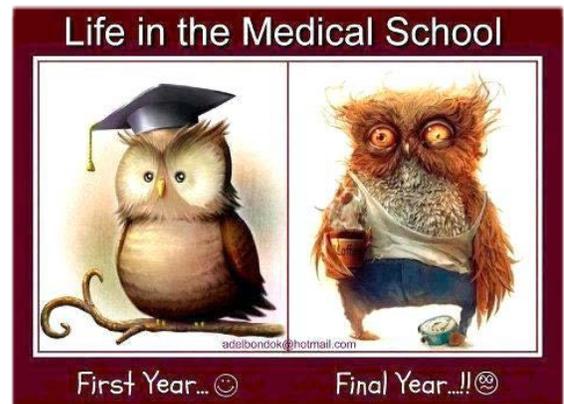
Dr. Ira Byock, the father of modern palliative and hospice medicine, often speaks of “dying well.” Dying well challenges us to live well. Byock once wrote that “At

some level of clinical care and counseling with dying persons, it is not what I do but rather *how I am* with a person that seems to matter most.” We cannot change our life circumstances, but we can focus our energy and time to where they are needed most. Whether in the OR, the delivery suite, the outpatient clinic or at home with our families, the only thing that we can do is concentrate on the horizon of what we individually understand to be a noble goal. Paul Kalanithi, author of “When Breath Becomes Air,” wrote before he died: “You can’t ever reach perfection, but you can believe in an asymptote toward which you are ceaselessly striving.” Perhaps this “asymptote of perfection” is what we each contain within ourselves, our drive, spirit, or soul.”

## LIFE AS A FIRST YEAR MEDICAL STUDENT

Aaki Shrestha  
M1

October has been a crazy month! As an M1, it was definitely the most difficult month we’ve had. It was filled with MDQ’s and exams. The whole month we’re either catching up on Anatomy or catching up on MCB. It is vital to stay on top of lectures, and going to the lectures this month has forced me to not fall behind too far. But



get free talktime at [WWW.AMULYAM.IN](http://WWW.AMULYAM.IN)

Photo Credit: <https://www.pinterest.com/musicmed27/medical-school-prep/>

to keep ourselves sane, my friends and I made sure to fit in balance by going to Vala’s Pumpkin Patch and having our own “Fall Break” party. Vala’s was beautiful and a lot of fun. Fall break was also a great recharge of our batteries. Balance was a *definite must* this past month!

# SHRINK RAP: BALANCE!

**Michael G. Kavan, Ph.D.**  
**Associate Dean  
for Student Affairs**

**Balance:** The *Merriam-Webster* and the *American Heritage* dictionaries provide many definitions of balance that seem particularly relevant to the lives of medical students. They include: “A counterbalancing weight, force, or influence.” “A harmonious or satisfying arrangement or proportion of parts or elements.” “A state of equilibrium or parity characterized by cancelation of all forces by equal opposing forces.” “A stable mental or psychological state; emotional stability.” Seeking life balance has become an increasingly popular topic among medical students and professionals as we all try to enhance our quality of life.

So is there harm in living an unbalanced life? The literature is replete with studies demonstrating how unbalanced lives can lead to a host of negative effects including burnout and stress-related psychological and physical problems. Burnout, defined as a psychological syndrome involving emotional exhaustion, depersonalization, and a diminished sense of

personal accomplishment, has been shown to be present in 50% of medical students. In addition to just feeling crappy, burnout is associated with an increased risk for cardiovascular disease, type II diabetes, male infertility (okay, now I have your attention), sleep disorders, and musculoskeletal problems. And although we all need some level of stress to function, excessive stress can lead to irritability, fatigue, problems with concentration, and various health problems such as lowered immunity, headaches, back pain, GI distress, cardiovascular disease, and the list goes on and on...

You can certainly see that living an unbalanced life does not bode well for a long and satisfying existence. But, as medical students, is there anything you can do to enhance balance? Well, actually, yes. One of the more important things you can do is to stay attuned to your psychological and emotional state through reflection. Look for trouble spots in you day or life and consider how you can either change them or your reaction to them. Also, as medical students be aware of the problem with over commitment. Over commitment is often self-imposed and it may be helpful to develop a daily schedule that includes opportunities for personal time, exercise, and



Photo Credit: [www.gocreighton.com](http://www.gocreighton.com)

## WELLNESS CHRONICLE

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Photo Credit: <http://liftfightlove.com/post/my-year-of-balance/>



reflection. Psychologist Sandra Lewis, Psy.D. writes about the importance of finding “self-care strategies that you can integrate in rather than add on [to your schedule].” She adds – “honor the small things.”

A recent article in the American Psychological Association’s *Monitor* (July/August 2016) on professional balance stressed the importance of using the following research-based strategies for achieving better balance in life:

**1. Practice mindfulness:** Develop a reflective habit of checking in with yourself at least a couple times daily.

**2. Look for silver linings:** Look for positives in negative situations.

Positive reappraisal is a way of taking control.

**3. Draw from positive psychology:** Positive emotions boost resilience and facilitate wellbeing, and can be enhanced by expressing gratitude on a regular basis.

**4. Take advantage of social support:** I have mentioned this several times before, but seeking support from other people is critical to wellbeing. So, avoid avoidance – get out and connect with others, even if you don’t feel like it.

**5. Seek out a good mentor:** It’s helpful to have someone you can go to for support and guidance. Also, a good mentor can provide proper perspective as well.

**6. Get moving:** Again, something I discuss a lot. Exercise can help

with stress and can improve mood and mental efficiency.

**7. Go outside:** Better yet, move outside and spend some time in nature. Too often, students are holed up in class, at home, or in coffee shops; get outside and enjoy the fresh air!

**8. Make your life meaningful:** Seek a meaningful existence through religion, spirituality, or volunteerism. We seem to function better when it becomes more than just “all about me.”

These truly make sense and I encourage everyone, including myself, to make a special effort at integrating the above strategies into our lives in order to enhance balance and to live a more satisfying and value-driven life. All the best!

## **SALIENT PSYCHIATRY: YOUR QUARTERLY PEAK AT MENTAL ILLNESS PAST, PRESENT, AND FUTURE**

*John Dobleman,  
Psychiatry Interest  
Group Co-President, M4*

### **“Section 7.3 aka The Goldwater Rule”**

*What do the world's leading psychiatrists have to say about the emotional disequilibrium of the candidates on full display during this year's presidential race? In their professional opinion, do these candidates suffer from any mental illness?*

In 1964, *Fact* magazine published the article "The Unconscious of a Conservative: A Special Issue on the Mind of Barry Goldwater." The magazine polled psychiatrists about American Senator Barry Goldwater and whether he was fit to be president. Goldwater would sue the editor of the magazine for defamation and win a libel suit. What followed was **The Goldwater Rule (1973)**, the informal name given to Section 7.3 in the American Psychiatric Association's (APA) code of ethics, which states that *it is unethical for psychiatrists to give a professional opinion about public figures they have not examined in person and obtained consent from to discuss their mental health in public statements.* In such circumstances, however, a

psychiatrist may share with the public his or her expertise about psychiatric issues in general.

### **“It's a boy!!! It's a girl!!! It hasn't decided yet?!” A Closer Look at *Gender Identity Disorder***

In the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), the diagnosis termed Gender Identity Disorder (GID) or *Gender Dysphoria* (first introduced in DSM-3) recognizes persons who suffer distress from identifying with a gender (may include sex and gender roles) different from the one they were assigned at birth. In addition to psychological or behavioral causes, new developments in genetic analysis and exposure of certain hormones before birth may provide an explanation.

According to DSM-5, *gender nonconformity is not in itself a mental disorder. The critical element of gender dysphoria is the presence of clinically significant distress associated with the condition.*

Based on the current criteria, this diagnosis may apply to approximately 1 in every 20,000 persons. Persons with GID are at increased risk for stress, isolation, anxiety, depression, poor self-esteem and suicide.

**Current Psychiatric Treatment:** psychotherapy or to support the individual's preferred gender through hormone therapy, gender expression and role, or surgery  
**CURRENT CONTROVERSY:  
PRE-PUBERTY**

The question whether to counsel young children to be happy with their assigned sex, or to encourage them to continue to exhibit

behaviors that do not match their assigned sex—or to explore a transsexual transition—is controversial. Some clinicians report that a significant proportion of young children diagnosed with gender identity disorder later do not exhibit the dysphoria.

(Sources: UpToDate, MedScape, CareersinMedicine, Wikipedia)

**For more information regarding the  
ever-evolving and fascinating field  
of Psychiatry,  
Please consider joining the  
Psychiatry Interest Group!**

# **PSYG**

*The Psychiatry Interest Group's mission is to provide an open space where students and faculty can interact to learn more about the emerging field of psychiatry and its career opportunities. The interest group aims to increase understanding about topics related to mental health, as well as serve our local community in ways that parallel our mission.*

# THE POWER OF THE MINDSET

Michele Millard

Academic Success Specialist

A recent book entitled “*Mindset: The New Psychology of Success*” by Carol Dweck, PhD, speaks to the power of a person’s mindset in determining an approach to life. A mindset is a set of attitudes and assumptions that creates a framework for viewing ourselves and the world. Dweck has identified two mindsets that impact success in all areas of our lives. The first is a fixed mindset, where we believe that qualities are carved in stone and can’t be changed (e.g., “I am a failure”, “The world is out to get me”). In contrast, the growth mindset is characterized by viewing ourselves and the world as changeable; our abilities and qualities can be changed with effort (e.g. “I’m going to study harder for my next test”).

Fixed mindsets, on one hand, represent rigid thinking, fear of judgment and failure as well as an identification with static qualities that allow no room for growth or learning. Malcolm Gladwell, author of several bestselling books, including “*The Outliers*”, suggested that we tend to value natural, effortless accomplishment over achievement as a result of effort. He says, “It’s as if Midori popped out of the womb fiddling, Michael Jordan dribbling and Picasso doodling”. This attitude

Growth mindsets, on the other hand, are the basis for real learning and accomplishment, putting the learner into the creator role with the ability to create change with effort. Jackson Pollack, one of the greatest American painters of the twentieth century, had no intrinsic artistic talent. He fell in love with art and just started doing it, finding others to mentor him and working until he found his style. A growth mindset is the belief that the brain is like a muscle that can grow stronger through hard work and determination.

**“The good news is that our mindset is changeable; it just takes a decision to approach something differently.”**

*-MICHELE MILLARD*

However, growth is not just a product of trying, but trying in a way that integrates a strategy for improving. Obstacles and failures do not provide proof that you cannot do something, but opportunities to figure out what you need to do in order to be successful.

The two types of mindsets can be contrasted in the following ways:

Fixed Mindset	Growth Mindset
Failure defines me	Failure challenges me
Either I have an ability or I don't	Abilities can be nurtured and learned
Criticism is unwelcome and devastating	Criticism is not fun, but helpful
Intelligence is a fixed trait	Intelligence can be enhanced and increased
Obstacles inhibit advancement	Obstacles create opportunity for growth
Compete with others	Collaborate with others



## SILENCE

Reverend Ben Osborne  
Chaplain of Creighton School of  
Medicine

Emily Dickenson writes *“Hope” is the thing with feathers - / That perches in the soul - / And sings the tune without the words - / And never stops - at all.* The living in the first world in the twenty-first century means that our lives are full of all kinds of chatter and distraction, things that divert our attention from the deep place within us where hope perches and quietly sings. I’d like to suggest that intentionally making room for silence in our lives is key to our ability to hear that tune without words welling up inside of us.

From September of 2010 until I left for Africa at the beginning of January this year I worked at the Jesuit Retreat House in Lake Elmo, Minnesota. Forty-seven weekends a year between sixty and seventy people would come to spend three days in silence and prayer. My job was about helping people enter into the silence and pay attention.

Slowing down for an extended period like that is really helpful for living a grounded, balanced life, and I’d encourage anybody who is so inclined to seek out those opportunities. But it’s at least as important to find some room for silence in the midst of daily life. I see part of my job here as trying to help the students, faculty, and staff of the School of Medicine to find ways to pay a little more attention to their interior lives.

I can already hear the objections, “That’s very nice for you, Fr. Osborne, but you obviously don’t understand

how busy I am. Finding space for silence in my life is about as realistic as finding my way through a wardrobe to a magical land with talking animals.” I would have a couple of responses to that. First the busier we are the more important it is to be intentional about making some space for silence. Otherwise hope’s tune gets drowned out and we cede control of our lives to our calendars. We allow ourselves to be carried along unreflectively from one class, meeting, or event to the next. Second, room for silence is there; we just have to use it. Try going without the radio on your commute. Take a ten-minute study break and just sit on a bench

“Silence that nourishes  
is something more than  
the absence of exterior  
noise.”

somewhere and feel the sunshine or marvel at the clouds. Put your phone and other distractions away while you eat. It can be done.

I could imagine a medical student saying, “I have plenty of silence in my life, thank you very much. I already spend way too many hours in the library or in my apartment studying in silence.” That’s a fair point, but that’s not the kind of silence I’m talking about. Silence that nourishes is something more than the absence of exterior noise. The interior noise generated by trying to cram more information into your head is equally exhausting. Silence has to do with

finding a place of stillness in the midst of the torrents of information coming at us from all directions, which then allows us to pay attention to the information coming up from within us.

At this point you might be saying something along the lines of, “Silence? Stillness, are you nuts? Whenever I’m alone with my thoughts, my mind just starts racing at a million miles an hour and I end up even more exhausted.” Fair enough, but that suggests the need to practice being quiet rather than an excuse for avoiding it. Like any skill, learning how to be quiet takes time and practice. Given the noise inherent in contemporary life, it’s not surprising that there’s some interior hangover when we try to slow down. There is an element of choice in what we do with our racing thoughts. Often we just allow ourselves to be swept along by the currents of our racing thoughts. It is possible, however, to find some anchor point or place of stillness from which to observe the thoughts as they rush by without getting swept up in them. That’s not necessarily natural or easy. It requires intention and the willingness to keep trying.

For St. Ignatius of Loyola, hope is just one way that God moves and speaks in the deepest part of a person. In the Ignatian tradition, as in many other traditions, silence is a privileged pathway toward developing the capacity for attention to those human depths and toward appreciation of the beauty and goodness of the tune that never stops at all. Give it a try.

# Meet the Creighton SOM staff:

## **Dr. Kavan:**

**-Where are you from?** I was born and raised in Omaha. I went to Creighton University where I majored in psychology and then to the University of Nebraska-Lincoln for my Master of Arts and Ph.D. in Counseling Psychology after participating in a year-long internship at the Veterans Affairs Medical Center in Minneapolis.

### **-Job title and short**

**description** – I am a professor of Family Medicine and a professor of Psychiatry, in addition to being the Associate Dean for Student Affairs at Creighton University School of Medicine. I am involved in overseeing medical admissions and a variety of student support services within the School of Medicine. I also teach a variety of behavioral medicine and interviewing courses within the school, participate in research, and see patients two half



days per week at the CHI Health Clinic in Bellevue.

### **-How long have you been part of the Creighton family?**

As mentioned, I attended Creighton University as an undergraduate from 1978-1982 and then returned to Creighton University School of Medicine Department of Family Practice as the Director of Behavioral Sciences in 1988 and have been fortunate to be employed here ever since.

### **-Your unique advice to Creighton medical students**

– Balance! And take time to reflect on what is important to you. Your values will serve as an extraordinary compass as you go through life. I value my family and my work with students, and I can say I truly enjoy my life and am grateful for everything God has provided for me. Life is good!

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## **Cate Pogge:**

**Where are you from?** - Born in St. Paul, MN, lived in Dallas for 7 years (age 4-11), 2 years in Tehran, Iran (age 12-13), then Eagan, MN, been in NE for 28 years but still consider MN home.

**-Job title and short description** – M1 Curriculum Coordinator, Responsible for coordinating the first year students' schedule, curriculum including testing & all activities, and being an advocate for them.

### **-How long have you been part of**



**the Creighton family?** 12 years

### **-Your unique advice to Creighton medical students**

– Make sure to take time for yourself and have some fun. Ok, not too much. 😊  
Balance is critical. Enjoy getting to know your classmates. They will be extremely important to you through the years. These years go VERY fast so reach out when you need help. We are all here for you.

# Big News



*Adeline Noelle Peterson,  
born 9/9/2016 (WT  
7LBS 8OZ, 21 inches  
long)*

*Daughter of Jacob and  
Danika (M4) Peterson*