India CURA Trip
Matthew Borchart — M2

During this past summer I had the opportunity to travel to India with Project CURA. Between the many difficult times doing clinical work with impoverished communities, we sometimes had time for a little bit of fun. This particular instance happened during our last day in Pune, a city near Mumbai, where we were working with a local nonprofit organization to provide basic health services to populations that were in need. After two weeks of being in India, where coffee isn't necessarily a norm, we were really craving some Starbucks. As luck would have it, there was one just down the road, and since we had the afternoon free a few of us decided to walk to it. If there was one thing I learned during my time in India, it was to expect the unexpected. This particular day we encountered two camels wandering down the road, accompanied by two men. As we approached them we took out our iPhones to capture the moment on Snapchat, true to our Starbucks-patron forms. One of the men walking the camels took note of our awe at the beasts and asked if we wanted a ride. After quoting us a price in rupees that equaled approximately three American dollars, I gave the quickest ‘yes’ I’ve ever uttered in my life. Suddenly we found ourselves mounting camels in Pune, marching down the street as onlookers, who were taken aback at the site, cheered us on. While CURA was a diversity of experiences that were often very challenging, this was one of the little moments that fueled our incredible journey through India.
THE BEST BURGER IN OMAHA: A SINGLE-BLIND STUDY OF A MIDWESTERN METROPOLITAN’S BEEF BENEFACIONS

EK Daugherty1,2, M.S.; AW Hasebrook1,2, M.S.; JP Bowens1,2, M.S.
Creighton University School of Medicine1; Dundee Food & Alcohol Science Collaborative2, Omaha, NE

Figure 1: Head-to-head, single-blind, randomized ER evaluation. A. Meticulous, pre-tasting data collection. B. The single-blind part of our study; note the tuxedo t-shirt, communicating that, “I want to look formal, but I am here to party.”

Introduction
Trump or Clinton, Nickelodeon or Cartoon Network, Coke or Pepsi - it is impossible to approach consensus related to some topics, even with only two choices. The plethora of restaurants in Omaha (OMA) has resulted in an abundance of satiating hamburgers, with many opinions regarding which is truly the best. Hamburg steaks were first served by German immigrants in New York in the late 1800s (Avey 2013). The origins of the modern hamburger are elusive, but whoever first placed beef on bread was truly Einsteinian. Comprised of ground beef and cheese on a bun, cheeseburgers (CBs) may be misleadingly simple; however, a well-crafted burger has the potential to right a bad week, turn a first date into a second, or even preserve world peace (Fort 2007). The purpose of this study is to determine the best CB within the OMA metropolitan area.

Methods
This study was part of a single-center, long-term evaluation of various restaurants and bars offering CBs on their menus. CBs were sampled by three expert raters (ERs), with more than 81 years of combined eating experience. A list of CB eateries was compiled based upon their observations (Table 1). The three best-received CBs (Block 16, Dario’s, and Dinker’s) were returned to the testing location for head-to-head, single-blind, randomized evaluation. CBs were divided into three equal portions and separated onto receptacles of identical design. Much like before piñata hitting, ERs were blindfolded and receptacles were rotated randomly to control for rater bias. ERs ranking immediately followed tasting, with CBs ranked 1 to 3 (best to worst). A non-parametric Mann-Whitney U test was utilized to compare CB score values, using the software IBM-SPSS. P values < 0.05 were considered significant.
Table 1: “Top 10” list of CB-serving restaurants in the OMA metro area, listed based on proximity to Creighton University (2500 California Plz. Omaha, NE 68178). Menu item noted. Prices rounded to nearest $0.25 and include French fries. *Denotes inclusion in head-to-head trial.

<table>
<thead>
<tr>
<th>Restaurant</th>
<th>Menu Item</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dario’s Brasserie*</td>
<td>Dario’s Cheeseburger ($14)</td>
<td>Walking distance to eCreamery for dessert</td>
</tr>
<tr>
<td>Dinker’s*</td>
<td>Cheeseburger ($6.25)</td>
<td>CBs come with side of prime people watching</td>
</tr>
<tr>
<td>Block 16*</td>
<td>Block Burger ($6.50)</td>
<td>Innovative menu; try the Croque Garcon burger</td>
</tr>
<tr>
<td>Jams</td>
<td>Jams Burger ($13)</td>
<td>Great salads to enjoy on the side if you are a rabbit</td>
</tr>
<tr>
<td>Omaha Taphouse</td>
<td>Signature ($9.50)</td>
<td>Wacky burgers named for local celebs</td>
</tr>
<tr>
<td>Stirnella</td>
<td>Blackstone Burger ($14)</td>
<td>New to the scene; try if you are in Blackstone</td>
</tr>
<tr>
<td>Louie M’s Burgerlust</td>
<td>Cheeseburger ($8.50)</td>
<td>Perfectly toasted buns and alcohol infused milkshakes</td>
</tr>
<tr>
<td>Barrett’s</td>
<td>Husker Burger ($6.75)</td>
<td>Half price burgers on Mondays</td>
</tr>
<tr>
<td>Stella’s Bar &amp; Grill</td>
<td>Cheeseburger ($5.50)</td>
<td>Try the Stellanator challenge, a huge sextuple burger</td>
</tr>
<tr>
<td>Sinful Burger</td>
<td>The Sinful Burger ($9)</td>
<td>Gluttony is a sin, thus, Sinful Burger</td>
</tr>
</tbody>
</table>

Results
The Dario’s Cheeseburger was unanimously ranked first (1.00±0.00 mean ranking). The Block Burger came in second (2.33±0.58), with the Dinker's Cheeseburger (2.67±0.58) coming in just behind it. These results are summarized in Table 2. The mean rankings for CBs from Block 16 and Dinker's were found to not differ significantly (Mann-Whitney U = 3.000, n1 = n2 = 3, P > 0.05 two-tailed; Supporting Data).

Table 2: Results of head-to-head, single-blind, randomized ER evaluation.

<table>
<thead>
<tr>
<th>Restaurant</th>
<th>Mean</th>
<th>N</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dario’s Brasserie</td>
<td>1.0000</td>
<td>3</td>
<td>0.0000</td>
</tr>
<tr>
<td>Block 16</td>
<td>2.3333</td>
<td>3</td>
<td>0.5774</td>
</tr>
<tr>
<td>Dinker’s</td>
<td>2.6667</td>
<td>3</td>
<td>0.5774</td>
</tr>
</tbody>
</table>

Discussion
For years, OMA has been called the “New York City of Nebraska” because of the culture’s ultra-refined palate. This meat-infested wonderland has sought the answer to this burger quandary for even longer than the question “What exactly is in a Runza?” Our systematic approach controlled for external variables, including the time between different restaurants, order of consumption, greasy smells emanating from fellow patrons, general restaurant vibes, whether the CB is served on a piece of wax paper (like you are homeless) or on a fine piece of ceramic, and - most importantly - French fry biases. Our findings show Dario’s has the best CB in the OMA metro area. One taster described it rather explicitly as, “Like angels are having an orgy party in my mouth.” The unique combination of grilled onions and perfectly cooked, $14 meat is what sets this CB apart. Our study was not powerful enough to separate Block 16 and Dinker's in the rankings. Block 16 did bring some extra flavor with their distinctive mustard, with one taster describing it as, “An explosion of flavor so intense, I feel that I have left my body.” However, the taste of the mustard may be a downgrade for some and bun quality was lacking in texture and appropriate toastiness. Some may re-
gard Dinker's CB as too plain. The burger has little flash compared to Dario’s and Block 16, which exhibit stronger character based on meat quality, bun texture, condiment utility, and provide a better all-encompassing mouth adventure. In many other markets, Dinker’s would represent the pinnacle of the burger spectrum - but OMA is no ordinary market.

Our results correlate with findings from Alexander (2017). Their robust study required the monstrous appetite to taste nine CBs in one day; however, they failed to control for biases including the time taken between restaurants, comparisons to other national burgers, jet lag, and, “I want to vomit my meat-filled stomach contents.” Regardless, it was the most comprehensive study performed prior to our own. Our results somewhat violently disagree with those of Hansen (2012), whose study was conducted over the course of many days - as if the entire community wasn’t depending on a study of this magnitude. They even had the audacity to conclude that there was no true winner. The choice to include establishments such as Phoenix’s Food and Spirits, a 3.7/5.0 rated joint, and Tommy Colina’s (which we assume is a Mexican dive bar) was sketchy at best. Moreover, Dario’s was not even a participant. We acknowledge that there may be biases in our own study as well. These included one taster’s negative attitude toward mustard, another’s propensity to claim that everything he is tasting is the, “Best thing he has ever put in his mouth”, and our third taster demolishing a family sized frozen pizza just hours before the tasting. Future studies may better control for the geographic distance traveled, and the moisture accumulation within Styrofoam to-go containers over various distances. Finally, we acknowledge that to make a fair comparison, each burger was kept as like the others as possible, and may not representative the best overall CB that these establishments have on their menu.

Conclusion
Our data concludes that Dario’s Brasserie has the best CB in the supersaturated OMA burger scene. Future studies, with more replicants, may better elucidate the hierarchy of burgers in the metro area.

Conflict of Interests
We have no conflicts of interest or financial obligations to the institutions included in the study. We are in severe, crippling, student loan debt, and therefore well represent the opinions of the common man.

References


Shrink Rap: 2017 Welcome!
Michael G. Kavan, Ph.D. — Associate Dean for Student Affairs

I want to welcome our 155 new medical students and welcome back all of our M2s, M3s, and M4s! It is always great to see everyone and to get back into the groove. Life gets busy and medical school can certainly add to the busyness and the stress that accompanies life. This has been an exciting year with our medical center move to the Creighton University Medical Center-Bergan Campus. Being more distant from the main university campus can present some challenges, but we are doing our best to be available at both places. Please let me know if you need to meet and I will do my very best to make it work. My drop-in office is in the Graduate Medical Education area on the second floor of CUMC-Bergan Building #2. Keep in mind that Dr. Dunlay, Dr. Soukup, and I also meet regularly with class officers, so, if you are more comfortable passing along information to them, please feel free to do so and we can address any issues in that manner as well.

And just a reminder about BALANCE - as you progress through the semester, I encourage everyone to keep up with those activities that allowed you to lead balanced lives prior to medical school or, for those more senior students, while in medical school. As you know, it is so easy to put off those things we know we need to do because of time constraints. Because of this, make sure to not only schedule study time, but also time to exercise and engage in hobbies, social, and recreational activities. These help us maintain our connection with others and with those endeavors that give us proper perspective. Finally, take some time to reflect each day and to focus on what you are grateful for. I am not only grateful for my wonderful family, but also for having the opportunity to work with an incredible group of students – thank you and God bless!

Prereading
Linda Pappas — LMPH, CPC

Can we think idealistically here for a moment? I believe in the strategy of prereading before a lecture. I just heard a collective groan from hard working medical students. Yes, I know that there is so much material to cover in medical school that the idea of being able to read before the lecture seems totally idealistic!

Good students (like you) are in the habit of reading very constructively. They carefully go through the material, taking notes, examining the details, rereading to make sure they understand, underlining, highlighting, etc., etc.

Prereading is a whole different animal. It is fast; 10 minutes max per hour of lecture time. You are looking for main points and spotting patterns of relationships between topics. This helps you to develop a map or outline in your memory to understand what you are going to be introduced to in lecture. You are also introducing yourself to the vocabulary, seeing the new terms for the first time. That brief familiarity will help you to process quicker in lecture.
So you sit down to study with intention of plowing through those four lectures and understanding them thoroughly by the end of the day... but that just doesn’t happen. Instead, perhaps this is what really goes down (example from the M2s---the rest of you can extrapolate):

Okay... exam on Monday... need to get those causes of hypothyroidism down... oh, wait... let me check Facebook first... hahaha... I can't believe she posted that... ok---Hashimoto thyroiditis. Subacute thyroiditis... oops, my phone just buzzed---must have a text message... someone else freaked out about their rotation schedule for next year... Iodine deficiency, Riedel thyroiditis, Lithiummmmmmm... mad... I'm so mad at him... how could he have said that to me... back to the exam... I'm never going to remember this stuff for the boards... .

What could have potentially been a productive study session turned into a huge waste of time because of all the distractions, both from our environment and in our heads. Daniel Coleman, in his book “Focus: The Hidden Driver of Excellence” identified one of the most important predictors of success and excellence is the ability to have a healthy focus on specific tasks in the middle of distractions. He categorized distractions into two areas; the first being sensory,
which is all the incoming stimuli of your environment---what you touch, taste, hear, see, feel. The second and the most powerful are those emotional distractors---the sound of your name, the buzz of a text message coming in, the intrusion of those memories of that break-up. How do distractions impact performance? Dramatically, the research says. The more our focus gets disrupted, the worse we do. A test of how prone college athletes were to distractions correlated significantly with their performance in the upcoming season. Our brains are wired to either get pulled in different directions by distractions or the ability to focus. The neural wiring for selective attention and the ability to stay on one target is found in the prefrontal regions where specialized circuitry boosts the strength of incoming signals we want to concentrate on and dampens down those we choose to ignore. That ability to focus is essentially “cognitive control” or the ability the keep focus on the one thing that’s important while ignoring distractions. Psychologist Angela Duckworth uses the term “grit” as the ability to keep focus on long-term goals and strive for them despite setbacks. Grit and cognitive control are essentially types of self-regulation which is a major part of emotional intelligence and essential for success.

It’s easy to find ourselves in a state of “mindlessness” where we flit from thing to thing in our heads and meander through our tasks rather than getting on a direct train to get things done. The opposite state of “mindfulness” is the act of becoming intentional about what we are doing and how we are doing it. Both of these mental states are actually habits---we become used to a way of doing something and that becomes our default mode. Becoming more mindful is like strengthening a muscle---with a little practice and exercise, it can become the default state.

A few tips on how to build those “mindfulness” muscles:

1. Manage those temptations.
   A. Turn your phone/facebook/twitter/Instagram/email accounts off, only allowing yourself to check them at certain points during the day. Truthfully, is it really that important to see the Facebook post of what your friend had for lunch?
   B. Use technology to manage your technology
      There are apps that can help you stay focused; Nanny for Google, Stay Focused, Self-control, Freedom, Time Out, Tasker, Do Not Disturb are just a few of the apps or programs that limit the amount of time you can spend in your inbox, on Facebook, etc.
   C. Minimize distractions within your physical environment, such as noise and people. Create the environment that will maximize your focus.

2. Check in to what’s going on in your head.
   Notice where your mind has gone and choose to bring it back to where it should be. That act reinforces those neural circuits that help maintain focus.

3. Avoid the myth of effective multi-tasking.
   We think we’re good at it, but the reality is, our productivity is probably 20-40% lower. We may believe we are accomplishing multiple things at one time, but the reality is, we’re switching focus quickly from task to task, reducing our effectiveness at actually getting something done.

4. Take care of yourself.
   Be productive for a while, and then take a break.
   Make sure you get enough sleep, exercise and appropriate nutrition---all of which helps maintain focus.
It was Randy’s second hospital admission in as many months for trying to take his life. This followed another failed attempt to give up the bottle, the best friend that had stolen all things precious to him. It was difficult to see how this admission might be any different after scrolling through his chart, already forming opinions about his probability for success in my head.

I was in the first week of my psychiatry rotation, working with an attending whose example and presence inspired nothing but the best efforts from her students and patients. I expected my psychiatry experience to be like my other rotations, where I was much more the giver, and that encounters with patients would still be largely cerebral and somewhat distant. In no way was I prepared to spend every session, led by the example of my attending, in an exchange with my heart—giving and taking. I did not expect to be hearing their experiences and sharing mine in a way that made me stronger as a student and them stronger as persons recovering from their illness.

Randy had tired, sad, piercing blue eyes that spent most of the time searching his patterned hospital gown, bleached sheets, or tiled floor for answers as I asked him to tell me a little about his past and where he was in his life now. This soft spoken father broke down into tears as he shared with me the familiar story of an addict with a slow but steady decline. The addict’s story told through him was that of young person full of promise who fell prey to a temptress, with a grip so strong that losing jobs, losing a marriage, losing a son, and now losing housing was not enough to cause a now-aging man to pull away from his destroyer.

Recognizing his fragility, we worked to have some type of breakthrough as we waited for a bed to open in an inpatient psychiatric facility. The first day was spent speaking of his prior efforts in sobriety. My attending was quick to recognize the flaws in his previous recovery attempts. He had completely bought into the notion that he was a “no good drunk.” Through her compassion and grace, my attending tactfully revealed her spiritual gift of making each of us feel important, from student to staff to patient. She gently reminded Randy that the higher power in whom he believed does not create mistakes but masterpieces. She allowed him the opportunity for a myriad of second chances and a lifetime of forgiveness by noting that nothing Randy could do could make his God love him any less. She reminded him of the opportunity he had to be the father his son needed, and of the hurt and pain his son would endure if successful in his attempts at ending his life. Randy was sobbing as she slipped her porcelain hand softly into his weathered palm while he began to process all the interaction had revealed. Minutes felt like hours as she let him cry.

Finding the Weathered Hand in All of Us

Sarah Pietruszka — M4
“From that first day, Randy was different. He still struggled with anxiety, fear, and insecurity, but there was no longer the impossibly impenetrable wall that separated him from the rest of humanity.”

until finally he looked up and through uncertain and wet eyes said, “Thank you.”

From that first day, Randy was different. He still struggled with anxiety, fear, and insecurity, but there was no longer the impossibly impenetrable wall that separated him from the rest of humanity. We sometimes met outside in the healing autumn air to escape the constricting environment of the hospital. Over cups of black coffee, Randy would share with me or the team the small gains that felt like mountains he conquered every few days — a phone call to his sister telling her he had been hospitalized, a birthday card to his son, or drafting a letter seeking forgiveness from his ex-wife.

While I lacked the training and experience to give Randy the professional help he needed, my attending and patient taught me the healing powers of compassion and time. Randy allowed me the chance to share in some of his pain, and because of this, I believe both us of grew. From bringing him crossword puzzle books to fight anxiety, a blank birthday card for his son, a poster to celebrate his first week of sobriety, I began to recognize how such small efforts on my behalf could communicate and reinforce the curative influence of love for humankind.

My attending quoted the words of the Jewish religious leader, Hillel, “If not now, when?” She helped me understand how crucial every interaction with our patients might be in helping them take their first steps toward health. She explained her sensitive approach by this simple statement: “Judge how good of a doctor you are not based on your patient outcome, but based on the amount of effort you put into caring for the patient.” This statement changed the trajectory of my third year. I allowed my heart to lead me in patient interactions from that point. The pain of a marriage that crumbled, the elation of falling in love again, the ache of the death of a loved one, and the joy of the birth of my son all became potential fodder for establishing compassionate and open relationships with my patients. Even if I lack the training to be a physician at this point, I am wonderfully competent at being a loving presence who can hold a hand in a time of need.

Brokenness comes in so many forms. All of us have experienced a piece of our heart being chipped away. As I worked with Randy and with my attending who led by example, Randy began to realize how similar we all are. It is only through the kindness of others who walk with us in these desperately deep valleys who can offer a saving arm to pull us back up. When that outstretched hand of compassion starts to lift us out of the valley, perhaps we cannot yet feel the sunshine, but we can once again sense that it exists.

Photo from www.hdwallpaper.nu
You may have HIV,” the doctor told our patient after reviewing the initial test results. “But don’t worry. We need to do confirmatory testing, and it’s likely a false positive. Everything will be alright.” The patient was terrified. She was a 31-year-old female who presented to the clinic for STI testing after having five new sexual partners in the past three months. Her prior history included IV drug use and treatment for Gonorrhea and Chlamydia.

Did the physician believe that the result was a false positive and that everything would be alright? My guess is no, but he said the words anyway. During my 3rd year clerkships I witnessed many such instances, where genuine attempts to mitigate the sting of painful news unintentionally imparted a false sense of optimism.

In another example, a 67-year-old male presented to the emergency department with SOB, and I was tasked with his intake when he was transferred to the floor at 1:30 AM. He was a veteran who had worked in a shipyard for 26 years and smoked a pack a day since he was 16 years old. He had recently been to the VA hospital where they had “put a tube in his chest.” The initial CXR showed plural effusion.

Two weeks later, he was in the ICU. A chest tube was in place, multiple antibiotics were on board, continuous telemetry showed AFib with RVR, a rebreather mask was set at 10L O2, a PCA was in hand, and he was diagnosed with lung cancer. The outlook was grim. His functional status deteriorated daily, and he, along with his family, decided to withdraw care. Telemetry was turned off, the antibiotics stopped, and the plans were made to pull the chest tube.

That would have been the end of the story, but a resident on our team recalled cancer treatments exhibiting a “Lazarus Effect,” taking a patient from brink of death back to life. To use these medications, the cancer must have specific gene mutations; this analysis takes two weeks to complete. The resident was determined to save our patient and talked to the family about this option. They latched on with desperate hope. Telemetry was turned on, antibiotics were restarted, and the chest tube remained in place.

I could not believe it. While a part of me also wanted to grasp at the sliver of hope, I was overwhelmingly taken aback. Why were we tempering an exceedingly bleak prognosis? The odds of a positive outcome were minuscule. The cancer was unlikely to display the required gene mutations, and there was a good chance the patient would die in the two weeks required to obtain the test results.

In the end, the first patient’s diagnosis of HIV was confirmed, and the second patient died before the gene mutation test came back – it was negative. I will never forget sitting in the crowded conference room in the ICU with his family as we delivered, for the second time, the awful news that he was going to die. “But that doctor told us he could be cured,” his sister cried, tears streaming down her cheeks. “You gave us hope, and now you’re telling us he’s going to die!”

What is it that compels us to give false hope to a patient? Fear of admitting defeat? Of confrontation? A natural bias towards action over inaction? The laudable desire to comfort others in times of pain? I believe it is all of these things and much more. And yet the consequences can be so very damaging. False hope ensnares a patient and their family in an uncertain realm between reality and possibility. It can leave loved ones woefully unprepared for tragedy and in some cases, cause families both financial and psychological destitution.

The language of hope is a powerful tool, invaluable when used appropriately, but eminently harmful when used improperly. As doctors, we speak the language of hope on a daily basis. It is essential that we remember to wield it wisely.
Big News

Nick Dubay (M1) and Kelly Anderson (M2)
Engaged: May 10th, 2017 in Omaha, Nebraska

Taylor Noel (M4) and Aleah Bond (M4)
Engaged: June 4th, 2017 in Nehawka, Nebraska
Atman Dave (PGY-1 UNMC) and Amanda Dave (M4)
Married: June 17th, 2017 in New York, New York

Scott Elson and Alisandrea DelCore (M4)
Married: June 24th, 2017 in Omaha, Nebraska