JulyAug 2025

AMERICAN ASSOCIATION OF MEDICAL ASSISTANTS.

Volume 58 | Issue 4

Medical Assisting Today

The Magazine for Professional Medical Assistants

Step Up to Overcome Gender Bias in Health Care

Published by the American Association of Medical Assistants®

Getting the Word Out

One evening last October, as I passed by a medical office here in Virginia Beach, I noticed something on their rolling sign that immediately caught my eye: "Medical Assistants: Bridging the Gap," followed by a thank-you to their medical assistants for all they do. I was so excited to see the AAMA's Medical Assistants Recognition Week (MARWeek) theme in public that I pulled into the lot, took a picture, and even took a quick video. Fast forward to last month—while going through some reminders—I recalled my intention to send a thank-you note to the practice manager for recognizing their medical assistants and to introduce myself. Life had gotten busy, and I had not followed through. But on that day, I decided to do something better: I stopped by the office with a sweet treat for their team of medical assistants and to personally thank the practice manager.

I am so happy I did this! The manager and I ended up talking for over an hour—about the AAMA, the 2025 AAMA Annual Conference in Arlington, Virginia, and the incredible value the AAMA offers in continuing education, networking, and both personal and professional growth.

What surprised me most from the conversations that day was that none of the medical assistants at the office realized that by being a member of the AAMA, they were also members of their state society—and were missing out on even more opportunities for continuing education and networking.

This made me wonder how many states are in the same boat. So, how do we get the word out? My advice: Take the risk. Start the conversation. Ask your coworkers whether they know about the AAMA. If they say yes, take it one step further—ask whether they know they are also part of their state society and possibly even a local chapter in their own backyard. One simple conversation can open a world of opportunities!

Do you have other ideas that could help the AAMA? There are so many ways to get involved! The AAMA offers a variety of committees, strategy teams, and task forces you can join.

Visit the **"Volunteer Opportunities"** webpage on the AAMA website. There, you'll find the **AAMA Volunteer Leadership Application**—download it, fill it out, and submit it by August 1. Whether you're interested in the Board of Trustees, the Continuing Education Board, or the Certifying Board, there's a place for your voice and passion.

Want to learn a little more information before committing? Check out the **"Volunteer Resources"** and the **"Leader's Center"** webpages. And read the ***Volunteer Leadership Position Descriptions*** document to learn more about each committee, strategy team, or task force and the time commitment involved.

So, what's your passion? What's your *why*?

I can't wait to hear your stories and see you all in person this September in Arlington, Virginia, for the AAMA Annual Conference!

Virginia Thomas, CMA (AAMA)

Virginia Thomas, CMA (AAMA)
2024–2025 President

AAMA® Mission

The mission of the American Association of Medical Assistants® is to provide the medical assistant professional with education, certification, credential acknowledgment, networking opportunities, scope-of-practice protection, and advocacy for quality patient-centered health care.

CMA (AAMA)® Certification

The CMA (AAMA) is awarded to candidates who pass the CMA (AAMA) Certification Exam. PSI Services LLC constructs and administers the exam. The CMA (AAMA) credential must be recertified every 60 months by the continuing education or exam method.

This publication printed on paper that contains 10% recycled content.

PRINTED WITH SOY INK

Medical Assisting Today (ISSN 1543-2998) is published bimonthly by the American Association of Medical Assistants, 20 N. Wacker Dr., Ste. 3720, Chicago, IL 60606. Periodicals postage paid at Chicago, Illinois, and at additional mailing offices.

Subscriptions for members are included as part of annual association dues. Nonmember subscriptions are $60 per year.

The opinions and information contained in *Medical Assisting Today* do not necessarily represent AAMA official policies or recommendations. Authors are solely responsible for their accuracy.

Publication of advertisements does not constitute an endorsement or guarantee by the AAMA of the quality or value of the advertised services or products.

Contact us at MarCom@aama-ntl.org or 800/228-2262.

Postmaster: Send address changes to AAMA Membership Department, 20 N. Wacker Dr., Ste. 3720, Chicago, IL 60606.

Candidates for the AAMA Board of Trustees

Vice President

Sherry Bogar, CN-BC, CMA (AAMA)
Together, we need to meet all members' needs, showcase our value to employers, and elevate our profession. Through teamwork and a shared vision, we will empower the AAMA to reclaim its leadership position for all medical assistants, drive excellence, boost membership engagement, and ensure long-term growth.

Vital Stats
Member: 2004; Certified: 2004

National Volunteer Teams

Chaired: Ad Hoc on Higher Education; Awards; HOD Minutes; Marketing; Membership Development; Social Media

Served: Speaker of the House; Vice Speaker of the House; Trustee; Annual Conference; Bylaws and Resolutions; Career Professional Development; Conference CE Sessions; Endowment; Leadership Development; Nominating; Partnership; Strategic Issues Planning

AAMA Awards: Medical Assistant of the Year (2018)

Speaker of the House

Claire Houghton, CMA (AAMA)
As medical assistants, we have embraced new technologies, protocols, and guidelines to ensure the highest quality of care for patients. Despite the uncertainties of the future, we are confident in our skills and dedication to continue serving patients and communities to the best of our abilities.

Vital Stats
Member: 2002; Certified: 2003

National Volunteer Teams

Chaired: Bylaws and Resolutions; Documents; Editorial Advisory; Leadership Development; Strategic Issues Planning

Served: Vice Speaker of the House; Trustee; Ad Hoc on Higher Education; Annual Conference; Educators Collaborative; Endowment; HOD Minutes; Marketing; Maxine Williams Scholarship; Membership Development; Test Construction

Jane Seelig, CMA-A (AAMA)
The AAMA needs to offer members education and benefits they find valuable and useful. To continue to represent our profession, we must find a way to attract and retain members with both the CMA (AAMA) and other credentials. We need to be an organization of inclusion and not restrict entry.

Vital Stats
Member: 1979; Certified: 1981

National Volunteer Teams

Chaired: 2011 Annual Conference Education; 2008 Annual HOD Tellers; 2014 Annual HOD Credentials; 2019 Annual HOD Reference; Awards; Bylaws and Resolutions; Documents; Leadership Development; Marketing

Served: Speaker of the House; Vice Speaker of the House; Trustee; Annual Conference; Career Professional Development; Conference CE Sessions; Endowment; Maxine Williams Scholarship; Membership Development; Nominating; Public Affairs; Strategic Issues Planning

Vice Speaker of the House

Aimee Quinn, BHA, CMA (AAMA)
Leadership takes strategy, heart, and bold moves—just like Yahtzee. As AAMA Vice Speaker of the House, I'll listen, lead with integrity, and amplify your voice. I'm committed to collaboration, growth, and advancing our profession. Let's roll the dice together—for progress, unity, and a future where every member thrives.

Vital Stats
Member: 2005; Certified: 2005

National Volunteer Teams

Chaired: Social Media

Served: Trustee; Bylaws and Resolutions; Documents; Marketing, Membership Development; Nominating; Partnership

Secretary

Shirley Sawyer, CMA (AAMA)
I want to be able to empower medical assistants through advanced education, career pathways, and greater recognition as vital health care team members. I will work to bring in new leaders to help foster leadership to elevate our profession and enhance patient care.

Vital Stats
Member: 1991; Certified: 1995

National Volunteer Teams

Chaired: Continuing Education Board; Career Professional Development; Conference CE Sessions; Editorial Advisory; Partnership

Served: Annual Conference; Assessment-Based Certificate; Bylaws and Resolutions; Documents; Educators Collaborative; HOD Minutes; Leadership Development; Maxine Williams Scholarship; Membership Development and Marketing; Nominating; Practice Managers; Reference

AAMA Awards of Distinction: Leadership and Mentoring (2018)

Trustee

Christa Smith, CMA (AAMA)
It is important to me to show our members quality, value, and learning. We continually need to show the quality and value to employers, that the AAMA is the professional organization for all medical assistants. By mentoring we are demonstrating learning. This is vital to the existence of the AAMA.

Vital Stats
Member: 1994; Certified: 1994

National Volunteer Teams

Chaired: 2024 Annual Conference Education

Served: Annual Conference; Leadership Development

Jeanette Tyler, BAS, CMA (AAMA)
My vision is to promote medical assisting as an essential profession in health care; unify all *medical assistants, regardless of credential, by demonstrating there is a seat at the AAMA table for all; and empower growth through collaboration, innovation, and benefits that strengthen the profession and community.*

Vital Stats
Member: 2009; Certified: 2010

National Volunteer Teams

Served: Annual Conference; Conference CE Sessions; Leadership Development; Social Media

Sandra Williams, CMA (AAMA)
My vision of the AAMA's future lies in actively connecting with all credentialed medical assistants. I propose a focus on identifying and mentoring passionate individuals and encouraging their professional advancement, including engagement at all available levels of the organization.

Vital Stats
Member: 1987; Certified: 1987

National Volunteer Teams

Chaired: Career Professional Development; Membership Development; Practice Managers; Strategic Issues Planning

Served: Trustee; Continuing Education Board; Annual Conference; Endowment; Leadership Development; Maxine Williams Scholarship

AAMA Awards of Distinction: Leadership and Mentoring (2019); Medical Assistant of the Year (2021) ✦

Your Deadline to Group Up

Reminder: AAMA Volunteer Leadership Applications are due by August 1.

You can find the application on the "Volunteer Opportunities" webpage, accessible via the teal "Join the AAMA" drop-down menu. Or simply search for "AAMA Volunteer Leadership Application" in the search bar. ✦

BOT Qualifications

Thinking of running for the AAMA Board of Trustees? Check the *AAMA Bylaws* on our website (on the "Leader's Center" webpage) to make sure you meet the requirements for nominations. Nominees have already been announced, but candidates may put forth nominations from the floor at the AAMA Annual Conference. Paperwork is due to the Speaker of the House and Nominating Committee Chair by Aug. 20.

Join the CEB!

The Continuing Education Board (CEB) is looking for experienced volunteers to continue its mission of developing and administering quality continuing education opportunities for medical assistants.

Overview: Responsibilities will include remotely assisting with CEB projects as needed throughout the year, as well as travel to three meetings in late winter or early spring, summer, and fall.*

Experience (preferred): The ideal candidate is a CMA (AAMA) who has worked in the medical assisting field for the past three years and has experience as both a state or chapter officer and a program planner.

For more information, download the AAMA Volunteer Leadership Application via the AAMA website.

**CEB members are reimbursed for travel to their annual meetings and are provided free lodging at the host hotels.* ✦

The Present and Future of the Medical Assisting Profession

Donald A. Balasa, JD, MBA
AAMA CEO and Legal Counsel

In the next 10 years, the number of medical assistants is projected to increase at a greater rate than the average rate of all other professions or occupations. This has been the case for at least 25 years.

Alternatives to medical assisting programs accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) and the Accrediting Bureau of Health Education Schools (ABHES) are increasing. These programs include the following:

- Training programs with less depth, breadth, and rigor than accredited programs
- In-house programs provided by health systems and clinics that offer simultaneous employment and training
- Programs in secondary schools
- Various apprenticeships
- On-the-job training

In general, medical assistants with less training than graduates of accredited medical assisting programs drive down the average remuneration for all medical assistants. Some employers may pay graduates of accredited programs more than they pay other medical assistants. However, this differential is often perceived as not large enough to justify the cost of accredited education. This is one reason why fewer medical assistants are choosing to enroll in accredited programs that are longer and more expensive than the aforementioned alternatives. This is also a reason why there is a shortage of accredited program graduates who are CMAs (AAMA)®.

The Feasibility of an Add-On Credential

A strategy for the CMA (AAMA) credential to regain market share is to position the CMA (AAMA) so that its holders are proficient in advanced tasks in addition to entry-level medical assisting tasks. This would differentiate the CMA (AAMA) from other medical assisting credentials.

The Certifying Board (CB) of the AAMA is exploring the feasibility of establishing an add-on credential to the CMA (AAMA) in intravenous initiations and discontinuations. The add-on credential would require the completion of a course in the theory and technique of IV starts and discontinuations. To be considered, a course would require the successful performance of a sufficient number of IV starts and stops on live subjects (i.e., to clinical competence). It would also require the passing of an exam on IV starts and stops offered by the CB. Those who complete the course and pass the exam would be able to add the letters "IV" to their CMA (AAMA). The full credential would be "CMA (AAMA)-IV."

The CB surveyed current CMAs (AAMA) and asked whether they would be interested in obtaining an IV credential as an add-on to the CMA (AAMA). A high percentage (95%) of the 10,000 current CMAs (AAMA) who responded to the survey answered in the affirmative.

The CB has issued to education providers (including accredited medical assisting programs) a request for proposal for a course in IV initiation and discontinuation for medical assistants. The CB will review any proposals it receives to determine which courses meet the CB's standards.

Significantly, the request for proposal would be for a course in IV *starts and discontinuations*, not for IV *infusion*.

If the CB identifies one or more courses in IV initiation and discontinuation that meet its standard, it will explore the feasibility of creating an exam on IV starts and stops that would result in an IV add-on credential to the CMA (AAMA).

State Law on IV Delegation

Six states permit medical assistants—who, in some of the six states, meet certain requirements established by law—to initiate IVs: Florida, Maryland, Montana, Washington, Texas, and Oklahoma. These IV legal provisions were not the result of efforts by the medical assisting profession in the six states. In Florida, the impetus for the Florida Board of Medicine to issue a 2009 opinion allowing physicians to delegate to medical assistants IV infusion was a request of a physician. As best as can be determined, the boards of medical examiners in the other five states did not oppose the legislation or regulations that permitted delegation to medical assistants of certain IV tasks.

Approximately 15 states forbid medical assistants from performing IV tasks.

Approximately 29 states' laws neither specifically authorize nor forbid medical

assistants to be delegated and to perform IV tasks.

The creation of a course and credential in IV initiation and discontinuation for medical assistants could result in boards of medical examiners and boards of nursing amending their regulations to allow medical assistants to be delegated IV tasks by (respectively) (1) physicians and physician assistants and (2) advanced practice registered nurses, particularly nurse practitioners.

If this occurs in some states, some providers would have an incentive to hire CMAs (AAMA)-IV.

Potential Impact

Some prospective medical assisting students who want to focus on the clinical aspects of medical assisting would want to attend a CAAHEP- or ABHES-accredited medical assisting program so they would be eligible for the CMA (AAMA) Certification Exam and subsequently for the IV add-on credential.

This would distinguish the CMA (AAMA) credential from all other medical assisting credentials and would likely result in CMAs (AAMA)-IV being paid more for their additional knowledge and skill in IV starts and stops.

If the CMA (AAMA)-IV comes to fruition and is successful, it may be prudent to determine whether other advanced add-on clinical credentials should be considered. It has been suggested that a credential in inserting urethral catheters may be a possibility. ✦

Questions may be directed to CEO and Legal Counsel Donald A. Balasa, JD, MBA, at DBalasa@aama-ntl.org.

Every year, we celebrate Medical Assistants Recognition Week (MARWeek) during the third full week in October:

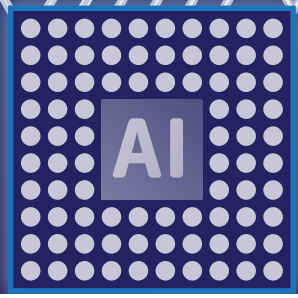
MARWeek: October 20–24, 2025

MARDay: October 22, 2025

The AAMA provides tools (i.e., promotional MARWeek packets and products) to help you celebrate medical assistants as true partners in health care. Visit the AAMA Store online in August to order.*

**Orders will be sent out through early October while supplies last. You may also download the MARWeek logo and materials, such as sample messaging, from the MARWeek webpage, which is found within the "Education and Events" tab.*

TO THE CORE



AI In the Classroom Introduces Unique Challenges

by Fred Lenhoff

In the age of artificial intelligence (AI), technological aids promise efficiency, insight, and innovation. Notably, common AI tools include ChatGPT, Gemini, and Microsoft Pilot, which use natural language processing to generate intelligent—and intelligible—responses to queries and help users draft everything from medical reports to texts.

But when do AI tools become not an aid to learning but a way for students (or professionals) to cheat? Do they undercut the challenges and gains of true education with a facile, superficial "knowledge?" Does AI undercut the core of education: "meaningful engagement that joins critical thinking to engender authentic intellectual growth?"[1] As any web search quickly uncovers, AI is still "learning," so the accuracy of information and citations can be suspect.

AI in the allied health curriculum raises questions about ethics in teaching, learning, and practice. These concerns become particularly critical in medical assisting—where professional communication, ethics, and empathy are foundational. As AI continues to transform health care, educators are asking: "How do we prepare students to work not only *with* AI but also *wisely* and *ethically* with AI?"

"At the end of the day, AI can never replace the care, compassion, and human connection that medical assistants bring to the table. But it is reshaping how we do our jobs," says Melody P. Gibson, BS, CMA (AAMA), CPT(ASPT), a program director of medical assisting and phlebotomy at Gaston College in Dallas, North Carolina. Students, she argues, need to become confident and comfortable navigating AI—not overwhelmed or left behind. The educator's job is to enhance medical assisting education to ensure that new technologies like AI are included in the curriculum.

The Future Is Now

AI is no longer the distant future—it is embedded in the tools, platforms, and workflows that health professionals use every day. From electronic health record (EHR) systems to software that manages billing, coding, referrals, and patient scheduling, AI is rapidly becoming part of the clinical infrastructure.

"If we don't get on board, we're going to get left behind," says Toni Coffman, CMA (AAMA), assistant professor of medical assisting at Santa Fe Community College in New Mexico. Indeed, increasing numbers of hiring managers and physicians are seeking AI skills among new hires.

Syncing Up

More and more medical assisting educators have begun integrating AI into the classroom. Jessica Blessinger, CMA (AAMA), CTTS, clinical lead preceptor and tobacco treatment specialist at Hancock Health in Greenfield, Indiana, emphasizes the value of AI for simulation-based learning. "It could give students an opportunity to have simulated experiences that are closer to real-world scenarios," she explains. "It will also allow for real-time feedback for both the educator and instructor."

Similarly, Karen Renee' McIntyre-Pearson, MHA-Ed, a PhD candidate and medical clinical assistant educator at Miller-Motte College in Wilmington, North Carolina, adds that AI can support diagnostic training and clinical proficiency by enhancing curriculum design and helping students engage with more complex medical scenarios, including issues on patients'

privacy and data information.

Other potential pedagogical paths for incorporating AI literacy into the curriculum include the following:

- An introduction to the basics of generative AI, chatbots, and their applications in health care
- Analyses of AI applications and real-life testing and evaluation of their usefulness and reliability
- Interactive exercises using AI to aid learning by creating personalized study plans or brainstorming projects
- Simulated AI patient scenarios to support communication training based on mock clinical situations, triage exercises, and EHR documentation tasks
- Projects using chatbots to build outlines or presentations—with the caveat that students must verify accuracy and cross-reference sources
- Exploration of AI ethics with regard to bias, equity, regulatory compliance, misinformation, and professional responsibility—often in partnership with experts from other academic departments (information technology, for example) as well as medical ethicists, legal experts, and campus librarians

Moreover, new educational models emphasize the need to treat students as collaborators in educational transformation. Including their voices can ensure that AI education is relevant, reciprocal, and respectful.[2]

Tech with a Byte

AI should be used as a tool for learning rather than the avoiding of learning. Indeed, some prefer the term "augmented" versus "artificial" intelligence to underscore the tool-like nature of AI and the need for human control for appropriate use.[3]

Although Coffman admits she might be optimistic, she believes that most students—if shown trust and respect—will not use AI for unethical ends. "In health care, you can't cheat," she says. At the institution level, a new school policy allows educators at her school to tailor AI use (zero, moderate, or full use) to their educational objectives and teaching style. Most educators are choosing the zero option—most likely, she thinks, due to fear, skepticism, and lack of understanding. That said, the appropriate use of AI can make students' and teachers' lives easier. For example, Coffman recently used ChatGPT to revamp outdated lesson plans.

Amanda Sturgill, PhD, an associate professor of journalism at Elon University in North Carolina who researches the intersection of AI and engaged learning, warns that overreliance on AI risks reducing education to mere performance, where students comply with tasks rather than engage in genuine inquiry.[4]

Erik Winero, an educator and researcher, explains that the central issue is deeper than technology—rather, it is our perspective on education and its value (e.g., the focus on achieving a goal, such as a good grade, as a valid reflection of learning).[5]

Winero uses the sport of pole vaulting as a metaphor for a technological enhancement that radically changes the game. The development of flexible poles to replace wood made reaching previously unimaginable heights possible. "If generative AI can be used as a flexible pole to help our students overcome even higher obstacles, then surely that's a good thing," he says.[6]

Or is it? Technical enhancements can create the illusion of learning, authenticity, and authority. Winero argues that learning is an individual and individualized struggle and can and should be challenging, complicated, and sometimes confounding. In other words, no resistance, no learning. AI is like learning—you only get out what you put in.[6]

This underscores the need for educators to teach not only AI *tools* but AI *judgment*:

- When and how to use AI ethically
- How to verify output, sources, and accuracy
- How to balance AI use with professional standards

In health care, where the stakes are high and misinformation can cause real harm to patients, these skills are indispensable. ✦

For additional information and resources on AI, email FLenhoff@aama-ntl.org with "AI" in the subject line.

Trust the Process(or)?

Machine-intermediated communication may be as momentous as the move from oratory to written communication millennia ago. But today's societal transformation in information sharing and dissemination is happening over months and years, not decades or centuries.

The spread of AI is, therefore, not merely a technical challenge—it is a cultural, ethical, and cognitive transformation for society at large.

For these reasons, educators must teach AI not as a shortcut but as a tool for deeper engagement, critical thinking, and professional excellence. For the medical assisting profession, the future belongs not to AI but rather to those who can use it with care, competence, and compassion.

References

1. Sturgill A. When education becomes performative, learning suffers. *Center for Engaged Learning* blog. Elon University. February 21, 2025. Accessed June 15, 2025. https://www.centerforengagedlearning.org/when-education-becomes-performative-learning-suffers
2. Students as partners. *Center for Engaged Learning* blog. Elon University. Accessed June 15, 2025. https://www.centerforengagedlearning.org/resources/students-as-partners/
3. Vinter R. Artificial vs augmented intelligence: what's the difference? Braidr. February 2, 2023. Accessed June 15, 2025. https://braidr.ai/blog/augmented-vs-artificial-intelligence-whats-the-difference/
4. Sturgill A. AI and anxiety: perspectives from higher education. *Center for Engaged Learning* blog. Elon University. November 15, 2024. Accessed June 15, 2025. https://www.centerforengagedlearning.org/ai-and-anxiety-perspectives-from-higher-education/
5. Cheating or learning? walking the AI tightrope in education. TedX Talks. December 1, 2023. Accessed June 15, 2025. https://www.youtube.com/watch?v=mEtAfbFr6RE

Driven Resistance to Alzheimer Disease Development

The risk of death due to Alzheimer disease is "lower for taxi and ambulance drivers than for other occupations with a similar mean age at death," finds research published in the *BMJ*. The study's authors speculate that these drivers develop structural changes in their brains as they work.

The key differentiator? Unlike the other 441 occupations analyzed by the researchers, these jobs require navigation and spatial processing skills.

The study, as profiled in a recent Harvard Health Publishing newsletter, states that taxi and ambulance drivers are "much less likely" (more than 40%) to die an Alzheimer disease–related death.

The protective benefit does not extend as readily to other transportation workers, such as aircraft pilots and ship captains, who had some of the highest Alzheimer disease–related death rates.

Well, Owl Be!

Those who identify as night owls may be more prone to developing depression, according to a study in *Plos One*. The results point to opportunities for improved mental and behavioral health interventions, especially given the "high (and increasing) prevalence of depression and anxiety amongst young adults," the authors note.

The study, comprising 546 university students in the United Kingdom, found that those who preferred evenings had higher levels of depression symptoms versus their counterparts who favored mornings. These symptoms include poorer sleep quality with increased sleep debt and daytime fatigue.

Night-owl individuals also had lower levels of "acting with awareness," an aspect of mindfulness; meanwhile, results indicated a protective role "acting with awareness" offers against poor mental health. The authors recommend increased attention to this aspect in mindfulness interventions to enhance the interventions' efficacy and impact.

The Staffing/Quality Link

The type of clinician staffing (i.e., physician versus advanced practice providers) can affect patient quality of care for specific conditions, finds a study in *JAMA Network Open*. The authors conclude that "tailored approaches to health center staffing based on community-specific needs are warranted."

The study comprised patient data from 791 health centers nationwide. The researchers identified five distinct clinician staffing models, based on clinician staffing ratios, expressed as the fraction of full-time equivalents (FTEs) of physicians, advanced practice registered nurses (APRNs), and physician associates (PAs).

Next, they analyzed the staffing models' impact on quality of care for 14 different clinical quality metrics. Of the 14 metrics, half were associated with the staffing model: "physician FTE ratio was associated with higher performance in cancer screening, infant vaccinations, and HIV testing; APRN FTE ratio was associated with higher performance in preventative health assessments; and PA FTE ratio was associated with higher performance in infant vaccination."

The authors note the research's policy and practice implications—for example, the need for flexibility in the scope-of-practice laws between and within states to ensure appropriate staffing of non-physician practitioners—and the importance of staff hiring decisions based on care quality (especially as value-based care reimbursement models become more common).

Climate Change Shortchanging Future Generations

A new study by climate scientists from the Vrije Universiteit Brussel, profiled in *Science Daily*, highlights the public health risks for millions of children as they face a future of "unprecedented lifetime exposure to heatwaves, crop failures, river floods, droughts, wildfires and tropical storms under current climate policies."

The study also underscores the disproportionate threats to children in low-income countries. Indeed, many of these countries are particularly susceptible to increased weather-related disasters that are the result of higher temperatures and the global rise in sea levels.

These large-scale threats will have significant health impacts on many individuals. The health repercussions of climate change are well documented, including heatstroke, worsened respiratory conditions and allergies (resulting from air pollution and the spread of infectious diseases), and mental health conditions from climate change–related stress and displacement. In 2022, the American Medical Association adopted a new policy that declared climate change "a public health crisis that threatens the health and well-being of all individuals."

Step Up to Overcome Gender Bias in Health Care

By Mark Harris

The goal of modern medicine is to prevent, treat, and relieve suffering caused by illness and disease. As such, the health care system strives to deliver high-quality patient care, promote wellness, and improve quality of life.

Aligned with these goals, an important principle in health care is the concept of health equity. This concept means that everyone has what the Centers for Disease Control and Prevention (CDC) describes as a "fair and just opportunity to attain their highest level of health."[1]

But health systems face many hurdles and challenges on the road to achieving health equity. These include broad societal or nonmedical factors—known as social determinants of health—that can influence access to care and health outcomes. Economic stability, the accessibility of quality health care and education, neighborhood and community safety, family relationships, and one's social context can all affect health equity.[2]

Accordingly, a lack of job opportunities, exposure to domestic or community violence, limited access to nutritious foods and physical activity, racism, discrimination, and language and literacy barriers are among influences that can contribute to health care disparities.[1]

Barriers to Health Equity for Women

Gender bias is another significant barrier to health equity. This involves disparities that women, including transgender and non-binary individuals, may encounter in the course of receiving medical care and treatment. Two major facets of gender bias in health care are (1) the history of cis-male-focused research and (2) the prevalence of women's health concerns or symptoms being dismissed, underdiagnosed, or misdiagnosed by clinicians.

Exclusion from Research

In the past, women were often excluded from clinical research studies. As a result, the historical focus on male research subjects has led to gaps in understanding the full impact of some medical conditions and treatments on women.

To some degree, the earlier exclusion of women from clinical studies reflected a time when few women in science or medicine were in clinical or research leadership positions. But,

in the United States, there was another factor. In 1977, the Food and Drug Administration (FDA) recommended women of childbearing age, even those who used contraception or were single, be excluded from Phase 1 and early Phase 2 drug trials. The policy reflected concerns over potential drug harms, particularly the serious harm caused by the drug thalidomide, a sedative that had been widely prescribed for morning sickness to pregnant people in Europe and Canada in the 1950s and early 1960s. The drug was later linked to thousands of severe birth defect cases.[3]

Consequently, it was not until 1993 that the U.S. Congress passed legislation requiring the inclusion of women and minorities in clinical trials funded by the National Institutes of Health (NIH). Today, NIH-funded research must be designed to also ensure the results show whether the variables under study affect women and minorities differently than other trial participants.[4]

Unsatisfactory Interactions

An important aspect of quality care is the degree to which patients feel satisfied with their health care providers. Is the patient-provider relationship based on mutual respect, open communication, and shared decision-making? Does the patient feel the provider actively listens to their health concerns? Are they empathic? Do they respond with informed, timely, and appropriate treatment recommendations?

Unfortunately, women are more likely to report negative health care encounters than men. According to the 2024 KFF Women's Health Survey, 23% of women report being treated unfairly or with disrespect by a physician, health provider, or staff. Men also report negative experiences, but to a somewhat lesser degree (18%). Notably, more Black (26%) and Hispanic (25%) women report disrespectful or unfair treatment than White (21%) women.[4]

Of course, there can be many reasons for a dissatisfying encounter with a provider. The KFF survey cited weight as the most common reason patients felt disrespected or unfairly treated. 9% of women cited gender as the principal reason for feeling disrespected. A significantly larger share of the LGBTQ population, women with disabilities, and those in a low-income category also reported negative encounters with providers.[4]

Maternal Health

Poor communication can worsen maternal health outcomes[9]:

- Pregnant women may find it hard to ask questions or share concerns. Maternity care providers can improve communication by creating an environment of trust.
- Providers can take time to really hear women's concerns and have an open conversation to make sure any issues are adequately addressed.
- When there is good communication about health concerns between moms and providers, it is more likely there will be accurate, timely diagnoses and treatment for potentially life-threatening pregnancy complications.

A 'Man's Disease'?

The culmination of these two facets of gender bias is exemplified in cardiovascular care. The health system tends to be weighted toward the male experience of how a person experiences a heart attack, observes Ambika Eranki, MD, MPH, AAHIVS, an infectious disease specialist at the University of South Florida Health in Tampa, Florida.

"In popular culture, a heart attack is often portrayed as a very male-centered event in which the man just clutches his chest and keels over, and there you go, he's having a heart attack," she says. "But the outcomes for women who have cardiac events are actually poorer because of these underlying gender biases. Women tend to have more subtle symptoms of cardiovascular events, and they are labeled as 'atypical' because the male experience is considered the norm. Oftentimes, women delay seeking out care for cardiovascular events and end up having poorer outcomes because there's a delay in diagnosis and treatment."

These observations likely resonate with the experiences of many women with heart disease. "Generally, we do think of a heart attack as that elephant sitting on your chest," says Denise Sullivan, CMA (AAMA), ABC-AHE, an onboard instructor in human resources for Northern Light Health in the Bangor, Maine, region. "But we know with women the symptoms can be very different from men. They might involve nausea and vomiting; sudden extreme fatigue; jaw, back, or shoulder pain; and other less obvious symptoms."

As a heart disease patient, Sullivan is especially sensitive to the unique needs of female cardiology patients. As a supporter of WomenHeart, a leading peer support organization for women living with or at risk of heart disease, Sullivan regularly shares her story and advice on living with heart disease with other women and groups. A *WomenHeart Champion*, Sullivan has completed the group's patient advocate and educator training program in conjunction with the Mayo Clinic in Rochester, Minnesota.

Her medical story includes quadruple bypass surgery at the age of 47 and later a transcatheter aortic valve replacement. A passionate advocate for women's health needs, Sullivan recognizes that women's concerns about heart issues can sometimes be dismissed or overlooked. In turn, she emphasizes how important it is for women to seek out providers who will listen carefully and respectfully to their health concerns.

Similarly, Sullivan also emphasizes how vital clinic staff listening skills are to patient interactions. "For medical assistants, just really listening to the patient is so important," she says. "What you write down in the pre-examination or when checking in the patient—don't think [it's] something not important just because you've heard it before. If we've heard it before, we probably should be listening better. You can help the provider in this by bringing some concerns to their attention. These days, health care providers can move around, and patients very often don't see the same health care provider. The continuity of care is not always there. If the medical assistant knows that a patient is seeing a different provider than usual, they can make sure the provider is aware of certain issues or health complaints that may not have been resolved."

Respectful Maternity Care

While measures of health equity and quality care are universal concerns in medicine, these concerns come into particular focus in reproductive health care.

"We know there is a plethora of evidence and anecdotal reports of delays to diagnosis, misdiagnoses, and dismissal of women's health care concerns," says Lucy Bucher, DO, an ob-gyn and the vice president of clinical affairs at OhioHealth O'Bleness Hospital in Athens, Ohio. "For one particular condition, endometriosis, the average time from first voicing concerns about the symptomatology related to endometriosis to getting a diagnosis is seven years, which is just absurd."

Fortunately, a developing care model known as *respectful maternity care* (RMC) is increasingly recognized for its emphasis on a rights-based framework of maternity care. This is a patient-centered model of care built on the respect for the rights of women during pregnancy and postpartum, recognizing the harm caused by disrespect, mistreatment, and abuse during pregnancy and postpartum. The RMC model emphasizes criteria for respectful care, such as patient privacy, informed consent, dignity, safety, and equitable care. The value is on patient-provider relationships informed by good communication and a fundamental regard for the patient's well-being.[5]

The value of respectful care for all pregnant people is especially important in the context of a worsening U.S. maternal health crisis, says Amy G. Cantor, MD, MPH, FAAFP, a professor of medicine in the medicine, family medicine, and obstetrics and gynecology departments at Oregon Health & Science University (OHSU) in Portland.

"Maternal morbidity and mortality in the United States are higher than any similar country, with even higher rates among Black women," says Dr. Cantor. "Increased awareness of maternal health disparities in the United States has led to urgent calls for changes in health care delivery that improve safety, eliminate racism, and improve health outcomes for all who are pregnant and postpartum. Although many factors contribute to maternal health disparities between the United States and other high-resource

countries and within the United States, particularly between White and Black women, there is increasing attention to the role that [RMC] may play in shaping these outcomes.

"There are many factors that contribute to substantial disparities in maternal morbidity and mortality for Black women," adds Dr. Cantor. "While there is general agreement that clinicians have moral and ethical obligations to treat birthing people with dignity and respect, emerging research suggests that mistreatment during childbirth plays a prominent role in maternal health disparities. A 2023 CDC survey described that 1 in 5 women recalls experiences of mistreatment during maternity care. Lack of respectful maternity care, or disrespectful care, has been identified as part of systems' failures leading to worse outcomes among those who are the most vulnerable during childbearing. The failure to listen or failure to respond to concerns or symptoms of pregnant or birthing people is a central factor associated with an increased risk for severe maternal illness or death."

As Dr. Cantor notes, the disparities in maternal health outcomes take on even more significance as they occur in the context of an already poor comparative U.S. standing in global measures of maternity care. In turn, the RMC model represents an emerging response to an important component of health equity in women's health care.

"Respectful maternity care has been described extensively throughout the literature and has become recognized in the obstetric community as a strategy to improve patient care and reduce maternal health disparities, but a consensus around a common definition is needed," explains Dr. Cantor, principal investigator for a recent OHSU-led study on RMC in *Annals of Internal Medicine*.[5]

"Mistrust in the medical system is a huge problem," remarks Dr. Cantor. "This ranges from how patients relate to their personal clinicians to how they interpret scientific evidence and guidelines. There is so much misinformation lately that it is up to the scientific community to uphold standards that are based on strong evidence and also to call out areas where there are gaps and where we need more research."

Dr. Cantor identifies several key aspects of RMC:

- Recognizing the unique needs and preferences of women and families
- Protecting patients from harm or mistreatment
- Providing care based on dignity and respect for autonomy
- Providing information to facilitate informed choices that are respected
- Supporting individuals and their needs in the labor and delivery context
- Facilitating connectedness between these individuals and their babies and families

"None of this can occur without trusting and respectful relationships in the health care setting," she adds. "And RMC is one important strategy for moving this forward."

Funded by the Agency for Healthcare Research and Quality, the OHSU-led study provides a framework for further research and work in this area. "Clinicians who provide pregnancy care can use this report to help inform a clearer understanding of strategies to measure how health systems are doing in the context of RMC, including the impact on maternal health outcomes and patient experiences," says Dr. Cantor. "Unfortunately, unconsented procedures, poor communication, and failure to listen or failure to respond to concerns or symptoms of pregnant individuals are key factors framed within *disrespectful* care and associated with an increased risk for severe maternal illness or death. Collectively, clinicians can use strategies such as shared decision-making to engage patients and families in care decisions to improve patient autonomy and document consent to improve equity along the care continuum."

As many experts acknowledge, a patient-centered approach is a critical driver in efforts to reduce barriers to equitable maternity care.

"The patient's experience is central to how the implementation of RMC impacts care decisions and leads to clinical outcomes," emphasizes Dr. Cantor. "Results of our review signal the need for a careful consideration of respectful care for all childbearing individuals—with particular attention to racial disparities and populations at risk for experiencing discrimination—to inform culturally competent care as well as safe maternity care systems. These failures have been characterized as 'dismissal'—proposed as one of three leading racism-related drivers of U.S. maternal mortality that include 'denial, delay, and dismissal.' As a fundamental driver of disrespect, these factors should be examined both as an underlying contributor to maternal health disparities and overall rates of maternal morbidity and mortality in the United States. While mortality is the most severe outcome, the examination of RMC raises questions beyond death to include the consideration of a person's humanity across the childbearing cycle."

Addressing Implicit Bias

Another barrier to health equity involves the issue of implicit bias. This involves the more subtle or unconscious forms of bias or discrimination that people may display toward others.

"We know there's explicit bias, which is basically overt racism, sexism, homophobic attitudes, and other actions or behaviors on the part of individuals or even organizations," says Dr. Eranki. "But then there's this more insidious thing called *implicit bias*, which essentially means the subconscious attitudes that people have. Most people have at least a few intrusive biases. These are unconscious

Heart Disease

Several factors contribute to why women with heart disease are misdiagnosed[10]:

- Medical bias and outdated research
- Gender stereotypes in medicine
- Cultural norms that discourage women from speaking up

attitudes or stereotypes that can lead to unintended consequences."

Health care professionals must be aware of implicit bias and its potential to affect patient care, says Dr. Eranki, who is also an assistant professor at the University of South Florida. "There is actually a lot of research on implicit bias in health care," she notes. "What that data shows—and this has held true for many years—is that White patients get preferential treatment over patients of color. This has been proven in multiple settings. This can lead to disparities both in how or how often people seek out needed medical care, their access to medical care, how the provider communicates with the patient, and the overall quality of care."

As Dr. Eranki notes, implicit bias can influence many aspects of patient care, from decisions regarding pain management and other treatment decisions to preventive care issues such as whether a provider offers someone a colonoscopy or mammogram.

"There are interventions that have been proposed to mitigate or to at least counteract some of these implicit biases," says Dr. Eranki. "The problem is it's not easily measurable. There are scales or tools that have been developed; the most famous one comes out of Harvard [i.e., Project Implicit[6]] that has been used by researchers to try to measure implicit biases in health care provider groups. Some groups have looked into providing trainings on implicit bias, either in-person or virtual, as part of medical training. But the data is not that promising on whether this actually works. There's no easy answer to this issue."

In terms of countering gender bias, Dr. Eranki believes the availability of more female clinicians can help create more equitable care for women. "There is data in the past several years that shows women providers and clinicians tend to have better health care outcomes, both in ambulatory and in-patient settings. This is important especially in a clinic setting. It's been shown that women providers actually take more time than male providers to sit down and listen to their patients' concerns. Not to generalize, but the data has shown this objectively. Finding a woman provider would be another strategy I would recommend."

If there are no straight paths to address implicit bias in health systems, that does not mean health care professionals are powerless to effect change. "I think the onus falls on us as providers to actually be aware that implicit bias even exists, and then to try to address it," says Dr. Eranki. "Especially those of us who are teaching medical students or other students in health care, we have to make a conscious effort to actually be inclusive in how we train them so that their biases are not magnified as they're going through their training."

Indeed, the health system's response to implicit bias and other barriers to health equity is complex, intersecting as it does with often entrenched cultural and social influences. In today's challenging times, this is all the more reason perhaps why health care professionals should persevere in pursuit of their improvement goals in women's health care.

"Longstanding inequities in the way that health care is accessed, received, and experienced are the result of interactions between individuals, clinicians, health systems, and society at various levels," remarks Dr. Cantor. "All of these factors affect the quality and experience of care. Some institutions have or were previously incorporating bias training as an expectation for their health care workforces. I can't speak to how those efforts are going in our current environment. But perhaps now, more than ever, it is vitally important for the health and safety of all patients to have this as part of staff training so efforts to achieve health equity are elevated and not undermined."

Patient Voices, Patient Advocacy

Certainly, health care providers want good outcomes for their patients—and for patients to be satisfied with the care they have received. Ideally, the health system should provide equal opportunity for everyone to achieve their best health.

And yet, any and all patients can take practical steps to ensure their needs are properly addressed and to best advocate for themselves as patients.

To ensure their questions and concerns are addressed, Dr. Bucher tries to talk to her patients about the importance of preparing for appointments. "If you can take some time to prepare beforehand for your visit, that can be helpful," she suggests. "Think about the questions you may have and write them down ahead of time. Document your symptoms clearly and concisely. It can also be really beneficial to bring a second pair of ears, a trusted support person, a family member—whomever you can bring with you. Oftentimes, having two sets of ears is better than one."

As a physician, Dr. Bucher does not want any patient leaving an appointment feeling unheard. "If you feel like you're not being heard at your appointment, try to think about the language you need to address that concern. You might try to restate your question or concern in a way that highlights what's important about it to you. An evaluation or treatment plan for a particular health concern can rest on how impactful it is to the patient's day-to-day life. So, for example, 'I know my headaches are impactful because they're causing me to miss work three times

Resources

Interested to learn more?

Center for Women's Health at Oregon Health and Science University
https://www.ohsu.edu/womens-health

OhioHealth Women's Health
https://www.ohiohealth.com/services/womens-health

WomenHeart: The National Coalition for Women with Heart Disease
https://www.womenheart.org

Association for Women in Science: Fighting Gender Bias
https://awis.org/fighting-gender-bias

a month. What can we possibly do?' Couch your concerns in a way that highlights their importance and the impact on you."

In terms of follow-up, Dr. Bucher also suggests that patients review their records for their visits. "You have a right to view your medical records," she remarks. "You can review your records after the visit, and see the notes and laboratory results. Make sure you understand what's in that note. Does it confirm what you remember about the visit? Are there things that don't make sense? If so, then follow up on them. This is advice I would give to anybody to guard against that sense of not feeling heard."

"What I've learned is that you really do have to advocate for yourself," says Sullivan. "If you go to a physician or a provider, and they don't seem to listen, go to someone else. With heart health especially, if you have a symptom or you just feel something's not right, you suddenly break out in a cold sweat or have unusual back pain for example, don't dismiss it. You know when something's not right. It's your body. Nobody knows it as well as you do. Do not just say, 'Well, they said it's all in my head or it's just indigestion.' Women are so worried about going to the emergency room and being told they're fine that [*that*] can prevent them from going."

If a patient is frustrated with their care, they should know they can take steps or make other choices, says Dr. Bucher. "Trying to navigate the health care system, you always have the opportunity to try and make your voice heard. If you don't feel like your health care providers or team is advocating for you, or that you're not being heard, there are options. You can ask about patient advocate options, for example. So, there are ways to escalate these concerns. While it can feel uncomfortable in the moment, it's super important."

More generally, Dr. Eranki encourages patients to research their rights and what health services are available to them. To note, a patient advocate is someone assigned to support a patient in their health system interactions. They may accompany a patient to appointments, take notes, assist with questions, and otherwise ensure the patient's concerns are being appropriately addressed. Many hospitals and health systems have trained patient advocates available upon request.[7]

Address *All* Gender Bias

The American College of Physicians (ACP) recognizes that women's health requires proactive and empowered patient-care approaches. The 2018 ACP Position Paper, "Women's Health Policy in the United States," acknowledges that biological and social factors can lead to differences in disease expression and treatment between men and women. For this reason, the ACP encourages the medical community's ongoing consideration of the impact of sex and gender in its approach to women's health care.[8]

These considerations need to take into account every group impacted by gender bias, urges Dr. Eranki. "Gender bias in itself is already a very significant issue that affects not just cis-gendered heterosexual women but, of course, gender minorities," she notes. "I think probably some of the most disadvantaged persons among these are transgender [or] non-binary individuals. When you add racial and ethnic and socioeconomic disparities to that mix, it gets magnified significantly."

Toward a Bias-Free Future

Due to turmoil over funding of public health and research programs, uncertainty about the future of the health system is perhaps greater than ever. Yet historic efforts to advance health care equity and to improve women's health care are also ongoing and not without success.

Obviously, the medical community alone cannot solve all of these challenges. Nevertheless, health care professionals can play a valuable role in promoting greater awareness of gender bias, including the ways implicit bias and prejudicial attitudes may impair the quality of women's health care. Working together, health care teams can also do a lot to counter the negative impact of gender bias on patient care and organizational cultures.

Despite the hurdles and barriers to progress, providers must continue to work for a more equitable health care system. Women's health care advocates' expertise, dedication, and vision should be a source of hope for the eventual achievement of a health care future free of gender bias. ✦

The CE test for this article can be found on page 28.

References

1. What is health equity? Centers for Disease Control and Prevention. June 11, 2024. Accessed June 15, 2025. https://www.cdc.gov/health-equity/what-is/index.html
2. US Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Healthy People 2030: Social Determinants of Health. Accessed June 15, 2025. https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health
3. NIH inclusion outreach toolkit: how to engage, recruit, and retain women in clinical research. National Institutes of Health. Updated April 24, 2024. Accessed June 15, 2025. https://orwh.od.nih.gov/toolkit/recruitment/history
4. Gomez I, Frederiksen B, Salganicoff A. A closer look at negative interactions experienced by women in health settings: findings from the 2024 KFF Women's Health Survey. March 12, 2025. Accessed June 15, 2025. https://www.kff.org/womens-health-policy/issue-brief/a-closer-look-at-negative-interactions-experienced-by-women-in-health-settings-findings-from-the-2024-womens-health-survey/
5. Cantor AG, Jungbauer RM, Skelly AC, et al. Respectful maternity care: a systematic review. *Ann Intern Med*. 2024;177(1). January 2, 2024. Accessed June 15, 2025. https://www.acpjournals.org/doi/10.7326/M23-2676
6. Project Implicit. Harvard University. 2011. Accessed June 15, 2025. https://implicit.harvard.edu/implicit/index.jsp
7. Use an advocate or be an advocate for others. The Joint Commission. Accessed June 15, 2025. https://www.jointcommission.org/resources/for-consumers/take-charge/use-an-advocate-or-be-an-advocate-for-others/
8. Daniel H, Erickson SM, Bornstein SS. Women's health policy in the United States: an American College of Physicians position paper. *Ann Intern Med*. 2018;168(12). May 29, 2018. Accessed June 15, 2025. https://www.acpjournals.org/doi/10.7326/M17-3344
9. Many women report mistreatment during pregnancy and delivery. Centers for Disease Control and Prevention. Updated September 29, 2023. Accessed June 15, 2025. https://www.cdc.gov/vitalsigns/respectful-maternity-care/index.html
10. "Ms. Diagnosed": why women's heart disease symptoms are often overlooked. Accessed June 15, 2025. WomenHeart. https://www.womenheart.org/womens-heart-disease-symptoms-overlooked

Available on the e-LC and in hard copy!

Introduction to Nutrition

16 AAMA CEUs
(12 clin, 4 gen)

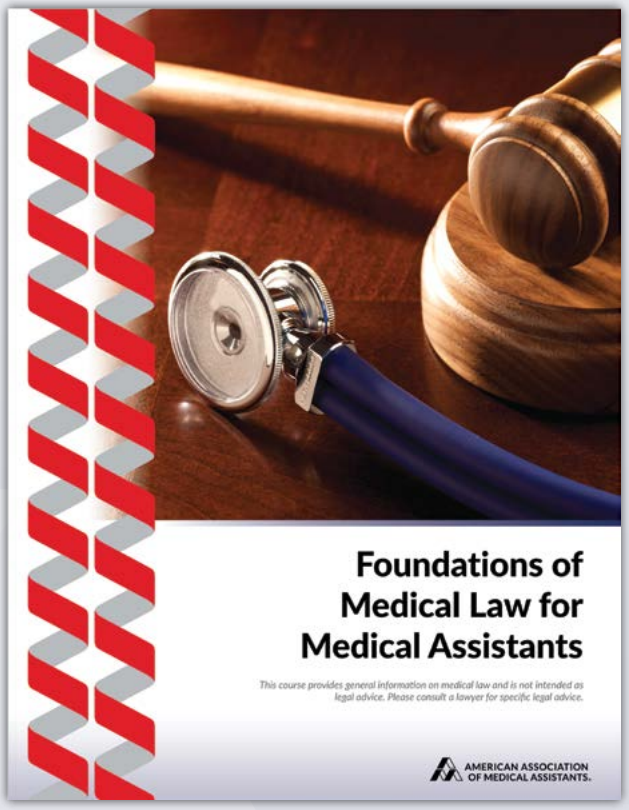
Available in print and 10% discounted digital option

Scan code to see purchase options:

AMERICAN ASSOCIATION OF MEDICAL ASSISTANTS®

Available on the e-LC and in hard copy!

Medical Law



25 AAMA CEUs
(gen/admin)

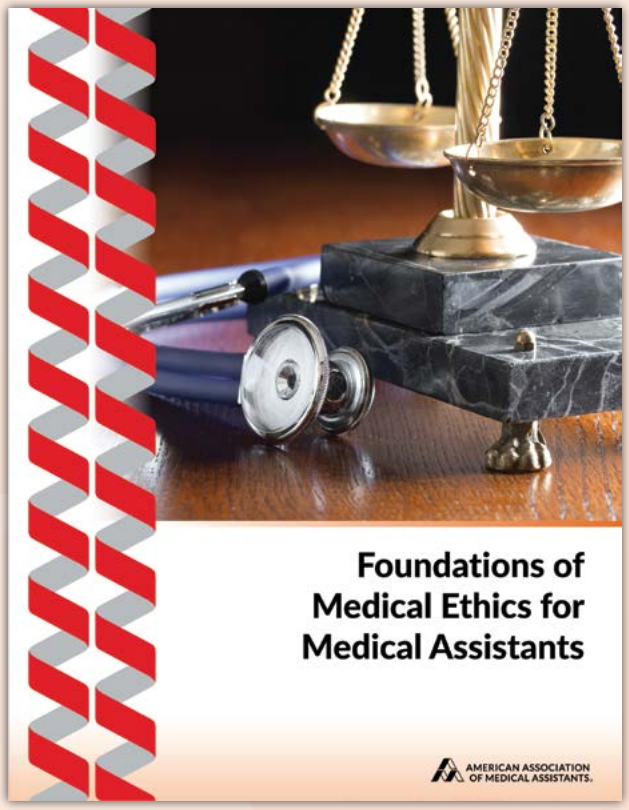
Explore essential legal concepts for health care professionals:

- Scope of practice
- Professional negligence
- Medical malpractice
- Workplace laws and regulations

And examine emerging legal trends:

- Telehealth
- Genetic privacy
- Cannabis
- Artificial intelligence

Medical Ethics

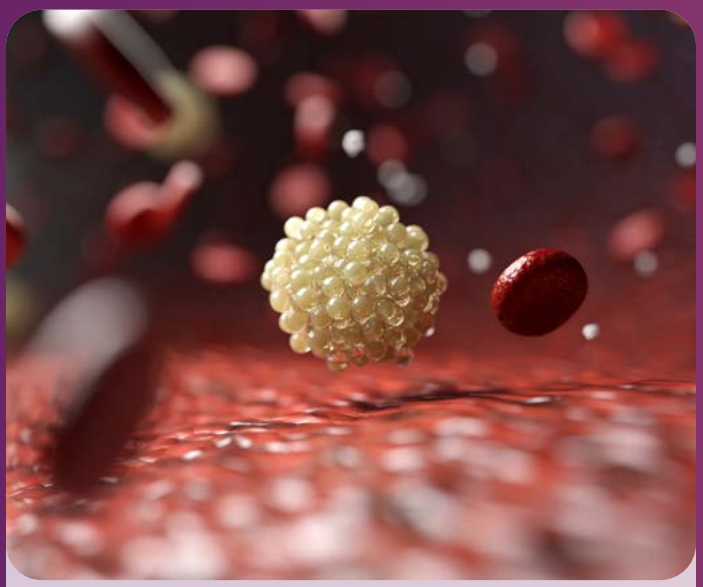


15 AAMA CEUs
(gen/admin)

Take a detailed look at professional, medical ethics for medical assistants and other health care professionals:

- The evolution of medical ethics and bioethics
- Cultural competence
- Personal vs. professional ethics and moral conflicts
- Ethical issues in emerging technologies
- The functions of health ethics committees
- Case studies based on the AAMA Code of Ethics

Available in print and digital options



Keep Cholesterol at Bay

Shore up your health status by tracking and monitoring your cholesterol levels, which can affect many cardiac ailments, from heart disease and stroke to peripheral artery disease. Follow these simple steps to make waves in improving your heart health, as recommended by Mayo Clinic:

- **See where you stand:** A cholesterol test (also known as a *lipid panel* or *lipid profile*) is a blood test that measures fat and cholesterol. Fasting is required for the most accurate results. Have cholesterol checked every five years, beginning at age 18, unless you have a history of obesity or diabetes or a family history of heart disease that necessitates more frequent testing.
- **Accentuate the positive; eliminate the negative:** Remember, not all cholesterol is unhealthy. High-density lipoprotein cholesterol is good cholesterol; it collects excess cholesterol in the blood and transports it to the liver for removal from the body. Meanwhile, low-density lipoprotein cholesterol can accumulate within the artery walls, leading to a heart attack or stroke.
- **Make your plate great:** Decrease saturated and trans fats in your diet by limiting red meat and dairy products made with whole milk. Also, increase your intake of fruits, vegetables, whole grains, poultry, fish, and nuts, while hitting the brakes on sodium, sugar, and fried foods.
- **Work it:** Increased physical activity offers a host of health benefits, not the least of which is improved cholesterol numbers. Make your goal a minimum of 150 minutes of physical activity per week.
- **Smoke out:** Smoking and vaping lowers good high-density lipoprotein cholesterol.

Destressing 101

We all lament the stress in our lives—from heavy traffic disrupting our schedules to ongoing demands from family and careers. Stress not only takes an emotional toll but also can fuel adverse heart health down the road.

Stress causes persistent, low-grade inflammation in the body, increasing risks to cardiac health. Stress also drives unhealthy behaviors—like eating unhealthy food, smoking, or using alcohol or drugs—that can lead to additional heart damage.

Shift into a better gear with these five simple steps to mitigate stress and its many negative effects, as suggested in Harvard Health Publishing.

- **Laugh a lot:** Share a giggle or guffaw with friends or find some online hilarity to lighten the mood and brighten your day. Laughter lowers levels of stress hormones and reduces inflammation in the arteries.
- **Get your "om" on:** Take time for meditation, mindfulness, prayer, or spiritual reflection, and reap the psychic and physical benefits, such as lowered blood pressure.
- **Move it:** Both extrinsic and intrinsic exercise (going to the gym versus taking the stairs or biking to work) help release mood-elevating endorphins and provide significant health and stress-relieving benefits.
- **Sign off:** Remember life without constant cell phone calls, text messages, social media, emails, and apps? Turn off the information firehose for a few minutes or hours. Some people even take a "digital sabbatical" once a week.
- **Find your happy place:** Pay attention to how certain activities make you feel and then pursue those that offer a sense of relaxation and recreation.

Don't Forget Your Vitamin P (for Pleasure)

In our society's incessant drive to analyze, quantify, measure dietary intake and nutritional value, and classify foods as "good" or "bad," something essential is lost: food is fun.

In other words, seeking your daily dose of pleasure is a worthy goal and not something to be overlooked, according to Healthline. Indeed, eating something delicious causes a release of dopamine in the brain and throughout the body. Pleasure also contributes to a more efficient and effective consumption and processing of nutrients from the food.

Additionally, "happy" foods are not necessarily "happy meals"—in other words, healthy foods can be pleasurable to consume, not just a means to good health.

Food has strong emotional, social, nostalgic, and cultural ties. Consider the Norman Rockwell–inspired Thanksgiving scene; birthday cakes and Halloween candy; or the sheer diversity in something as simple as a sandwich—the tortas, panini, and banh mi.

Better with Age

A balanced diet can delay the onset of dementia, according to Everyday Health. Further, common sequelae of unhealthy dietary habits—including diabetes, cardiovascular disease, and obesity—are known risk factors for dementia.

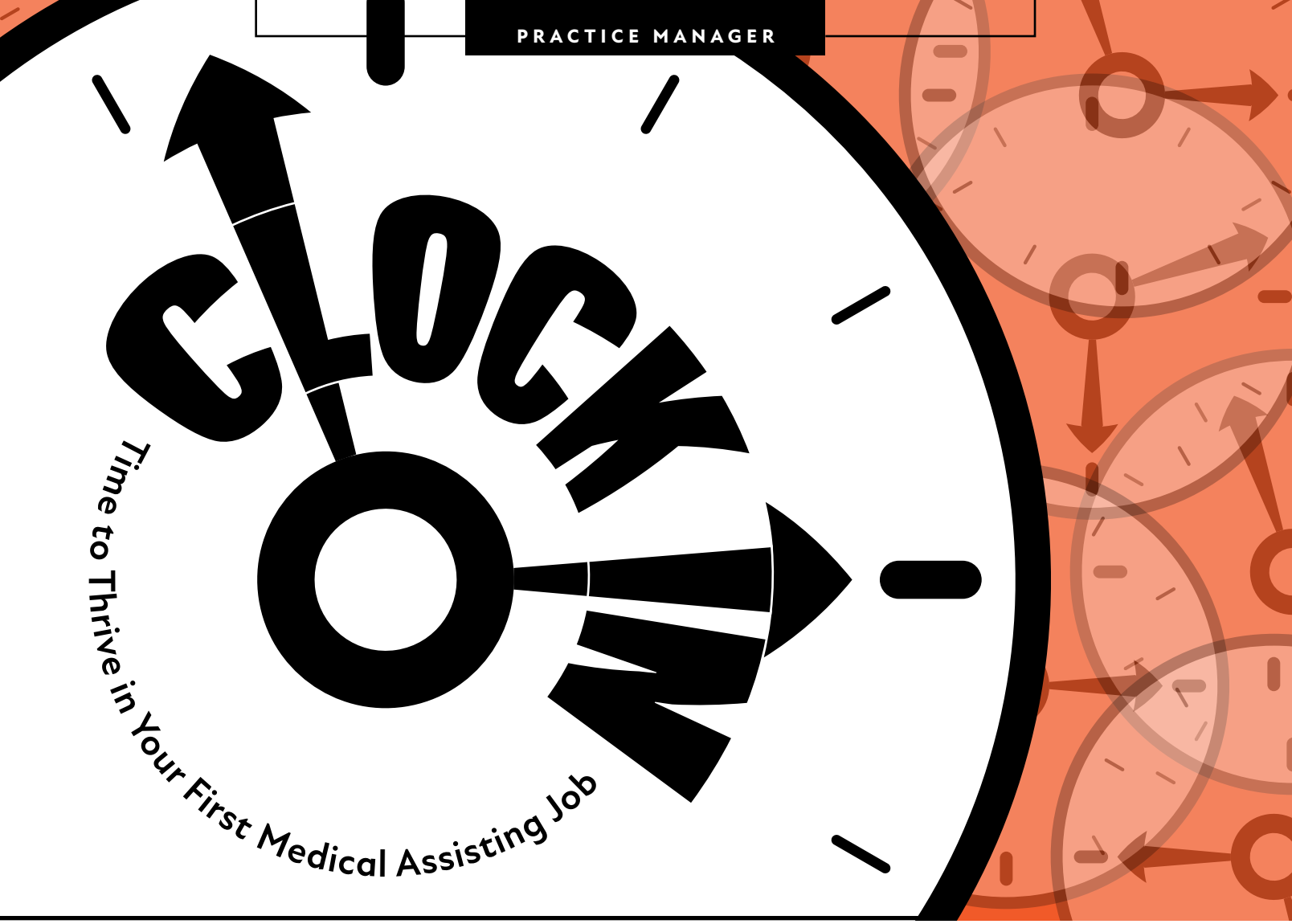
The good news is that if you're middle-aged, you can still make dietary changes to make a difference. Research published in *JAMA Open Network* focused on middle-aged study participants over a 21-year period. The authors conclude that their findings "suggest that interventions to improve diet and manage central obesity might be best targeted in midlife (ages 48–70 years)."

A Head Start

Investing as little as five minutes a day in physical activity can pay dividends for brain health, especially as we age.

Aging brains change: They lose volume, their cortex gets smaller, and they begin to produce lower levels of neurotransmitters, all contributing to cognitive decline. But a new study in *Age and Aging* found that "older adults who stay active through moderate-to-vigorous physical activity during the day have significantly better processing speed, working memory, and executive function than those who spent less time," according to Medical News Today.

The surprising bang for your buck: The study found that neophytes (aka *newbies*) to exercise who went from zero to the daily minimum of activity saw the most cognitive gains. So, it's never too late to start exercising and experience positive brain and body synergy for yourself.



By Brian Justice

The first thing medical assisting students may learn when transitioning into careers is that while the hands-on skills they bring to that first job are invaluable, other skills can be acquired only through the daily activities of a busy, fast-paced clinic. In those situations, new medical assistants develop good habits, strong working relationships, and drive to not just succeed but also thrive.

Help Wanted

How can you get off on the right foot in your first job? Within the first few weeks, find out what success looks like in your new role.[1]

"New medical assistants are highly motivated and ready to learn," says Eleya Montroy, the manager of clinical care services and the apprenticeship program at Henry Ford Health in Detroit. "In school, the environment is controlled, and any scenario can be set up to meet a competency, but they aren't fully prepared for the realities of clinical practice and real-world patient interactions. That's a steep learning curve!"

Ask your manager about both big-picture and day-to-day expectations, including priorities, meetings you are expected to attend, and the policies about communicating after hours.[1] Knowing these basics will help avoid confusion and build confidence from the start, knows Carmin Watson, a certified medical assistant coordinator at Henry Ford Health. "There's no such thing as a dumb question," she says. "They are just out of school and still learning. I want them to feel safe about speaking up when they don't understand something and [to know] it's okay to not know everything."

Good relationships with coworkers are the significant part of a congenial and productive workplace. Initiating one-on-one conversations over coffee, during breaks, or even quick chats between tasks, as well as socializing outside the office, are great strategies for learning about the workplace in a more relaxed and casual atmosphere. Make note of how you might make coworkers' jobs easier, because your success includes contributing to your colleagues' success too.[1]

First Job Jitters or the Last Straw?

Whether a first job, a new position, or a career change, every workplace has its own culture, and fitting into it can be stressful. When the initial nervousness around a new job fades away, doubts can still linger, but are they simply "growing pains" or red flags, and how do you tell the difference?

Appreciate the Experience

Even after every effort has been made, a job may simply not be a good fit. There is no shame in moving on, so take time for thoughtful reflection and focus on finding the right position. Also, remember that every work experience, whatever its nature, teaches you something valuable to remember and use throughout your career.

Still, workplace conflicts will invariably happen. "When it comes to coworkers, I've always taken the position that we are all adults, and we should be able to sit down and talk about our issues calmly," advises Sara VanHorn, CMA (AAMA), who formerly worked at Manuli Internal Medicine in Elizabeth City, North Carolina. "They may be going through something personal that's affecting them at work; so just ask, 'Hey, are you okay?' "

Check in about your work performance, even as early as in the first few weeks, and whether the organization subsidizes off-site learning opportunities, seminars, or conferences. That will show seriousness about growing within the job and the profession. Take uncomfortable input in stride and not personally. Feedback can help you refine skills and become part of the team.[1]

"Ask for feedback," says Lauren Welles, vice president of primary and immediate care at Endeavor Health in Chicago. "Don't just assume that managers are going to automatically give it, and whatever it is, accept it and respond to it. Ask a new work friend for help, or do some research or seek out education, but react to it."

Finding Your Footing

New jobs are major life events, with routines, environments, and expectations very different from school. That can be uncomfortable and cause some self-doubt, especially in the first few weeks, but those feelings should pass as you learn the rhythms of the clinic, your coworkers' personalities and talents, and the vibe of the place.

Give yourself time to adjust, get to know everyone, and give yourself credit for even the smallest early contributions. Allowing time to properly adjust will allow confidence to grow and flourish.[4]

Work in Progress

While you should establish your aptitude and attitude in the first few months, what you say and do through the rest of that first year is key too.

Doing solid work is expected, but stand out by going a step further. Ideas for making tasks and the practice more efficient prove that you not only understand the job but the organization as a whole.[2]

"Effective time management and organization are essential to success," agrees Patricia Boutilier, MBA, MS, BS, EDS, CMA (AAMA). "Setting goals using the SMART [Specific, Measurable, Achievable, Relevant, Timebound] framework helps prioritize tasks and maintain focus, makes decision-making easier, and enhances productivity."

It also shows your potential for promotion. Keeping track of the problems you have solved and compliments received will come in handy come review time or when applying for another opportunity. It may seem too soon, but update your résumé immediately and create an engaging LinkedIn profile.

No one does it alone, especially in health care, which depends on a staggeringly wide range of educational levels, skill sets, and experience. Become the go-to person for a specific task or skill. For example, when others learn that you are good at math or managing complex processes, or have mastered some aspect of the job that helps the whole team, your contribution becomes more valuable. Also, acknowledge people who help you, from mentors to managers and coworkers. More than just good manners, it shows appreciation and creates connections who will advocate for you when needed.

Time for Evaluation

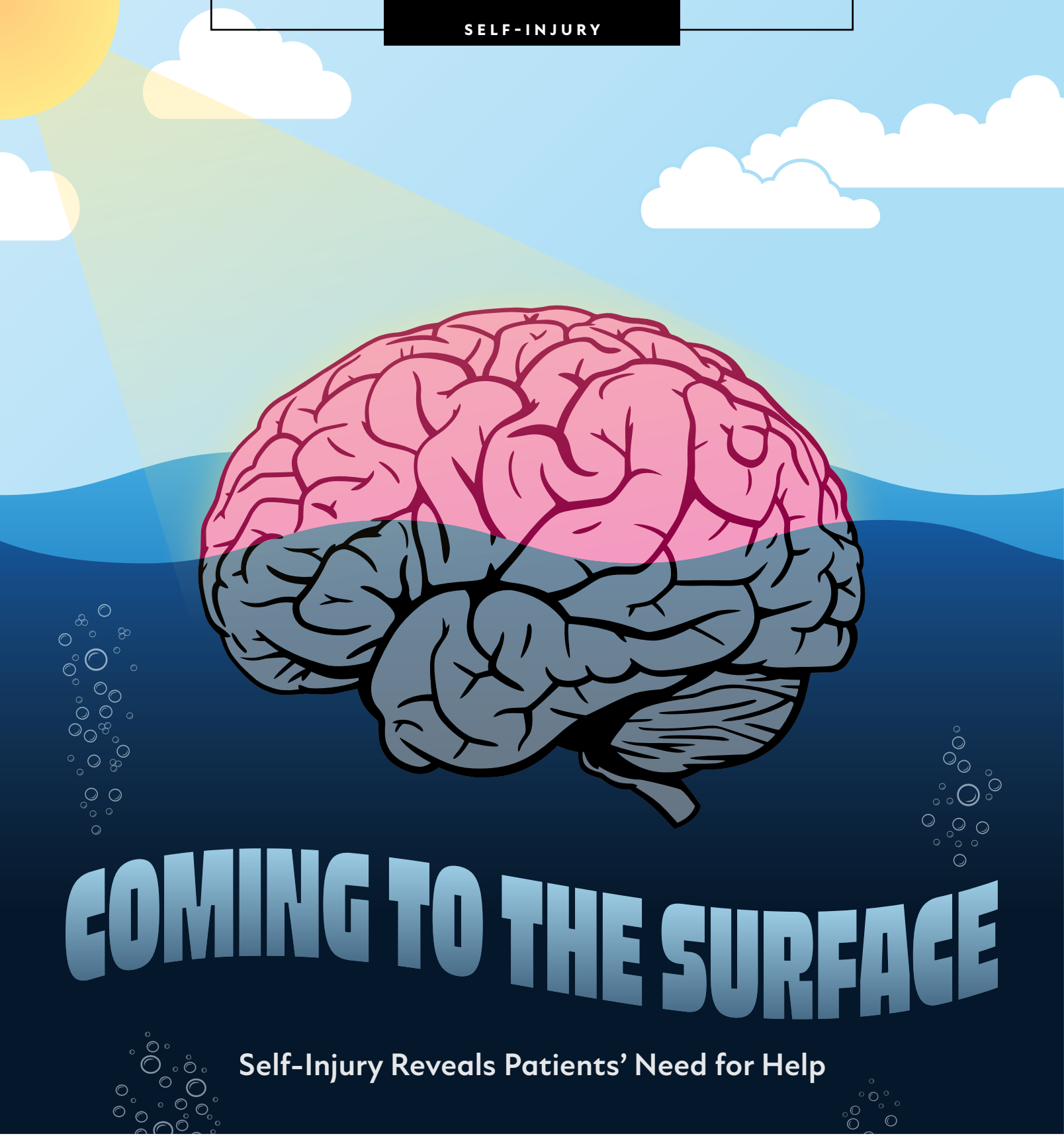
Six months should be enough time to acclimate,[5] but if serious uncertainties last beyond that, it may be something more. Maybe the role is not as described, the management style is not a fit, or the environment includes tensions beyond the norm in a professional health care setting. However, it took time and energy to prepare for this career and to find this job, so take the same care to determine your next steps.[4]

Identify the source of discomfort. What can be done to change it? Many issues (e.g., unclear expectations, awkward interactions, or erratic schedules) can be resolved. Managers truly want employees to succeed, so initiate a candid conversation about how to make changes.

Finally, experts recommend staying in your first job for at least a year.[3] That shows future employers that you are reliable and capable of committing to a role, even when it is challenging. Leaving too soon can raise questions. That kind of pattern can make hiring managers think twice, but giving yourself a year sets a strong foundation for the rest of your career because it signals professionalism, reliability, and the stability needed to see things through. ✦

References

1. Dunlap T. How to succeed in your first job out of college. Harvard Business Review. October 19, 2021. Accessed April 10. 2025. https://hbr.org/2021/10/how-to-succeed-in-your-first-job-out-of-college
2. Grant S. Five Ways to Succeed at Your First Job. Accessed April 21, 2025. https://business360.fortefoundation.org/five-ways-to-succeed-at-your-first-job
3. Murtagh T. How long should you stay at your first job out of college? March 15, 2023. Accessed April 21, 2025. https://www.honorsociety.org/articles/how-long-should-you-stay-your-first-job-out-college
4. Issid J. You just got a new job and you hate it: growing pains or hate? Accessed April 21, 2025. https://www.monster.ca/career-advice/article/you-hate-your-new-job-ca
5. Hawthorne C. How long should you give a new job a chance. August 10, 2024. Accessed April 21, 2025. https://www.careeredge.org/advice/career-development/how-long-to-give-a-new-job-a-chance/



COMING TO THE SURFACE

Self-Injury Reveals Patients' Need for Help

By Pamela Schumacher, MS, CCMP

Content Notice: This article contains descriptions of self-injury. If you or someone you know needs support, call the suicide and crisis lifeline at 988.

Self-harm, also known as *self-injury*, refers to someone harming themselves on purpose in a way that is not intended to be lethal.[1] Self-harm tends to begin in teen or early adult years. Some people may engage in self-harm a few times and then stop. Others do it more often and have trouble stopping.[2]

Self-injury occurs in approximately 17% of teens, 17–35% of college students, and 5% of adults.[1] So, medical assistants will likely encounter patients engaging in

this behavior.

"Medical assistants are often the first to notice that patients are intentionally harming themselves," says Nicholas J. Westers, PsyD, ABPP, a clinical psychologist at Children's Medical Center Dallas and associate professor at the University of Texas Southwestern Medical Center. "So, it's important they learn to recognize the signs and symptoms of self-injury so they can offer resources and advice."

Filter the Differences

Self-harm, or non-suicidal self-injury (NSSI), is the "deliberate and direct destruction of one's body tissue without suicidal intent and not for body modification purposes."[2] This definition excludes tattoos, piercings, or indirect injury such as those caused via substance use and eating disorders, notes Jennifer J. Muehlenkamp, PhD, a professor in the psychology department at the University of Wisconsin-Eau Claire. "It is also distinct from self-injurious behaviors—SIB—which are commonly seen among individuals with intellectual and developmental disabilities," she says.

"We tend not to use the term *self-harm* anymore because self-harm can include many other things such as substance use, disordered eating, [or] suicidal behavior," says Dr. Muehlenkamp. "It's important to understand the differences between suicidal self-injury and non-suicidal self-injury. … People engage in NSSI behaviors mostly for coping reasons, and the actions are not culturally sanctioned, which separates them from tattooing and piercing."

Suicidal behavior refers to any act with the intent to end one's own life, such as attempting suicide, making a suicide plan, or expressing suicidal thoughts or feelings. While self-harm is not intended to be lethal, people who harm themselves are at a higher risk of attempting suicide if they do not receive help.[3]

"Some people feel their emotions so intensely that self-harm provides an immediate—albeit dangerous—relief," explains Amanda Kulesza, CMA (AAMA), who works at Pascack Valley Medical Center in Emerson, New Jersey. "Other people have thoughts of hurting themselves but never act on them, which is just as serious. The reason for this behavior varies by the individual and is not a one-size-fits-all problem or solution."

"[Self-harm is] hurting yourself intentionally in a way that helps you deal with the processing of difficult emotions, painful memories, and stressful situations and experiences. That's how I talk about it with patients because it seems to resonate with them," says Michael Wyszynski, CMA (AAMA), a transcranial magnetic stimulation program coordinator at the Duly Health and Care Behavioral and Mental Health Clinic in Romeoville, Illinois.

Sinking Feelings

People who self-injure report they feel empty inside, over- or under-stimulated, lonely, not understood by others, or fearful of intimate relationships and adult responsibilities.[1]

"There are multiple functions that self-injury can serve," says Dr. Westers, who also hosts and produces the *Psychology of Self-Injury* podcast. "The most common reason for self-injury is for affect regulation purposes, that is, they are experiencing intense emotional distress, and self-injury helps calm that distress very quickly.

"[However,] self-injury is not just a way to deal with negative emotions," explains Dr. Westers. "Some people self-injure because they're feeling euphoric, and it's overwhelming. They may also do it to punish themselves for a perceived wrongdoing, sin, or transgression that they committed, and this fulfills a form of self-penitence; it brings them back to a clean slate. There's also an emotional aspect, where patients may feel numb or empty, so they'd rather feel pain than nothing at all."

This numbness was the reason Wyszynski started self-injuring when he was 12. "I was very depressed after my grandpa, [who was] my best friend, passed away. The pain and slight euphoria of cutting myself let me know I was alive. I thought, 'I can cut myself. I can still feel things.' It proved I wasn't completely dead on the inside, and it was the one thing in my life I could control."

"The biggest thing patients get from the

Wash Away Misconceptions

Learn the truth about common misconceptions[5]:

- **Not only females self-injure:** Between 30% to 40% of people who self-injure are male.
- **Self-injury is not always a suicide attempt.** Most studies find that self-injury is often a way to avoid suicide.
- **People of all ages engage in self-injury,** not just teenagers.
- **Those who self-injure are not "crazy."** People who engage in self-injury use it as a coping strategy, just like people who have substance use disorders.
- **Self-injury is not done only for attention.** In fact, many people who engage in self-injury hide their cuts, scars, or burns.
- **Self-injury *is* treatable.** Although self-injury can be difficult to control or stop, most people who engage in self-injury are able to stop eventually. However, the behavior of self-injury typically does not stop until the individual has found other methods to cope and is ready to stop self-injuring regardless of the treatment approach used.
- **Those who self-injure can be part of any subgroup.** Self-injury excludes no one. People who self-injure come from all groups, ethnicities, and economic backgrounds.
- **People who self-injure do not enjoy the pain or cannot feel it.** Sometimes, feeling pain is the whole point—a person may self-injure to reconnect with their body or just to feel something. Deal with these patients like any other patients and offer them numbing agents when treating their wounds.

Feeling Adrift

People may engage in self-injury to achieve various intentions[1]:

- Distract themselves from uncomfortable, unpleasant, or overwhelming feelings
- Express emotions they have difficulty articulating
- Develop a sense of control over their lives
- Process how they are feeling
- Punish themselves for things they think they have done wrong

behavior is a short-term sense of relief," says Dr. Muehlenkamp. "We know from interviews and self-report data that the driving motivation for an act of self-injury is to regulate their internal distress in some way. I've had some clients—young people who are highly perfectionistic high achievers—engage in this behavior because of the stress, pressure, and anxiety around performing well.

"But some will also use self-injury to quiet the noise in their mind so they can concentrate enough to take a test. It helps you focus very fast because the body responds to injury in a way that promotes survival, so things quiet down, and you zone in quickly," says Dr. Muehlenkamp. "It's not that different than why someone uses substances—it temporarily takes away the bad stuff in the individual's life. Those effects are short-lived, and they can create more stress and consequences down the road. But, they get that short-term benefit, which reinforces the behavior, and that's why it keeps occurring."

But not everybody knows why they are doing it; they just know it works, notes Janis Whitlock, PhD, MPH, a research scientist emerita and the founder of the Cornell Research Program on Self-Injury and Recovery. "For those who self-injure, we assume they know why they're doing it," she says. "They often don't know why it works; they just know that it works, and it works quickly.

"I continually reinforce … that self-injury comes from a psychologically healthy desire to feel better," she says. "The motivation is good, but the pathway is not functional. That is like a lot of situations—we do things that aren't healthy to help us deal with emotions that we don't want."

Signs Rise Up

Common forms of NSSI include behaviors such as cutting, burning, scratching, and hitting. Most individuals who self-injure report using multiple methods. These injuries can range in severity from minor to moderate. Medical assistants should be aware of these signs of self-injury[4]:

- Scars
- Long sleeves or pants, even in hot weather
- Lots of bracelets or wristbands
- Fresh cuts, bruises, bite marks, or burns
- Frequent reports of accidental injury
- Carrying knives or sharp objects on their person
- Talking about feeling worthless or helpless
- Emotional and behavioral instability and unpredictability

"Medical assistants should look for open wounds or scars that are often clustered," says Dr. Whitlock. "They might see lines of scars or multiple scars on the arms, shoulders, thighs, calves, or ankles. If there's a pattern or a symbol, that's something to look out for. If the patient is unwilling to expose their arms or legs during an examination, or if there's some sense of protection around body parts, that's another sign."

"Research shows that, on average 70% of self-injury is by cutting," says Dr. Westers, who is also the president-elect of the International Society for the Study of Self-Injury. "Self-burning is another method, but it's not that common. Severe scratching can be considered a form of self-injury. There's also carving, which is cutting, but it's qualitatively different. It's carving words or symbols into the skin. I see this in individuals with eating disorders who may self-injure after a binge when they're in distress because of food. They might carve the word *fat* or other pejorative words into their skin. In addition, there's embedding objects under the skin, self-hitting, and self-biting."

"Another common method is skin abrading," says Dr. Muehlenkamp. "Patients use an object or a nail or fingernail to rub the skin until it starts to ooze. It doesn't bleed, but it oozes and creates a type of burn or scab over the top of it. Some people label it as severe scratching. Another behavior is banging, when an individual bangs a part of their body, most often a forearm or a wrist, against a ledge or a shelf until the area goes numb or is in pain.

"Related to those behaviors is self-battery, [which is] punching themselves repeatedly with either an object or their own fist until it produces a bruise," she says. "Medical assistants might see cutting, burning, or severe scratching of the skin."

"I help treat patients who are depressed, and there are some who self-harm or have self-harmed in the past," says Wyszynski. "Signs and symptoms I look for are changes in moods, being a little bit more secretive, and avoiding certain situations in which they must show their arms or legs. I know to be on alert if it's the middle of a Midwest summer and they're still wearing long pants, hoodies, and sweatshirts. They may also come up with strange excuses for injuries. When I would self-injure, I worked in a coffee shop, and I said that my wounds happened when a coffee pot broke, and I accidentally cut myself."

Staying Afloat

A range of mental health issues can accompany self-injury, including bipolar disorder, depression, anxiety disorders, obsessive-compulsive disorder, personality disorders, and psychotic disorders such as schizophrenia.[1]

"People who engage in this behavior often have mood disorders such as depression and anxiety," says Dr. Westers. "They may have suffered childhood maltreatment or trauma, but not everyone who self-injures has suffered trauma. Childhood emotional abuse [is] the strongest risk factor for self-injury—above and beyond physical

or sexual abuse—and the more adverse childhood experiences, the greater the risk of developing this behavior. Bullying, both as the victim and the perpetrator, is a risk factor. And parental criticism is linked to higher risk for self-injury, especially if the individual agrees with the parent and is critical of themselves."

From a population standpoint, any individual with a marginalized identity can be at risk for self-injury, adds Dr. Muehlenkamp: "If the medical assistant knows that a patient holds a diverse sexual or gender minority identity, they may be at greater risk because [they] have higher rates of self-injury than cisgender heterosexual individuals. This is because of rejection, discrimination, and societal stigma."

Therapists can use several modalities to help those who engage in self-injury. Dialectical behavior therapy (DBT), cognitive behavioral therapy, and interventions that focus on understanding, tolerating, and accepting emotions (emotional regulation) while learning a healthy use of coping skills (such as interpersonal effectiveness) are typically most helpful.[5] Although self-injury can be difficult to control, most people are able to stop.

In primary care, medical assistants play a key role. "It's so important that the medical assistant leaves their judgment and biases at the door," says Dr. Westers. "Don't have a big reaction, such as 'Why did you do that?' Instead, be calm, compassionate, and curious. Say, 'When was the first time you [cut] yourself?', followed by 'When was the most recent time?' Then, ask, 'How do you typically take care of the wounds afterward? Do you have any other wounds?' Adopting a professional manner when investigating self-harm will help put the patient at ease and let them know you're there to help and not to judge them. Also, if they have an injury, offer a numbing agent during treatment as you would for other patients. Don't assume they like the pain or want to be treated without it."

Dr. Muehlenkamp agrees: "The first response from a health care provider is incredibly important. Convey compassion and a nonjudgmental approach, because there is data showing that if patients get a negative response from a health care provider, mental health professional, or counselor, they will shut down and be hesitant to ask for help in the future."

"Medical assistants can offer information and resources to help patients cope with negative thoughts and self-injurious behavior," says Kulesza. "It's easy to tell them about 988, the number for the national suicide and crisis lifeline. Anyone can speak to a trained counselor during times of crisis by dialing or texting 988 from any phone. Their official website also has a chat option, and 988 can be reached by videophone for [people with] deafness, hardness of hearing, or hearing loss."

School-based programs show promise for preventing self-injury. "There are social-emotional learning programs, such as DBT in Schools: skills training for emotional problem-solving for adolescents—or DBT STEPS-A—that are showing success," says Dr. Muehlenkamp. "I'm biased because I'm one of the co-trainers. It's a school-based social-emotional learning curriculum that teaches life skills about mindfulness, emotion regulation, distress tolerance … , and interpersonal skills. Schools see improvements in student behaviors, emotional coping, and academic performance when they implement these programs. Anything that helps develop a sense of resilience, being able to overcome hard times, challenges, and negative emotions, and learn how to cope can be preventive."

"Sometimes all you have to do is listen," says Wyszynski, speaking from personal experience and a patient perspective. "I had a [educator] in school who had a poster that said, 'Labels are for soup cans.' That stuck with me. You can have a big impact on someone's life just by putting yourself in their shoes and treating everyone like an individual. It's a scary world out there, and it's good to let patients know you're on their side." ✦

Ports in the Storm

- 988 Lifeline: https://988lifeline.org
- International Society for the Study of Self-Injury: https://www.itriples.org/aboutnssi
- National Alliance on Mental Illness: https://www.nami.org/About-Mental-Illness/Common-with-Mental-Illness/Self-harm
- *The Psychology of Self-Injury* podcast: https://the-psychology-of-self-injury.simplecast.com
- Self-Injury & Recovery Resources from Cornell University: https://www.selfinjury.bctr.cornell.edu
- The Trevor Project: https://www.thetrevorproject.org/pride
- To Write Love on Her Arms: https://twloha.com

The CE test for this article can be found on page 29.

References

1. Self-injury (cutting, self-harm or self-mutilation). Mental Health America. Accessed June 15, 2025. https://mhanational.org/conditions/self-injury-cutting-self-harm-or-self-mutilation/
2. Self-injury – a general information guide. Self-injury Outreach & Support. Updated August 31, 2018. Accessed June 15, 2025. https://sioutreach.org/learn-self-injury/general/#ffs-tabbed-11
3. Predescu E, Sipos R. Self-harm behaviors, suicide attempts, and suicidal ideation in a clinical sample of children and adolescents with psychiatric disorders. *Child*. 2023;10(4):725. doi:10.3390/children10040725
4. Self-harm. Substance Abuse and Mental Health Services Administration. Updated April 24, 2023. Accessed June 15, 2025. https://www.samhsa.gov/mental-health/what-is-mental-health/conditions/self-harm
5. Caicedo S, Whitlock J. *Top 15 Misconceptions of Self-Injury*. Cornell Research Program on Self-Injury and Recovery. 2009. Accessed June 15, 2025. https://selfinjury.bctr.cornell.edu/documents/15_misconceptions.pdf

Gender Bias in Health Care

Deadline: Postmarked no later than **September 1, 2025**

Credit: 2.5 AAMA CEUs (gen/admin) **Code: 144481**

Electronic bonus! This test is available on the e-Learning Center at learning.aama-ntl.org. Miss the postmark deadline? Take the test online instead!

Directions: Determine the correct answer to each of the following, based on information derived from the article.

T F

☐ ☐ 1. Women are less likely to report negative encounters with health care providers and their staff than men.

☐ ☐ 2. Social determinants of health include access to quality health care, job opportunities, and an adequate education but do not include family relationships and neighborhood safety.

☐ ☐ 3. A result of gender bias in health care is women's health concerns being underdiagnosed or dismissed by health care providers.

☐ ☐ 4. Because of scientific advances in health care, maternal mortality and morbidity are lower in the United States than in comparable countries.

☐ ☐ 5. Gender bias is defined as barriers and disparities that women, including non-binary and transgender individuals, may face in receiving medical treatment and care.

☐ ☐ 6. Poor communication by health personnel and failure to respond to concerns of pregnant individuals are key contributors to disrespectful maternal care.

☐ ☐ 7. No evidence suggests that female health care providers spend more time listening to the concerns of patients than male providers.

☐ ☐ 8. Before appointments, patients should write down questions and concerns they want to bring to the attention of their providers.

☐ ☐ 9. Patient advocates may accompany patients to appointments and make sure the patient's concerns are understood by the provider and are being addressed.

T F

☐ ☐ 10. In the United States, maternal morbidity and mortality are greater for Black women than for White women.

☐ ☐ 11. In 1977, the Food and Drug Administration recommended that women of childbearing age be included in drug trials.

☐ ☐ 12. The outcomes for women who have cardiac events are poorer than the outcomes for men because clinicians tend to evaluate such events as if they were happening to men.

☐ ☐ 13. Implicit bias is defined as overt racism, sexism, homophobic attitudes, and other actions or behaviors on the part of individuals or organizations.

☐ ☐ 14. As a result of 1993 legislation enacted by Congress, research funded by the National Institutes of Health must address whether the results affect minorities and women differently than other research participants.

☐ ☐ 15. Fewer Black and Hispanic women report disrespectful treatment by health care personnel than White women.

☐ ☐ 16. Health equity is defined as every individual having a fair and just opportunity to attain their highest level of health.

☐ ☐ 17. Respectful maternity care emphasizes respect for the rights of women during and after pregnancy.

Self-Injury

Deadline: Postmarked no later than **September 1, 2025**

Credit: 1 AAMA CEU (gen/clin) **Code: 144482**

Electronic bonus! This test is available on the e-Learning Center at learning.aama-ntl.org. Miss the postmark deadline? Take the test online instead!

Directions: Determine the correct answer to each of the following, based on information derived from the article.

T F

☐ ☐ 1. Self-injury is such a difficult propensity that most people are unable to stop self-injury practices.

☐ ☐ 2. Engaging in self-injury can be similar to using substances in that it provides a temporary escape from unpleasant elements of reality.

☐ ☐ 3. Individuals who have a diverse sexual or gender minority identity have a higher rate of self-injury than cisgender heterosexual individuals.

☐ ☐ 4. Young people who are under-achievers are more likely to engage in self-injury because of their lack of direction in life.

☐ ☐ 5. The term *self-injury* includes injury from substance use, eating disorders, tattoos, and piercings.

☐ ☐ 6. An individual struggling with self-injury should call the suicide and crisis lifeline at 988.

☐ ☐ 7. Parental criticism is linked to a higher risk of self-injury among children.

T F

☐ ☐ 8. Self-injury may be defined as a person harming themselves in a way that is not intended to be lethal.

☐ ☐ 9. Skin abrading is defined as rubbing skin excessively until it starts to bleed.

☐ ☐ 10. Engaging in self-injury can be motivated by feeling under-stimulated, overstimulated, lonely, misunderstood, or guilty.

☐ ☐ 11. The majority of individuals who engage in self-injury use only one method of injuring themselves, not a variety of methods.

Donate online and SUPPORT EDUCATION!

Donate through the AAMA Store online, and help foster the growth of the next generation of medical assistants.

The Maxine Williams Scholarship Fund

provides financial assistance for deserving medical assisting students.

For more information, visit the "About" page on the AAMA website.
www.aama-ntl.org

The Ivy Reade Relkin Surveyors Training Fund

helps ensure the quality of accredited medical assisting programs by training skilled surveyors. This fund is part of the Medical Assisting Education Review Board. Contribution checks should be made payable to the Medical Assisting Education Review Board, with a notation on the memo line that the funds are for the Ivy Reade Relkin Surveyors Training Fund. Checks may be mailed to:

MAERB
2020 N. California Ave., #213, Suite 7
Chicago, IL 60647

AMERICAN ASSOCIATION OF MEDICAL ASSISTANTS®

CEU Tests Submission Form

This submission form is for both or one of the CEU articles.

How to Receive AAMA CEU Credit
Applicants can choose to complete both or either of the tests. Only one submission form is needed whether two tests are completed or one is completed.

Credit will be awarded to those who achieve a score of at least 80%.

Online Method: Go to www.aama-ntl.org and click on "e-Learning Center" under the Education and Events tab. Pay for and take the test online.

Mail Submission Method: Complete the test(s) and this submission form, and mail them to the address below. Enclose a check or money order payable to the AAMA.

40% More CEUs; 0% More Fees
As a bonus for AAMA members, you may submit CEU Test 1 and/or CEU Test 2 for $20 total.

This offer will continue through the Sept/Oct 2025 issue. The Nov/Dec 2025 issue will not have this bonus.

Fee Information
The nonrefundable testing fee is $20 (members) or $40 (nonmembers).

Last Name

First Name & Middle Initial

Street Address

City/State/ZIP

AAMA Membership Status
☐ Member (CEU Test 1 and/or CEU Test 2) ($20)
☐ Nonmember (CEU Test 1 and/or CEU Test 2) ($40)

Test Submissions
I am including the completed test pages for:
☐ Gender Bias in Health Care (2.5 CEUs)
☐ Self-Injury (1 CEU)

Members—AAMA ID Number *(Required)*

Nonmembers—Last Four Digits of Social Security Number *(Required)*

Date Completed

Day Phone Fax

Email

Retain a photocopy of your payment and test for your files.
The AAMA does not keep copies on file after grading.
Send completed test submission form and fee to:

AAMA *Medical Assisting Today* CE Test
20 N. Wacker Dr., Ste. 3720
Chicago, IL 60606

Continuing education units (CEUs) are awarded based upon content, depth of article, learning outcomes, and length of time for completion per IACET (International Association for Continuing Education and Training) guidelines and criteria. IACET created the CEU for the purpose of providing a standard unit of measure to quantify continuing adult education. CEU value is awarded based upon the projected contact hours needed to complete the continuing education activity (e.g., 1 CEU equals 1 hour, or 1.5 CEUs equal 1.5 hours). *Medical Assisting Today* articles follow this standard for awarding CEU value. The $20 or $40 is a test processing fee. A $25 administrative fee will be assessed for returned checks.

**Mail-in test deadlines are maintained for administrative purposes. Electronic test deadlines on the e-Learning Center will vary. The AAMA reserves the right to remove any course at any time.*

A LIGHT IN THE DARK

CMA (AAMA) Supports Oncology Patients

By Cathy Cassata

After working in primary care for four years, in 2019 Grace Barnes Chavous, CMA (AAMA), felt a calling to work in oncology. "At the time, my fiancé was deployed, and I was living at home with my parents, and I knew that when he came back, we'd get our own place. I was ready for a new start," she says.

For years, she aspired to work at Augusta University in Georgia, so she visited their career website. Happy to see an opening for a medical assistant in oncology, she immediately applied. "Within 24 hours, I had the job," says Barnes Chavous. "I feel like it was a godsend."

She worked in the infusion suite, taking care of patients who received chemotherapy by drawing blood and monitoring for adverse reactions to treatment. "I would see some patients a few times a week and became close to them. Some felt like family," she says.

She connected with many patients and recalls one woman who left a lasting impression. While receiving treatment, the patient became unconscious. Barnes Chavous called over the attending nurse who gave the woman a sternal rub. However, when that failed, the nurse told Barnes Chavous that CPR was necessary. As a Basic Life Support instructor, Barnes Chavous did not hesitate.

"I jumped into action, and it was chaos around me, but I drowned everything out and focused on the patient and kept saying 'Not today; not on my watch,' " she remembers. After administering a couple cycles of CPR and compressions, the woman responded right before the ambulance arrived. "I was so happy she got to live another day," says Barnes Chavous.

Today, Barnes Chavous spends her days on the practice side of the oncology clinic taking patients' vital signs, preparing them to see the physician, and patient screening. She also assists with procedures in various specialties of the clinic, including Papanicolaou tests (i.e., Pap smears), biopsies, bladder scans, cyst scopes, and administering ECGs.

While she keeps a positive perspective, she has experienced many difficult and sad days working in oncology, such as when she sees patients pass away, their treatments fail, or on the practice side, receive a terminal diagnosis or prognosis. "It's heartbreaking hearing the emotional side of how patients process it all," says Barnes Chavous.

However, witnessing patients ring the bell—which signifies the completion of their cancer treatment—recenters her and brings her hope. "It's so rewarding to see them finish their chemo or when they come back for a follow-up and they're cancer-free," she says. "It reminds me that my purpose is to come to work every day and help patients during this difficult time."

Reassuring feedback from patients confirms that she is successfully living out her purpose. "I have a lot of patients tell me that my personality and compassion make them feel good and is a bright spot during their storm of fighting for their life," she says.

Even when she is going through a tough time herself, she pushes herself to stay uplifting for patients. "I know what they're going through is often the most difficult thing they've ever faced," she says. "If I can be a light in their dark day, then I'm doing my job." ✦

69TH ANNUAL
AAMA
CONFERENCE

STEP INTO A LEGACY OF GREATNESS.

Don't wait!
Register for conference today.

Join us September 19–22 for the 69th AAMA Annual Conference in Arlington, VA.