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Medical Assisting Today

The Magazine for Professional Medical Assistants

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A Chance to Celebrate

As we begin state society conference season, I want to take a moment to congratulate all the chapters and individuals recognized for their outstanding contributions to their state society!

One of my favorite things about the AAMA Annual Conference is celebrating the incredible work being done by state societies to get information out to their members to grow their state society and those individuals who are giving back.

The AAMA Annual Conference is our time to honor many incredible individuals via awards (deadlines for nominations and applications are noted below):

Due May 15, 2025

- **Maxine Williams Scholarship**—named for the first AAMA President and a founding member of the AAMA, this scholarship honors medical assisting students who show promise and dedication.

Due June 1, 2025

- **AAMA Life Member**—this honor recognizes a lifetime of service to the AAMA and profession.

Due July 15, 2025

- **State Society Excellence Awards**—these awards honor the work performed by state societies in the past year.
- **AAMA Rising Star Awards**—these awards honor AAMA members just beginning their leadership journey, full of energy and dedication to their state society.
- **Golden Apple Award**—this is awarded to an educator committed to shaping the future of medical assisting.
- **Leadership and Mentoring Award**—the winner is known for guiding others with wisdom and encouragement.
- **Medical Assistant of the Year Award**—the winner leads by example and makes a national impact.
- **Medical Assistant Employer of the Year Awards**—these are presented to private practices, facilities, and health systems that champion and support the professional growth of their medical assistants.
- **Student Essay Competition**—the award goes to a student who shows a passion for the profession.

But let us not forget: we are *all* winners because of our shared commitment. Your AAMA and state society membership speaks volumes about your dedication to the profession and your desire to keep learning, growing, and giving back. Through social media, recruiting members in the workplace, or even informing employers about your AAMA membership and volunteer activities, you show your passion and dedication to your profession.

You can always donate to the Maxine Williams Scholarship Fund. If you are attending the AAMA Annual Conference in Arlington, Virginia, this September, be sure to stop by the Society of Past Presidents' table to donate, or send your donations directly to the AAMA.

So, what are you waiting for?! Visit www.aama-ntl.org today to nominate your state, an inspiring individual, or a supportive employer for one of the AAMA Excel Awards.

I cannot wait to celebrate with you all this September in Arlington!

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.

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AAMA update

Step into a Legacy of Greatness

Register online for the 69th AAMA Annual Conference via Cvent. Registrants may securely pay their registration fees online, select the continuing education sessions they wish to attend, and note any dietary restrictions.

Reserve your spot in the AAMA room block at the host hotel by Aug. 26 to take advantage of the conference registration discount. You must provide a reservation confirmation number from the Hyatt Regency Crystal City at Reagan National Airport to get the conference registration discount.

Conference registration deadline: Sept. 12
Conference dates: Sept. 19–22
Hotel registration deadline: Aug. 26

Text Reminders for Recertification

Make sure the cell phone number on your AAMA profile is correct so you receive reminders and tips about CMA (AAMA)® recertification. Allow the AAMA to track your deadlines and keep you updated on when you must take action to maintain your credential. ✦

State Societies: Sponsor AAMA Conference Events

State societies: Show your state pride by being a sponsor at the 69th AAMA Annual Conference in September. Sponsorships are available for the Welcome and Awards happy hour and the Presidents Banquet happy hour. Information for advertising, exhibiting, and sponsorship is available via the Cvent website. ✦

AAMA Calendar

Events

AAMA Annual Conference
69th—Arlington, VA ··· Sept. 19–22

Medical Assistants Recognition (MAR)
MARWeek ··· Oct. 20–24
MARDay ··· Oct. 22

Board Meetings
Board of Trustees ··· June 6–7, 2025
Continuing Education Board ··· TBA
Certifying Board ··· July 25–26, 2025

2025 Deadlines

Life Membership nominations ··· June 1
State officer election notification submissions ··· June 1
State delegates and alternates submissions ··· June 23
Conference program advertising orders ··· July 1
Excel Awards submissions ··· July 15
National volunteer leadership applications ··· Aug. 1

Visit the "Leader's Center" webpage (which is available via the "Volunteer Resources" webpage) to access the information hub for deadlines and forms. (Sign-in required.) ✦

Volunteer Forms Due Soon

Find essential forms, deadlines, and more on the "Leader's Center" webpage, which is accessible via the "Volunteer Resources" webpage:

State and Chapter Officer Election Notification Form. State and chapter officers—don't miss important mailings! Complete and submit this form to OfficerNotification@aama-ntl.org by **June 1**.

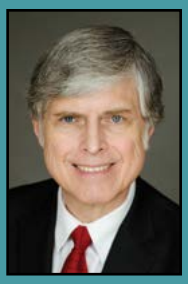
AAMA Life Membership Applications. State officers—nominate an outstanding leader of the AAMA for national Life Membership; send the application to SFlynn@aama-ntl.org by **June 1**.

Delegate and Alternate Form. AAMA members and state presidents—note this deadline:

- *Members*—talk to your state president about serving as a delegate or alternate in the AAMA House of Delegates. If you are attending, consider volunteering to serve on a House committee.
- *State presidents*—complete and submit this form to SFlynn@aama-ntl.org by **June 23**. ✦

Protecting Medical Assistants' Right to Practice

A Retrospective: Part I



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

The American Association of Medical Assistants® (AAMA) mission statement includes providing medical assistant professionals with scope-of-practice protection. The following article recounts highlights of the AAMA's successes in protecting their right to practice on the state level.

Connecticut

The struggle for medical assistants to secure the right to administer injections under Connecticut law is a long—and at times frustrating—saga. At least since the early 1990s, the Connecticut Department of Public Health had taken the position that unlicensed personnel such as medical assistants may not perform medication administration by any means, including by injection.

The Connecticut Society of Medical Assistants (CSMA) and the AAMA worked together to draft legislative language, submit testimony and comments, and engage with communities of interest to permit licensed independent providers to delegate the administration of vaccines to appropriately educated and currently credentialed medical assistants working under provider supervision in outpatient settings.

Finally, through my work on behalf of the AAMA and the dedication of my CSMA colleagues, legislation was passed and went into effect October 1, 2022:

> Sec. 47. (NEW) (*Effective October 1, 2022*) (a) For purposes of this section, "clinical medical assistant" means a person who (1) (A) is certified by the American Association of Medical Assistants, the National Healthcareer Association, the National Center for Competency Testing or the American Medical Technologists, and (B) has graduated from a postsecondary medical assisting program … that is accredited by the Commission on Accreditation of Allied Health Education Programs, the Accrediting Bureau of Health Education Schools or another accrediting organization recognized by the United States Department of Education, or (ii) offered by an institution of higher education accredited by an accrediting organization recognized by the United States Department of Education and that includes a total of seven hundred twenty hours, including one hundred sixty hours of clinical practice skills, including, but not limited to, administering injections, or (2) has completed relevant medical assistant training provided by any branch of the armed forces of the United States.
>
> (b) A clinical medical assistant may administer a vaccine under the supervision, control and responsibility of a physician licensed pursuant to chapter 370 of the general statutes, a physician assistant licensed pursuant to chapter 370 of the general statutes or an advanced practice registered nurse licensed pursuant to chapter 378 of the general statutes to any person in any setting other than a hospital setting. Prior to administering a vaccine, a clinical medical assistant shall complete not less than twenty-four hours of classroom training and not less than eight hours of training in a clinical setting regarding the administration of vaccines. Nothing in this section shall be construed to permit an employer of a physician, a physician assistant or an advanced practice registered nurse to require the physician, physician assistant or advanced practice registered nurse to oversee a clinical medical assistant in the administration of a vaccine without the consent of the physician, physician assistant or advanced practice registered nurse.[1]

Delaware

In Delaware, from 2020 through 2022, an increasing number of advanced practice registered nurses (APRNs)—including nurse practitioners—wanted to delegate to medical assistants the administration of injections. This trend may have been related to the COVID-19 pandemic and the need to meet expanded patient desire for access to care. Unfortunately, the state's nurse practice act lacked clarity in this regard. Accordingly, I wrote the following to the Delaware Board of Nursing in June 2022:

> It is the position of the AAMA that medical assistants who have completed a medical assistant training program that includes medication administration theory and technique, and who have a current national medical assistant certification such as the CMA (AAMA) that tests knowledge needed to safely administer medication, should be permitted to administer medication under the authority of advanced practice registered nurses (APRNs)—including nurse practitioners—and other licensed independent practitioners such as physicians.

The Delaware Board of Nursing subsequently added the following to its regulations:

> 8.7.15.1 APRNs are authorized to assign and supervise medication administration to a medical assistant if the medical assistant has successfully completed a medical assistant training program and possesses current national medical assistant certification.

A Note from the Author

Part II of this article, to be released in a future issue of *Medical Assisting Today*, will profile the AAMA's work in ensuring that credentialed medical assistants were allowed to enter orders into the computerized provider order entry system for meaningful use calculation purposes under the Medicare and Medicaid Electronic Health Record Incentive Programs.

> If a practice is solely operated by APRNs, the APRN must be present in the building when the medical assistant is administering medications and assumes liability for the actions of the medical assistant.
>
> 8.7.15.2 When a physician delegates to a medical assistant, and an organizational policy exists to allow the APRN to assign and supervise the medical assistant, the physician retains responsibility and accountability for the actions of the medical assistant and will be notified of unsafe or improper practices.[2]

Maryland

Similar to Delaware, in 2020 the authority of APRNs to delegate to medical assistants the administration of injections was not clearly established in Maryland law. I worked closely with the Maryland Society of Medical Assistants, the Nurse Practitioner Association of Maryland, and the Maryland Board of Nursing in drafting legislation to remedy this lack of clarity in Maryland law. All bodies representing organized nursing, as well as the Maryland Board of Physicians, supported the bill. It was subsequently enacted, and regulations were then promulgated by the Maryland Board of Nursing that eliminated any uncertainty about APRNs' authority to delegate to medical assistants the administration of injections.

Montana

In 2021, a misinterpretation of Montana medical assisting law was gaining credence within segments of the medical community. Some physicians were interpreting the law to mean that they were permitted to delegate to medical assistants the administration of injections but not the administration of immunizations.

I wrote and disseminated an opinion explaining that the Montana law permitted the administering of immunizations by medical assistants under a physician's *general* supervision, whereas other injections (and the intravenous administration of blood products and medication) could only be performed by medical assistants under the physician's *onsite* supervision. My opinion helped dispel this confusion.

Nevada

Nevada medical assistants were confronted with a grave crisis in 2009. An international medical graduate working as a medical assistant in a medical spa was indicted on nine felony counts for the unlawful practice of medicine for administering cosmetic injections. The Nevada Board of Medical Examiners (BOME) issued the following statement on September 30, 2009:

> **Medical Assistants and Administration of Prescription Drugs**
>
> Recent events have resulted in questions regarding what medical assistants (MAs) may or may not do related to the administration of prescription drugs. The short and correct answer is that MAs may ***NOT*** administer any prescription drugs. This document is intended: (1) to explain the law at issue; and (2) to explain the practical application of this law.
>
> …
>
> **Practical Application of the Laws**
>
> The Board [of Medical Examiners] is aware that most physicians and physician assistants in Nevada were allowing their MAs to administer prescription drugs. Our intent is to make clear that such practices must cease immediately. The practical application of the Nevada law includes the following points:
>
> - MAs may not administer any prescription drugs. MAs may not give injections. MAs may not administer an inhaled drug. MAs may not apply any prescription cream, ointment, or salve. MAs may not apply prescription ophthalmic or otic drops. MAs may not insert prescription suppositories. MAs may not start IVs (because doing so usually involves the use of saline or another product that is a prescription drug.) MAs may not apply or provide prescription drugs to the body of a patient by any other means.[3]

I assisted the Nevada Society of Medical Assistants with the drafting of legislation and regulations of the Nevada BOME. As part of this work, I attended in-person and virtual meetings and hearings of Nevada legislative committees and the BOME.

On October 6, 2009, the president of the Nevada BOME rescinded the September 30 order. Legislation and regulations that protect medical assistants' right to practice were adopted in Nevada and are still in effect.

North Dakota

For many years prior to 2004, North Dakota medical assistants had been permitted to administer intramuscular, intradermal, and subcutaneous injections under the authority and direct supervision of physicians. That changed on March 8, 2004, when the North Dakota attorney general issued an opinion stating that medical assistants would no longer be allowed to administer injections.

I attended a hearing in Jamestown, North Dakota, and worked with the North Dakota Society of Medical Assistants and the North Dakota Board of Nursing to regain medical assistants' right to be delegated injections. This effort was successful.

Nebraska

The fall 2018 *Nebraska Nursing News*, an official publication of the Nebraska Board of Nursing, contained inaccurate statements about the scope of practice of unlicensed personnel such as medical assistants. I responded to these inaccuracies by letter. The following are excerpts from my letter:

> You make the following statement in the [second] section of the first column of page 14:
>
> > Medical Assistants support the practice of licensed health care professionals. They may appropriately perform administrative duties like scheduling and computer entry—or clinical support tasks like rooming patients and collecting data and information from the patient that nursing and medical providers require to inform their plan of care (Nebraska Board of Nursing, July 2018a).[4]
>
> It is my legal opinion that Nebraska law permits physicians to delegate to medical assistants the duties and tasks referenced in the above paragraph. However, it is important to note that the Nebraska Medical Practice Act and the regulations and opinions of the Nebraska Board of Medicine and Surgery do not limit the tasks delegable by physicians to knowledgeable and competent unlicensed professionals such as medical assistants (under the legally-required physician supervision) to "rooming patients and collecting data and information."
>
> The following statements are made in the third column of page 14:

> Verbal orders are prescriptions from APRNs and medical providers responsible for the care of a particular patient with licensure authority to prescribe medications, diagnostic tests and therapeutic interventions. Medical Assistants, like other unlicensed persons, may not accept verbal orders from a licensed prescriber (Nebraska Board of Nursing, 2018b). They may, however, accept and complete a task for which they are otherwise qualified and may lawfully perform in response to a written order from a provider, e.g., phlebotomy to obtain a laboratory specimen.[4]

> The Nebraska Board of Nursing has the authority to forbid all nurses from issuing verbal orders to unlicensed allied health professionals such as medical assistants. However, the Nebraska Board of Nursing does not have the authority to forbid other licensed prescribers (such as physicians) from issuing appropriate verbal orders to knowledgeable and competent medical assistants.

To help eliminate such ambiguities about medical assisting scope of practice, I worked with the Nebraska Society of Medical Assistants and the Nebraska Medical Association in formulating an amendment to the Medical Practice Act. The amendment was enacted into law in 2020.

South Carolina

After medical assisting legislation was enacted in 2022, uncertainty quickly arose over the meaning of some of its provisions. I received the following question and responded as follows:

> [Question]
>
> I have been a Certified Medical Assistant (AAMA)® … since 1993. There were no accredited programs in my area back then, but I did take a review course that … enabled me to pass the [CMA (AAMA) Certification Exam]. With the [new 2022 legislation], my employer is stating that I have to complete a postsecondary medical assistant program to fulfill the state requirements. … I don't see anything in the new law about those who are certified having to go back and complete a postsecondary medical assisting program. I would appreciate it if you could please clarify this for me.
>
> [My response]
>
> Thank you for your question. Note the following from the new South Carolina law:
>
> …
>
> B. CMAs include medical assistants who are currently employed in that capacity as of the effective date of this act who do not have the certification required by this Section but who achieve such certification no later than two years after the effective date of this act.
>
> My legal opinion is that … because you have a current CMA (AAMA), you meet the requirements of this section. It is also my opinion that the new law does not require you to go back to school to complete a medical assisting education program.[5]

This ambiguity and lack of clarity in the 2022 South Carolina law was eliminated by legislation enacted in 2024 through my work on behalf of the AAMA alongside the efforts of the South Carolina Society of Medical Assistants.

Tennessee

In 2021 the Tennessee attorney general issued an opinion that medical assistants working in ambulatory hospital outpatient clinics had to be addressed in statute differently from medical assistants working in other ambulatory care settings. I worked with the leaders of the Tennessee Society of Medical Assistants in offering comments on proposed legislation to protect medical assistants' right to practice. The final bill signed into law reads as follows:

> (1) "Certified medical assistant" means personnel with training to function in an assistive role to a licensed physician or nurse in the provision of patient care activities in a facility used as an ambulatory outpatient hospital clinic as delegated by the physician or nurse …
>
> (c) A hospital licensed under this title may employ certified medical assistants to administer approved medications to its patients in a facility used as an ambulatory clinic or hospital outpatient department as set forth in this section.
>
> (d) When carrying out responsibilities under this section, a certified medical assistant shall wear a name tag visible to others that displays the designation "certified medical assistant".
>
> (f) To be eligible to register as a certified medical assistant, an applicant must:
>
> (1) Be at least eighteen (18) years of age;
>
> (2) Have completed the twelfth grade or its equivalent, or have successfully passed the test for and received a general equivalency diploma; and
>
> (3) Be certified by the:
>
> (A) American Medical Technologists (AMT);
>
> (B) American Association of Medical Assistants (AAMA);
>
> (C) National Center for Competency Testing (NCCT);
>
> (D) National Healthcareer Association (NHA); or
>
> (E) National Association for Health Professionals (NAHP).[6]

Conclusion

In summary, the concerted work of the AAMA and its component state societies is essential to ensuring (and enhancing) medical assistants' right to practice their profession in the service of patients. In cases of confusion, crisis, or unclear state legislation concerning medical assisting scope of practice, the AAMA stands ready to marshal its estimable forces and help bring clarity to state laws, with patient access to safe and high-quality medical care at the forefront. ✦

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

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Pros and Conflicts

Turn Classroom Disputes into Opportunities for Growth

by Brian Justice

Disagreements and difficult conversations are a part of everyday life and can take place everywhere, including the classroom. Whether the issue is between students or between a student and educator, differing opinions and personal experiences can spark conflict, frustration, and anger. However, instead of simply quashing a situation that is uncomfortable for everyone—including other students who witness the incident—educators can and should use conflict as an opportunity for learning, as well as personal and professional development.

"Working with students across a wide range of medical disciplines has shown me just how much pressure they're under," says Sandy Hyatt, PsyD, a trauma psychologist with LSU Health and the NOLA Trauma Recovery Center in New Orleans, Louisiana. "Balancing the intense demands of their studies with personal responsibilities can make them feel overwhelmed, especially in health care, where the stakes are high, and the pace is relentless."

When conflict is handled effectively, it can drive discussions that improve critical thinking, communication skills, and understanding. Developing tactics around conflict resolution is essential in creating a supportive and inclusive learning environment in which everyone feels heard, respected, and empowered.

All the Rage

Friction that occurs in the classroom does not have to be disruptive. Instead, it can serve as a valuable learning tool that fosters critical thinking, emotional intelligence, and stronger interpersonal skills. By equipping students with the tools required to identify conflict and strategies for counteracting it, educators can create an environment in which disagreements lead to growth rather than division. Educators can use these key strategies for turning discord into a constructive learning experience:

Understand conflict styles. Educators must understand and appreciate that people approach conflict in different ways, ranging from avoiding it entirely to facing it head on—and everything in between. Helping students identify their coping practices, and recognize those of their peers, empowers them to respond to difficult situations more effectively.[1]

Encourage active listening and communication. Active listening is not just hearing words. It means understanding a speaker's intent and meaning. Techniques include maintaining eye contact, responding to nonverbal cues, asking open-ended questions, and paraphrasing responses to indicate one is listening to understand rather than to simply respond.[2]

Tiffany Santiago, a medical assistant with MultiCare Infectious Disease Specialists in Puyallup, Washington, learned to appreciate the importance of open communication through her work with interns and apprentices in a previous position. "I was up front and honest with everyone," she remembers. "I told them, 'I want you to be able to talk to me just like I am talking to you now, because I want you to be the best you can be,' and that really helped keep the peace and manage conflict."

Recognize power and cultural dynamics. "A big part is ensuring that everyone feels heard and respected," says Dr. Hyatt. That includes creating an inclusive learning environment that respects and values diverse cultures and experiences.[1] "When everyone can express their perspectives without judgment or backlash, it leads to more constructive

and collaborative outcomes."

Creating an inclusive learning environment has a real impact. "When people realize, 'Wait, I was triggered. I had an emotional reaction. But I'm not going to get in trouble for this or lose my job or my place in the class,' you can actually see their faces change," says Bethany Friedlander, president and CEO of New Bridge, which provides free training for allied health careers, in Cleveland, Ohio. "That's when and how we build trust."

Integrate conflict-management lessons. If a discussion becomes a difficult conversation, prepare to use conflict resolution techniques such as collaboration, compromise, and problem-solving to help students navigate the discomfort. Establishing rules and norms and reinforcing them can also create a structured environment for constructive dialogue.[3] Incorporating conflict-resolution training into the curriculum—covering topics such as managing anger, maintaining dignity in disagreements, and being assertive without becoming aggressive[1]—further equips students with the skills to handle disputes with confidence.

"I always discuss my expectations and classroom rules and lead by example," says Shawnrae Isom, CCMA, the program director of the medical assistant program at Fortis College in Centerville, Ohio. "Acknowledging a concern or problem in a timely manner helps de-escalate and prevent recurring issues. Holding students accountable for their actions and rewarding improved behaviors, as well as treating adult learners with respect and dignity, helps prevent conflicts."

"Be open to listening to students when they are ready to talk, but don't force them into conversations they are not ready to have," adds Amanda Beaman, CMA (AAMA), the medical assisting and phlebotomy department chair at Montgomery Community College in Troy, North Carolina. "If you have an open-door policy, students will feel comfortable coming to you, and then you can really address the situation and help diffuse it before it escalates."

Hot to Go

Recognizing and addressing potential conflict before it escalates is a crucial skill for educators, particularly in the medical field, where teamwork and communication are essential. Awareness and adaptability are key in identifying issues early so they can be resolved effectively.

Naturally, people may be uncomfortable and uncertain when it comes to navigating conflict. However, fostering a respectful, empathetic, and appreciative approach helps establish a safe environment for students and a growth mindset that will serve them well in class and later in workplaces. Challenges within classroom discussions may spark complex conversations, and they provide valuable opportunities for both educators and students to learn and develop. In fact, taking advantage of effective strategies to deal with conflict makes classrooms more inclusive and supportive.

"Just be aware and take a deep breath. Yeah, it's going to be frustrating, and you're going to think, 'These people are adults!' but they're still people," says Santiago. "You yourself have to be willing to learn from your students."

A classroom environment in which conflict is used as an opportunity for growth requires intentional strategies, clear expectations, and open-mindedness. Doing so fosters mutual respect through dialogue that helps students develop critical conflict resolution skills that may not only prevent conflicts from escalating but perhaps keep them from happening in the first place. ✦

Trauma-Informed Practices

Emphasis on trauma-informed practices has been growing in educational settings. These strategies acknowledge and address the impact of trauma by creating supportive and secure environments. Prioritizing safety, relationship building, and student empowerment are trauma-sensitive practices that support a nurturing educational experience.[4]

"Conflicts can arise from personal stressors or misunderstandings in classrooms with diverse student populations and varying personal challenges," says Sandy Hyatt, PsyD. "Trauma, whether visible or hidden, tends to intensify those situations."

Trauma-informed practices include recognizing situations that may provoke strong emotional responses and responding to disruptive behaviors with compassion rather than judgment. Students who feel free to share thoughts and opinions develop emotional security, but if they exhibit signs of ongoing stress that manifests itself in challenging behaviors, they may need to be connected with a counselor, social worker, or psychologist.[4]

Adopting trauma-informed practices demands commitment, adds Friedlander. "When we decided to become a trauma-informed center, I went to the entire staff, and I said, 'Your lives are going to change because we have to model this ourselves, eight hours a day, every day,'" she recalls. "That means we have to be emotionally regulated, which means we have to practice it with each other, and I really think that we are all the better for it."

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Microplastics with Macro Health Consequences

Microplastics—the tiny shards of plastic found everywhere in the environment—are culpable for a host of health issues, including "at least three forms of cancer, disruptions to the endocrine system and hormone imbalances, endometriosis, male fertility struggles, and problems for fetus development," according to Ocean Blue Project.

New research has uncovered another threat posed by the proliferation of plastics—antibiotic resistance. Researchers from Boston University tested the reaction of the common bacteria *E coli* when exposed to microplastics and found that the bacteria used them as highly hospitable surfaces to grow supercharged biofilms that were impenetrable by antibiotics, reports *Science Daily*.

The study, published in *Applied and Environmental Microbiology*, calls microplastics "a significant environmental pollutant with profound implications for public health. ... This is especially true in areas with inadequate waste disposal and substandard public health infrastructure, such as low- and middle-income countries and vulnerable populations."

Missing Prostate Cancer Screenings May Have Deadly Consequences

For a variety of reasons, many men are often loath to attend cancer screenings. This has major implications for prostate cancer, the most commonly diagnosed cancer among men in 112 countries.

A new study finds that men who miss cancer screening appointments are much more likely to die of prostate cancer. Researchers collected data over 20 years from over 160,000 men across seven European countries, as part of the PRAISE-U project.

"Of 72,460 men invited to screening, around 1 in 6 men (over 12,400) were non-attenders and skipped every appointment. This group had a 45% higher risk of dying from prostate cancer compared with those who attended screening appointments," according to a press release from the 40th Annual Congress of the European Association of Urology.

With the prevalence of prostate cancer projected to double by 2040, these findings point to the need for a renewed effort by medical professionals to push for appropriate cancer screenings. Medical assistants can play a key role in this work to help ensure patients obtain potentially life-saving screenings, diagnoses, and treatment.

In the Business of Medical Practice

The financial pressures of the medical practice are weighing on America's physicians, with potentially dire consequences for patients and access to quality care. The negative impact of Medicare payment cuts, coupled with the skyrocketing costs of medical practice in today's highly regulated and litigious practice environment, are making physicians (especially solo practitioners) harder to find.

An American Medical Association (AMA) video interview underscores these challenges, reflected in the difficult decision by Lisa Egbert, MD, to close her obstetrics-gynecology practice in Dayton, Ohio, after nearly 30 years.

Dr. Egbert, a speaker of the AMA House of Delegates, describes the decision as "one of the hardest things I've ever done in my life." After years of trying to make ends meet, cut costs, and even defer her own salary, she finally came to the realization that, in essence, "the bottom line is, a practice is a business"—particularly for solo and independent practices like hers. With practice overhead continuing to grow (such as rent, liability insurance, electronic health records, and staff) and reimbursements (based on Medicare rates) trailing inflation, Dr. Egbert had no other option than to close.

Describing the impact on and reactions by her patients, Dr. Egbert details the cards, letters, gifts, candy, and the tears and hugs: "It was like losing a loved one ... and losing my identity as a physician."

Even in a mid-size town like Dayton, losing a physician practice has an impact—especially as Dr. Egbert is not the only practitioner to leave practice. She worries about her patients finding a physician willing to take on new patients.

The central problem, she emphasizes, is Medicare, since every insurance company bases its fee schedule on Medicare. She urges physicians and patients alike to contact their legislators and urge a permanent fix. "The Medicare physician fee schedule is broken," she says. "It does not work for physicians, and more importantly, it doesn't work for the patients we serve."

Learn more at www.fixmedicarenow.org.

Mis- and Disinformation on the Rise

Misinformation refers to false or inaccurate information shared without harmful intent, while disinformation is deliberately fabricated to mislead (for financial or political purposes, for example), as detailed in a recent *Medical News Today* podcast.

The episode features Stephan Lewandowsky, PhD, cognitive psychology chair at the University of Bristol in the United Kingdom. He provides some pointers to help clinicians deal with and disarm misconceptions that patients may harbor on such topics as vaccines and alternative treatments.

Develop your discernment muscles. For example, investigate a website or source to find out what it's really about (and encourage patients to do the same). Type the website address into a search engine to find out information about its background, funding, supporters, and reputation for accuracy (or lack thereof).

Distinguish between facts and feelings. If a given source is using hyperemotional rhetoric or focusing on specific individuals rather than the issues, it may be a sign that the source is less than trustworthy. Websites and social media platforms get paid through clicks and shares, so they have a vested interest in content that plays on emotions versus facts.

Empathize, always. Another important skill to cultivate when helping patients is being able to express empathy with their viewpoints (however misguided or clinically misinformed). Fostering a space for open, candid, and respectful conversation can help patients open their doors of perception and understand that science beats fiction.

Applying these lenses to information (and helping patients do the same) can yield benefits for all. Just as sharing disinformation helps give it false credence, playing one's part to stop the flow of misinformation and disinformation can help ensure that the cream rises to the top.

UP IN SMOKE

Nicotine Addiction Causes Preventable Deaths

By Mark Harris

Cigarette smoking and other forms of tobacco use are harmful to a person's health, a generally accepted truth because the medical evidence is undeniable. Cigarette smoking and other forms of tobacco use are linked to about 20% of all cancers and 30% of all cancer deaths in the United States. In fact, tobacco use causes about 80% of all lung cancer diagnoses and deaths.[1]

Indeed, the list of serious diseases and health risks linked to tobacco use includes not only cancer but also heart disease and stroke, chronic obstructive pulmonary disease, type 2 diabetes, autoimmune conditions such as rheumatoid arthritis, reproductive health and pregnancy complications, and more. All in all, more than 16 million Americans are currently living with a disease related to the use of tobacco products.[2]

When There's Smoke ...

Tobacco products contain a dense blend of toxic chemicals and a highly addictive chemical compound called nicotine.[3] About 600 ingredients are in cigarettes, including at least 69 cancer-causing chemicals, according to the American Lung Association.[4]

The use of nicotine-rich tobacco has a long history. Reports of tobacco being used in social and ceremonial settings date as far back as 1400 BC.[5] In 16th century Europe, as global trade expanded and tobacco use was introduced on the continent, interest also grew in potential medicinal uses for tobacco, including as a treatment for joint pain, epilepsy, and plague. In turn, tobacco use began to spread internationally.[6]

For the first half of the 20th century, while there were concerns about the safety of tobacco products, tobacco use became generally accepted in society. From the 1930s to the 1950s, cigarette manufacturers even advertised in medical journals or used physicians to endorse particular brands, offering attractive claims about the pleasantness and safety of their products.[7]

From the mid-1950s, this social acceptance began to falter, as medical evidence began to mount about causal links between tobacco use and the development of lung cancer and other health problems. A turning point came in 1964 with the release of the surgeon general's first Advisory Committee on Smoking and Health report, which linked cigarette smoking to lung and laryngeal cancer. Cigarette use was also cited as the leading cause of chronic bronchitis.[8]

The surgeon general's report marked the beginning of a long-term decline in tobacco use. Indeed, the overall percentage of people who smoke has declined from about 43% in 1965 to 12% in 2022.[9]

Gone now are the days of smoking sections in commercial and public transportation and other examples of the once widespread cultural acceptance of tobacco use. Today, both state and local laws commonly ban smoking in most enclosed public spaces, including workplaces, restaurants, bars, and public transportation.

A Slow Burn

With widespread public awareness of tobacco's harms, it might today seem unnecessary or a low priority for health care providers to continue to focus on tobacco prevention issues. But the overall decline in tobacco use is only part of the story, according to experts.

"We have made substantial progress in bringing down the prevalence of tobacco use in the general population, but we are far from being done in addressing tobacco use as a public health problem," says Maya Vijayaraghavan, MD, MAS, the director of the Smoking Cessation Leadership Center (SCLC) at the University of California San Francisco. "We need to celebrate that progress but also contend with the fact that 480,000 people die yearly from tobacco-related illnesses and that it's the leading preventable cause of death."

"Despite the gains, tobacco use accounts for more deaths than alcohol, AIDS, vehicle fatalities, illegal drugs, murders, and suicides all combined," adds Jennifer Folkenroth, national senior director of tobacco programs for the American Lung Association. "The current percentage of smokers is equal to 28.8 million people. And 10.1% of high school students, representing 1.58 million students, are also using some form of tobacco product, such as e-cigarettes, vaping devices, or cigarettes."

In many respects, tobacco use constitutes an unusually complex public health challenge.

"Tobacco is a unique legal consumer product," says Folkenroth. "It's the only one that kills half of its users when consumed as directed. When you're dealing with a product that is this lethal, it doesn't matter how healthy the individual is; the health risks are always significantly harmful. Watching the trends of tobacco and product use, even though we're seeing a decline in cigarette smoking, we also know it is not equal across the board. Tobacco use disproportionately affects the health and well-being of vulnerable populations. These include residents of rural areas, military veterans, LGBTQ people, adults [who] did not graduate from high school, [residents of] lower income areas, uninsured persons, communities of color, people [with] mental health or substance use disorders, as well as adults living in public housing. So, although we're seeing a decline, we are not seeing a significant change among specific disparate populations."

In fact, a 2024 report from the U.S. surgeon general's office "Eliminating Tobacco-Related Disease and Death: Addressing Disparities" concludes that many Americans remain uniquely vulnerable to the harmful effects of tobacco products due to disparities in tobacco use and exposure across the population spectrum:

> Despite strong progress in reducing tobacco use at the population level, disparities in use persist by race and ethnicity, level of income, level of education, sexual orientation, gender identity, type of occupation, geography, and behavioral health status.[10]

The report also documents that exposure to secondhand smoke is greater among the Black population, youth, and people from lower socioeconomic backgrounds than other racial and ethnic groups, adults, or those from wealthier socioeconomic backgrounds.[10]

A contributor to the surgeon general's report, Dr. Vijayaraghavan says public health policy, prevention, and cessation efforts must consider the full landscape of tobacco products currently in use. "Cigarette smoking is still the predominant form of tobacco use in these populations, but new and emerging

Smoke = Out

"The tobacco industry has designed, engineered, and marketed menthol cigarettes and other tobacco products that deliver multisensory flavor experiences which increase the likelihood of tobacco initiation, addiction, and sustained use," according to the 2024 surgeon general's report on tobacco-related disease and death. "Policies that restrict the availability of menthol cigarettes can reduce smoking initiation and prevalence among adolescents, young adults, Black people, and other population groups that have disproportionately higher use of menthol cigarettes."[17]

products like vapes and nicotine pouches are also contributing to this burden," she notes.

Tobacco control advocates should also remain alert to the ways the commercial tobacco industry works to circumvent public health initiatives to curb tobacco use. "There is a long history of some populations being specifically targeted by the tobacco industry, including Native Americans, the LGBTQ [community], low-income populations, and those with mental health and substance use disorders," says Dr. Vijayaraghavan. Native populations [who have a] history of sacred and traditional tobacco use … [also] have a history of sacred tobacco being taken away from them and replaced with commercial tobacco. This has normalized the use of commercial tobacco in these communities.

"In other communities, including LGBTQ groups and those experiencing homelessness, populations have been directly targeted by the tobacco industry's marketing strategies. The tobacco industry has capitalized on the unique, challenging experiences [of] these groups and the potential for tobacco to be used as a coping mechanism. This is a structural and systemic issue on how these disparities were initiated and perpetuated."

Smokescreen

The surgeon general's report also notes the strong relationship between tobacco use and mental health.[10]

A recent analysis by Dr. Vijayaraghavan and her SCLC colleagues in *Preventive Medicine Reports* highlights the scope of this issue, noting that compared to the nearly 12% of tobacco users in the general population, the prevalence of smoking among people with any mental illness is 23%. Notably, behavioral health conditions are estimated to be present in over half of the 480,000 people who die from cigarette smoking annually.[11]

"Tobacco use is a behavioral health issue," says Dr. Vijayaraghavan. "As the leading cause of preventable death, it is associated with substantial economic loss, loss in terms of improvement in mental health conditions, and loss in terms of overall quality of life and well-being. Any reference to thinking about tobacco use as anything other than a behavioral health issue is one major change that we need to make in terms of messaging, building awareness, and improving access to treatment and policies."

Accordingly, SCLC collaborates with health, community, and government partners at local, state, and federal levels to promote tobacco-free policies and increase access to tobacco treatment. This includes establishing Leadership Academies to facilitate cooperative action among mental health, substance use treatment, tobacco control, and public health departments.[11]

Light's Out

One key issue in the effort to curb tobacco use is how to best support individuals who want to quit. As an addictive substance, the nicotine in tobacco products can make the habit very hard to quit. Fortunately, many treatment resources and tools are now available to support smokers who want to stop smoking. For instance, the American Lung Association sponsors the Freedom from Smoking program, which offers multiple resources and treatment options.[12]

Led by certified facilitators, the goal of Freedom from Smoking is to address the physical, mental, and social factors involved in nicotine addiction and support program participants with counseling, stress management, relapse prevention, and more.

"The Freedom from Smoking program is an evidence-based smoking cessation program that has been around for over 40 years now," says Folkenroth. "The program is available in a variety of different modalities to fit the needs of the individual. Whether they prefer an in-person group class, a virtually delivered group program, working directly one-on-one with a counselor over the phone, a digital online option that can be accessed through any digital device, or our self-help kit, there are a variety of different ways that folks can begin their journey to freedom from tobacco and nicotine product use. The program has also proven effective. It has a 57% stay quit rate at six months post-graduation when used in combination with an FDA-approved [U.S. Food and Drug Administration–approved] cessation medication."

Going through multiple attempts to quit smoking is not uncommon, observes Folkenroth: "If someone has tried multiple quit attempts and has not been successful before, they are not alone. Unfortunately, that's the nature of tobacco dependency and it being a lifelong addiction, a chronic relapsing condition that requires repeat intervention. … Over 50 million individuals across America have successfully quit smoking. The Freedom from Smoking program has assisted over one million individuals in breaking free from tobacco and nicotine use and living a tobacco-free lifestyle."

The key to individual success in ending tobacco use is to have a plan. "It's so difficult to break free from nicotine addiction," she remarks. "The addiction has three different components. There is the physical addiction to nicotine, which involves stimulation of the receptors in the brain that release dopamine—that happy chemical. There is also the psychological or mental addiction. This can become an automatic behavior that's intertwined [with] your day-to-day lifestyle. The nicotine addiction becomes your best friend. It's how you deal with grief. It's your

anxiety medication. It is how you cope. The other link is sociocultural. This involves our natural desire to socialize and fit in with our peers. This is the major reason why the majority of individuals started tobacco use years before. [However], as we mature, those social factors can play a role in our continued use. We take smoking breaks with coworkers or have opportunities to socialize with friends or family where we would not otherwise. People can be reluctant to give up those connections."

Accordingly, a treatment plan should address not only the physical addiction but also the psychological and social components. "Without a proper plan in place to overcome all the components and challenges of the addiction, many times we will have increased urges and cravings and can struggle while attempting to quit," explains Folkenroth.

Often, physicians and counselors recommend a combination approach to smoking cessation, using both medications and counseling support. Such medications include prescription medications—such as bupropion (Zyban, Wellbutrin) and varenicline (Chantix)—and nicotine replacement therapies. Replacement therapies include over-the-counter products such as the transdermal patch, gum, and lozenge and prescription-only products, including nasal spray and oral inhaler.[15]

Fight Fire

Interested in becoming a Freedom from Smoking facilitator? The American Lung Association's training program is designed for a variety of people[19]:

- Public health professionals
- Health care workers
- Anyone interested in supporting their fellow community members in going tobacco-free

Fire Fighters

For support, smokers who want to quit may be referred to qualified counselors in tobacco treatment, such as certified Freedom from Smoking facilitators or other credentialed specialists. These trained tobacco treatment specialists work in different medical and community settings, including primary care, hospitals, neighborhood health centers, specialty practices, and schools.

Certifications available in tobacco treatment may be sponsored by professional medical organizations, regional medical centers, state public health agencies, and other groups. Many are accredited by the Council for Tobacco Treatment Training Programs.[14]

For instance, the Mayo Clinic's Nicotine Dependence Education Program sponsors a training program that allows participants to qualify as a certified tobacco treatment specialist (CTTS).[15]

"We rely heavily on utilizing best practice–advised methods for everything that we do," says Adam Bennett, MSW, LSW, CTTS, NCTTP, the tobacco cessation coordinator for Hillside Medical Center, an outpatient affiliate of the University of Pittsburgh Medical Center in Hanover, Pennsylvania. "This isn't just a 'Show up and I'll give you a few tips based on things I've heard or what I could Google about how to effectively stop using tobacco.' With a new patient or client, we always start with an intake assessment or what we call a *biopsychosocial assessment*."

This initial assessment entails a review of the patient's overall health, including mental or behavioral health concerns and other health issues, explains Bennett. The assessment will also include a discussion of the client's reasons for wanting to quit tobacco and their immediate and long-term goals.

In addition to his CTTS training, Bennett is a certified Freedom from Smoking facilitator. "The nature of tobacco treatment counseling should [strive] to empower the patient," he asserts. "Our approach is about forming a client- or patient-centered plan. A lot of experience has shown me that we need to make sure the client or the patient is in the driver's seat. A tobacco treatment specialist is most effective when they adopt the copilot role, as opposed to an approach that says 'I am going to pilot this, and you're going to come along for the ride.' "

In turn, a patient-centered approach emphasizes the importance of creating an individualized strategy or plan to help patients achieve their goals. This includes offering tools, resources, and education to support individuals to make the changes necessary to end their tobacco use. "The Freedom from Smoking program, while being a structured curriculum, works so well because it does just that," says Bennett. "It provides a framework for each participant to make their own individualized plan. It also provides the support that is so vital to long-term success. This applies to tobacco

Playing with Fire

Young people are at a higher risk of becoming addicted to the nicotine in tobacco products because their brains are still developing. Further, nicotine exposure can have negative consequences on normal brain development.[19]

"The younger a person is when they start using tobacco, the more likely they are to become addicted," according to the U.S. Food and Drug Administration. "Because of nicotine's powerfully addictive nature and major effects on the developing brain, no tobacco products are safe for youth to use."[19]

Resources

UCSF Smoking Cessation Leadership Center
https://smokingcessationleadership.ucsf.edu

American Lung Association
https://www.lung.org/quit-smoking

and nicotine dependence counseling or coaching on an individual basis as well."

As an experienced tobacco treatment specialist, Bennett offers insight into the nature of nicotine addiction and how it should be approached from a treatment perspective. "Tobacco and nicotine dependence is best viewed as being similar to a chronic disease," he explains, "like asthma and diabetes for example, with ongoing management being necessary, periods of success when things are going well, and periods where things go out of balance or relapse occurs. A common misperception by patients and health care providers is that tobacco and nicotine dependence is more like an acute condition that can be treated acutely and just goes away like an infection after taking a short course of antibiotics. This isn't the case for the majority of people when it comes to tobacco. But that's the way most of society views this issue, like you should be able to make up your mind to quit, like flipping lights off with a switch, and—poof—it's done. Most tobacco users don't quit the first time they try, relapse and slips are not uncommon, and there's typically no simple solution to 'just make it go away.' "

Accordingly, Bennett notes that a team approach works best for tobacco dependence. "As is the case with management of any other chronic disease, the health care team approach is essential to helping the patient learn about, treat, and manage the patient's condition over time," he says. "Tobacco treatment specialists are uniquely positioned to serve as the point person for this issue, keeping current on advancements in the field of tobacco and nicotine dependence treatment and translating that into practical steps and strategies that work to help real people … navigate a frustrating and confusing path toward becoming tobacco- and nicotine-free."

Like others, Bennett wants tobacco users to know that no matter how difficult, ending their nicotine dependence is possible. "Every single person has the ability to change this—to become free of this addiction—when they decide that it doesn't make sense to keep on with the status quo as it relates to tobacco use. If [they don't] see that yet, we tobacco treatment specialists can help the individual discover it [and] provide the resources they need to help them take action. When they're ready, we will be here to help them develop the skills and the confidence to bring it forward, put it to work, and make this change."

Notably, not all tobacco users today are cigarette smokers. "The most common cases I handle are those individuals that use nicotine vaping devices," says Jessica Blessinger, CTTS, a tobacco treatment specialist and clinical preceptor lead for Hancock Health in Greenfield, Indiana. "Very few of these patients smoke cigarettes."

In Blessinger's work, the initial patient assessment takes anywhere from 45 minutes to an hour, with subsequent follow-up visits lasting 20 to 30 minutes. "I assess a patient's dependence [on] nicotine [and] tobacco products, create personalized treatment plans, educate patients on long-term risks of smoking, benefits of quitting nicotine [and] tobacco products, and help identify barriers and potential hurdles along their cessation journey," she reports.

Patients are referred by clinic providers (e.g., physicians or nurse practitioners), who may prescribe medications or nicotine replacement therapy. "From my experience, the biggest challenge one faces achieving cessation is finding healthy alternatives to the tobacco habit," says Blessinger. "The time a person would spend smoking or using nicotine products leaves time for lifestyle changes to have a greater impact on their health—such as walking, trying new hobbies, learning new skills, or [generally] taking more time to care for themselves."

Brighter Futures

"To be successful when counseling patients, you must be open-minded to everyone's situation," says Blessinger. "Great communication skills, empathy, [adaptability], [and readiness] to solve problems [are] key to being a CTTS. Each patient is unique and will require personalized care plans. Being able to think outside the box [will] make the individual feel well cared for."

What do ex-smokers say about quitting? "I started smoking when I was 16 years old, and I am now 38 and have been smoke-free for three years," says Jennifer McCabe, CMA (AAMA), a staff member for Monarch Behavioral Health in Albemarle, North Carolina. McCabe initially sought help from her primary care provider to quit: "I was prescribed Chantix, which I needed to take for only two or three weeks. I also changed my habits. Instead of looking for that [post-meal] smoke, for example, I washed the dishes. I also have a supportive family [who] agreed not to smoke in my home or vehicle, especially in the early stages. Now, the craving still hits me on occasion, but I am able to take my mind off of it."

To best help patients who use tobacco, McCabe suggests medical staff be patient. "The best advice I can give is just to listen," she says. "You can only inform people to the best of your ability about the risks, but if someone is not ready to quit, they won't. If a patient shows a genuine interest in [making] that change, encourage them and try to connect them with a support network. And let the provider know what you have discussed so they can further educate the patient on their options."

As a former smoker whose parents smoked, Marjorie Van Duyne, CMA (AAMA), an adjunct medical assisting educator at Wayne Community College in Goldsboro, North Carolina, is sensitive to these challenges. In her experience working in an oncology unit, Van Duyne saw many lung cancer patients who felt guilt or shame about their smoking history. "There is a stigma that surrounds people who smoke and who develop lung cancer," she observes. "For some, the stigma is that they did this to themselves and deserve it. I think this can be a barrier to their care. The attitude

was often not the same as with other cancer patients—not quite as much the 'I'm going to beat this' mindset because of this tremendous guilt and shame. Some of these patients would also [avoid] seeking care or getting a diagnosis out of fear of a cancer diagnosis. We have to try to deconstruct that stigma. It shouldn't matter what the patient did or didn't do. What matters is that we're here now to get the patient through this and to support them."

While the challenges are certainly many, and tobacco use remains a persistent public health issue, there is reason for optimism about the future of tobacco control initiatives. Beyond continuing public education and support for access to smoking cessation resources, proposed FDA regulatory changes are under consideration to significantly reduce nicotine levels in cigarettes and other tobacco products.[16]

"I believe it is the combination of strong prevention programs, policies, and cessation interventions informed by the communities that are impacted that will really help us to move forward," concludes Dr. Vijayaraghavan. "We need to do this across multiple levels. It happens at the individual level, but it also happens at our health systems level, community level, and population level. We also need to be on top of the regulation aspect of tobacco products to stay informed and vocal about the decisions that the FDA is making about these products. So, there is a lot of work for us to do. But as a team and as a society, if everyone is working together, we're going to be able to achieve our goals."

In doing so, tobacco control advocates are indeed hopeful that society can continue to chart a path toward the goal of a healthy, tobacco-free future for all. ✦

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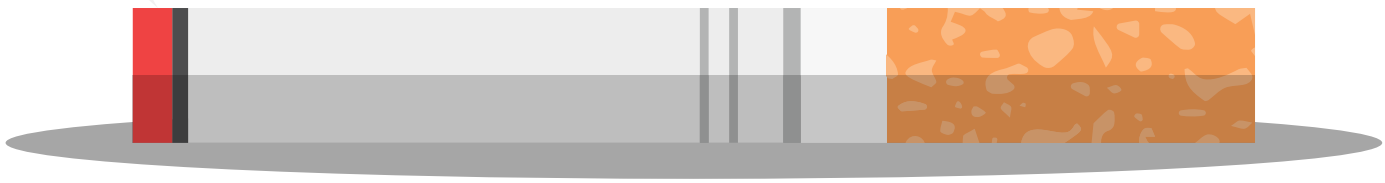

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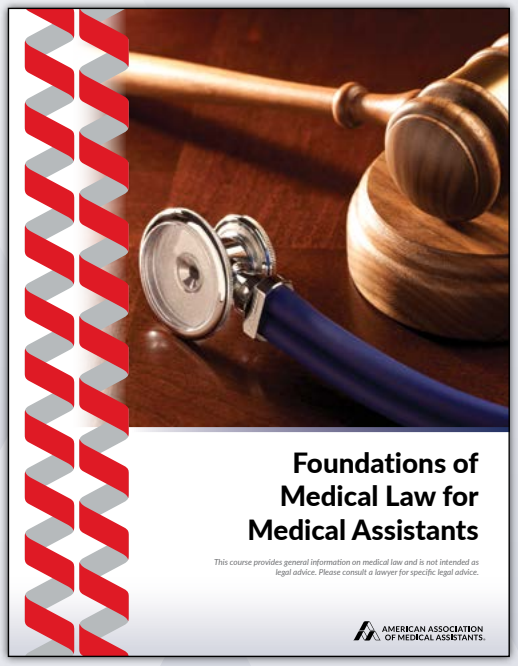

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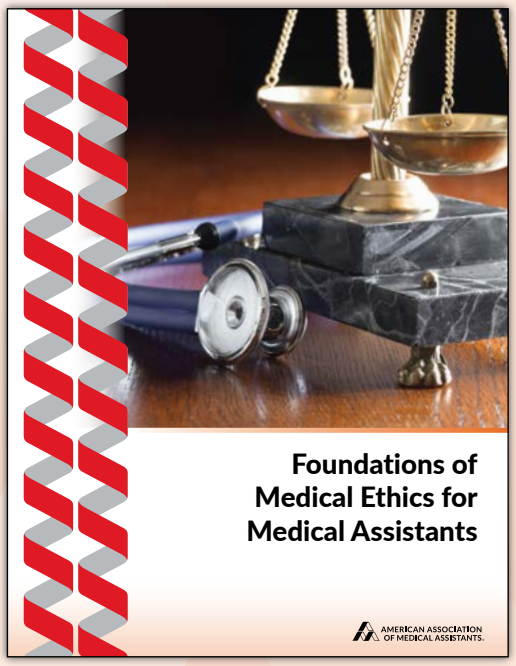

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Sounds Too Good to Be True?

Popularity has grown for using white noise to obscure other sounds that could disrupt one's slumber. A new systematic review on the practice in *Sleep Medicine Reviews*, however, raises questions as to its efficacy. In fact, overuse of white noise could negatively affect deep sleep and hearing, particularly if set to high volume.

Past studies of white noise and sleep have been mixed. "A study in infants and children showed that white noise may reduce heart rate and respiratory rate, effectively lulling an individual to sleep," says Sogol Javaheri, MD, MPH, an assistant professor at Harvard Medical School, in *Harvard Health Publishing*.

Despite claims to the contrary, "the quality of evidence supporting this assertion is very low," say study authors. They reached this conclusion upon review of nearly 40 studies on white noise, through which they found considerable and significant variation in research parameters, including "noise characteristics, sleep measurement methodology, adherence to the intervention, control group conditions or interventions, and presence of simultaneous experimental interventions."

Harvard Health notes the existence of different "colors" of sound, including pink and brown. Pink noise is similar to a gentle rainfall, while brown noise is analogous to crashing waves at the seashore. These sounds may be pleasing to the ear, but as with white noise, data on their effectiveness for sleep is limited.

Flabbergasting Fiber Facts

Like all too many dietary essentials, we all need fiber, but we don't get enough. Experts recommend 28 grams daily; the average person gets 17.

Increase your daily intake of some facts about fiber, as detailed in *Nutrition Action* from the Center for Science in the Public Interest:

At the heart of the matter. Surprisingly, the strongest evidence for fiber's beneficence points not to the digestive tract but rather the heart. Large prospective studies have shown that fiber intake protects against heart disease, the leading cause of death worldwide. Research on colorectal cancer does not show the same protective effect from fiber.

Does it add up? Fiber added to other foods may have different effects on the body, as opposed to naturally occurring fiber (such as in foods like grains, beans, vegetables, and other plant food). For example, a common fiber additive, inulin, which is found in many processed foods, raises calcium absorption. So the many benefits of fiber might not be attainable from a gummy or donut with added fiber.

Just say no. The processed food industry and agribusiness giants are using fiber to burnish the image of otherwise unhealthy foods—everything from ice cream and candy to cookies and baked goods. Proceed with caution: if you're in the cookie aisle and you keep seeing "good source of fiber," consider how "good" a source it really is, and ensure that your fiber intake comes from natural sources.

Foam Home, ET

However humble and low-tech they may be, those ubiquitous foam rollers you see at your local health club or gym can play an important role in keeping you flexible and limiting postworkout soreness, tension, and pain, according to Harvard Health Publishing.

Think of the roller as a mini-massage, says Marwa A. Ahmed, MD, MS, an instructor in physical medicine and rehabilitation at Harvard Medical School and medical director of the Spaulding Outpatient Center in Boston. Rolling can help improve blood circulation and move excess fluid out of the lymphatic system, helping relieve tension. And they're excellent as a warm-up to get blood pumping.

Dr. Ahmed offers additional tips for newbies ready to roll out:

- **Stand and deliver:** If getting down on the floor is too much of a pain, try standing against a wall with the roller on your back or legs.
- **Not so hard:** Choose a softer texture instead of a hard foam roller, which can be too intense if your body is not accustomed to rolling. For the same reasons, avoid rollers with bumps (which provide additional, deep pressure to trouble spots).
- **No bones about it:** Keep the roller on muscles and tendons and avoid bones.
- **Small ball:** Tools such as a tennis ball can be used to roll out specific, smaller areas of the body—like that tight spot in your shoulder.

Take It Down a Notch

When stress rears its ugly head, it's time to pull back, disengage, and unwind. Here are some quick fixes, as suggested by the editors of Healthline:

Walk it off. Some brief exercise can give your brain and psyche the break you need to recharge and refresh.

A friend indeed. Especially if your work is solitary, or you're based out of a home office, consider the chance for camaraderie and water cooler chats. A call or text can suffice, but physical proximity with friends, family, and other loved ones (yes, that means pets too) can be the pause that refreshes.

Riddle me this. Sudoku or other games can help clear the cobwebs.

Sleep, perchance to dream. A few z's in the afternoon can recharge the neurons and lower stress.

Go green. Spend some time in nature. Even a short break to watch squirrels cavorting or birds in flight can work wonders. Bonus: combine multiple stress-relief strategies by taking a slow, communal walk along a local river or other scenic byway, to meet, chat, and share a laugh.

Diverticular Disease

Understand the Twists and Turns of a Complex Condition

By John McCormack

"Medical assistants are often the first ones to respond to a patient call, and they often help with education," says V. Liana Tsikitis, MD, FACS, FASCRS, professor and division head of gastrointestinal and general surgery at Oregon Health and Science University in Portland. So, they need to know enough about diverticular disease to ensure that patients receive proper care, asserts Dr. Tsikitis. She wants medical assistants to be educated on diverticular disease, as they will likely have multiple opportunities to interact with patients at risk for or who already have the conditions that fall under this disease umbrella.

Melinda Hoffman, CMA (AAMA), a medical assistant at GI Associates in Wausau, Wisconsin, is involved in such activities on a day-to-day basis. "Medical assistants at our practice play a key role in educating patients about conditions such as diverticulosis and diverticulitis. We are typically responsible for processing the necessary medications for acute diverticulitis, scheduling follow-up colonoscopies, and providing guidance on the preparatory steps associated with these procedures," explains Hoffman.

As such, medical assistants working in specialty groups and primary care practices need to understand the condition well. This can be a challenge when it comes to diverticular disease, as nomenclature can be quite confusing and best practices are continually evolving.

A basic understanding of diverticular disease—including related symptoms, diagnosis, and treatment—is warranted. Perhaps more importantly, health care professionals must have a handle on changing care protocols and various misconceptions associated with this common disease.

Readers Digest

Understanding the conditions that fall into this disease category can be confusing:

> The term, "diverticulosis," comes from the word "divert," indicating that the path through intestines is diverging into these side pockets. Several pouches are called "diverticula," and one pouch is called a "diverticulum." They most commonly occur in the large intestine (colon), which is more likely to have denser food waste pushing against the weak spots, especially towards the end.[1]

With diverticulosis, patients have small pouches or pockets of diverticula in the inside walls of intestines. These diverticula develop over time in the inside lining of intestines and push into weak spots in the outer wall. Generally, this condition does not cause any symptoms. However, they could serve as a breeding ground for bacteria to hide out and multiply.[1]

While it sounds similar, diverticulitis means inflammation, typically a bacterial infection, is present in at least one of the diverticula. And, diverticulitis can cause pain and other symptoms.[1]

"The problem is a lot of people confuse the presence of diverticula, which is diverticulosis, as diverticulitis, and it's extremely different. The diverticula are just herniations in the colonic wall," says Dr. Tsikitis. "A significant number of the population has diverticulosis, but not everybody will develop diverticulitis, which is the inflammation and infection of those diverticula in the colon."

Typically, 10% to 25% of diverticulosis patients will develop diverticulitis in their lifetime.[2]

Notably, two categories of diverticulitis exist—uncomplicated and complicated. Uncomplicated diverticulitis is inflammation of the colon. Complicated diverticulitis, in addition to inflammation, also involves an abscess collection or some kind of major perforation of the colon, according to Yosef Nasseri, MD, FACS, FASCRS, an associate professor of surgery at Cedars Sinai in Los Angeles.

With an understanding of the conditions that fall under the diverticulosis umbrella, medical assistants can help get

patients on the right path. For example, if a patient calls or comes into the practice with pain on the left side, medical assistants should follow protocol as outlined by the supervising physician, which can mean recognizing "the possibility of diverticular disease and making sure the patient sees the physician, who can order a CT scan of the abdomen and pelvis, get the results, and provide the appropriate treatment," says Dr. Tsikitis. "Of course, if the patient says they woke up with severe pain and cannot keep any food down, the medical assistant needs to direct the patient to the local emergency room."

More than a Gut Feeling

In addition to a basic understanding of diverticular disease, health care professionals should stay on top of current research. The American Gastroenterological Association published a clinical practice update to provide practical and evidence-based advice.[3] Drawing from that guidance as well as input from health care leaders, medical assistants should keep the following insights in mind as they interact with patients with diverticula:

Diet makes a definitive difference. "If someone does have diverticulosis, the No. 1 most important thing we tell people is 'fiber, fiber, fiber.' Patients need to increase multigrain [foods and] raw fruits and vegetables, which have a lot of fiber content in them. … The thought is that fiber is both a bulking agent and also an anti-inflammatory agent, which takes away the pressure from the colon," notes Nasseri.

Real food is best. People should get 30 to 40 grams of fiber a day. "Food first, but … if you cannot get enough fiber by food, supplements are fine," Dr. Tsikitis says.

Fiber rules but not when recovering. Notably, fiber needs to be slowly reintroduced into the diet after a diverticulosis episode.

"Due to inflammation that occurs with diverticulitis, bowel rest may be indicated depending on the severity of the inflammation. This may mean a clear liquid diet or nothing by mouth. Consuming too much fiber too quickly can increase the risk of constipation, especially with inadequate water intake, and may cause the inflammation to worsen," says Sue-Ellen Anderson-Haynes, MS, RDN, CDCES, LDN, NASM-CPT, owner of 360Girls&Women and spokesperson for the Academy of Nutrition and Dietetics.

Dietitians can help. "When a patient [has] symptoms that disturb their daily living, including not being able to have proper bowel movements, … a registered dietitian should be consulted," says Anderson-Hayes.

Antibiotics are not the be-all and end-all. Antibiotic treatment should be used selectively rather than routinely.[3]

Antibiotics used to be prescribed in almost all cases. "Antibiotics are not needed with a mild diverticular attack, which more likely than not will resolve with just bowel rest, meaning a clear liquid diet," says Dr. Tsikitis. "The bowel rest is more important than the antibiotics."

Antibiotics are needed, however, when patients present with an active infection, significant inflammation, persistent pain, fever, or high white blood cell count.

Mindful eating. Some health care professionals used to tell patients to steer clear of popcorn, nuts, and seeds. "This is outdated advice," says Dr. Tsikitis. "When there is no acute attack, the popcorn, the nuts, and the seeds are not going to cause any problems. But people need to know how to chew their foods well and take their time to eat their meals."

Never assume. When a patient comes in with left-lower-quadrant abdominal pain, it is easy to assume that they have diverticulitis. But the patient might be presenting with other symptoms such as chronic constipation or difficulty with evacuating. It could be an ovarian cyst or abscess or tubal ovarian torsion.

"It's important to get a CT scan when the patient is having a flare," Nasseri concludes. "A CT scan will not only tell us whether the patient has diverticulitis, it would tell us the severity of the diverticulitis, and that documentation is important." ✦

Treatment

Diverticulosis. When thinking of treatment strategies, Yosef Nasseri, MD, FACS, FASCRS, stresses the importance of educating patients on preventing diverticulosis from becoming diverticulitis. "[Prevention involves] lifestyle management and alterations to prevent the diverticulosis ultimately turning into diverticulitis."

Diverticulitis. Patients are placed on a liquid diet until the symptoms resolve, and antibiotics are sometimes prescribed as well. Elective surgery is warranted when patients present with four or more cases of complicated diverticulitis in 12 months. When patients come in with complicated diverticulitis accompanied by a high fever and pus or stool is coming out of the colon, then an emergency colectomy might be called for. "Those patients end up with a temporary colostomy bag," says Nasseri.

Diagnosis

Diverticular diseases are diagnosed via various methods:

- Physical examination
- Blood test
- Stool test
- Imaging tests such as a CT scan, a barium enema, a flexible sigmoidoscopy or a colonoscopy

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Professionals Work Together to Improve Veterans' Health Care

By Pamela Schumacher, MS, CCMP

Medical assistants care for patients of all ages, backgrounds, and experiences and will likely encounter one of the more than 18 million military veterans who make up about 6% of the U.S. population.[1] A veteran is someone who has served in the military as a member of the Army, Navy, Air Force, Marine Corps, or Coast Guard or as a commissioned officer in the U.S. Public Health Service, Environmental Science Services Administration, or National Oceanic and Atmospheric Administration. Most veterans receive care from family physicians or cooperatively with the Veterans Health Administration, although more than one-half receive care from only the civilian sector.[2]

Interacting with veterans can be very different than with other patient populations. Medical assistants must understand how military service might have affected each veteran and what that means for their physical and mental well-being.

A Tank of a Different Color

Understanding military culture is the first order of business when dealing with

a patient who is a veteran. Military culture has distinct traditions, socialization, values, vocabulary, and norms. Taking the time to understand and appreciate their culture can improve the care provided to veterans and patient outcomes.[3]

"All health care providers and caregivers for veterans should recognize that military service changes an individual's perspective," says Edward Manning, MD, PhD, a pulmonary and critical care medicine physician at West Haven VA Medical Center, Connecticut. "When we're taking care of people, we need to understand how they perceive themselves, their surroundings, and their own health. Understanding the veteran's background really helps with that."

Dr. Manning, who was an officer in the Marine Corps before he graduated from medical school, experienced this firsthand. "In the military, we rely heavily on our caregivers and medical personnel to achieve our missions and goals. Sometimes a veteran will have a hard time trusting civilian medical professionals because they're used to working with people in only their unit. In addition, we typically put ourselves last because the ethic is 'mission first, individual last.' "

Sherry Bogar, CMA (AAMA), a certified breast cancer patient navigator at the University of Texas Medical Branch in League City, Texas, agrees. "The idea of 'mission first' does not go away when a person leaves the military, and it can be a tough hurdle to cross. My husband is retired military, and he has a lot of pain from a knee replacement after an accident while participating in physical training. We were stationed in a rural area and didn't have access to physical therapy services, and the knee has bothered him ever since. He also has hearing loss from working on an aircraft carrier. However, he is reluctant to be re-evaluated because his thought is, 'Why would I take money or care away from individuals who have lost legs, limbs, and even their life, while I'm getting up every day to walk?' "

Though military culture is a strong influence, it's not the same for every service member, says Bradford Felker, MD, a senior telemental health consultant at the U.S. Department of Veteran Affairs (VA) in Seattle, Washington. "People join the military for all kinds of reasons. We have a volunteer force now, and there are many reasons why someone decides to serve, and their experiences are quite diverse. The idea that a veteran is a unique human being is the first thing the medical assistant should understand.

"In addition, veterans have gone through a lot of transitions. The challenges of going from a combat zone to garrison life is a big step, but the step between active duty to civilian life is gigantic," says Dr. Felker. He is also a professor in the department of psychiatry and behavioral sciences at the University of Washington School of Medicine in Seattle and was deployed to Kuwait and Iraq in the Navy reserves. "Someone who has just transitioned out of the military is undergoing an enormous culture change. For example, when you serve in the military, you're expected … to know the mission. You're expected to know the duties of each day. … All that goes away in the civilian sector, and it can be very disorienting for veterans."

Military Precision

Medical assistants should use their listening, observational, and deductive reasoning skills to elicit relevant details about veterans' military experience and how that might be affecting them physically and mentally, explains Bogar. "Medical assistants are the Sherlock Holmes of the medical office; a big part of our job is to dig and investigate. We let people know we care by showing them compassion and interest in their experiences. I ask open-ended questions such as, 'I notice you're wearing a military hat; can you tell me about that? Where did you serve?' These questions open the door to a larger conversation about their health and general well-being."

"Medical assistants are the first person the veteran sees and the very last person the veteran sees, so they are the backbone of any medical team," says Dr. Felker who is board certified in both internal medicine and psychiatry. "They handle scheduling but also screen the patient and can alert the team if something is going on with the veteran.

"I would caution against automatically saying, 'Thank you for your service.' It's become so rote that it doesn't seem sincere," says Dr. Felker. "Instead, look them in the eye, listen to what they're saying, take a moment to pause before responding. Try to understand that these people have served, and their experience may have been complicated—meaning, they may have been in combat, [and] they may have seen some things that they'd rather not remember. They have the psychological stress of being a civilian who now must be in charge of their life, when before the military took care of everything. As I said, returning to civilian life can be very complicated for veterans."

Dr. Manning, who is a physician and a researcher, likes to find common ground when chatting with veterans. "I'll usually ask, 'Can you tell me what you did in the military? What branch were you in? I was in the Marine Corps. What did you do?' Not only does it connect us on a personal level, but as a pulmonologist, one of our greatest concerns for our patients are airborne contaminants. If they were a firefighter, I ask, 'Did you use firefighting foam? Tell me about that.'

"I ask where they served because the location can give you a clue to their exposures. If they were overseas, the risk of deployment-related respiratory disease is multiple factors higher than those who stayed in the states," says Dr. Manning. "What a rich resource it is to be able to screen their history and bring their attention to things of which they may not be aware. One of my patients taught me this. He would always bring up Agent Orange, which I didn't know a lot about. He was a Vietnam veteran and was wondering whether his asthma and cardiac conditions were related to Agent Orange exposure. And then he gave me the book *Waiting for an Army to Die: The Tragedy of Agent Orange*.

"This really opened my eyes. I'm an OIF [Operation Iraqi Freedom] veteran, and I was probably exposed to burn pits and other toxins. I thought to myself, 'I'm falling into the same pitfall of military culture and not taking care of myself,' " says Dr. Manning.

Role Call

Veterans want you to know[6] ...

- **They are not all soldiers.** Only Army personnel are soldiers. Each branch of the U.S. military has its own mission. Refer to veterans as "military personnel" or "veterans."
- **Not everyone in the military is infantry.** Active duty is made up of 1.4 million Americans among the five branches. The reserves have more than 800,000 members. There are many different jobs, including technicians, mechanics, cooks, administrators, lawyers, doctors, and musicians.
- **Military personnel are always on duty.** They live their work 24/7, which takes its toll—on their families too. Even when on leave, they can be called to serve at a moment's notice.
- **Reserves are part of the military.** There are two ways to serve in uniform: (1) Active duty is a full-time job, and (2) reserves are trained to serve *and* have day-to-day civilian jobs. Reserves have their own unique challenges because they live as a civilian, can be called to duty, and then return to their community.
- **They do not all have posttraumatic stress disorder** which can be caused by many different types of trauma, including combat.
- **It's hard to ask for help.** The military has a long-standing history of promoting emotional and physical perfection and emphasizing needs of others over self. If you understand that it is hard for veterans to ask for help, you are one step closer to connecting with them.

At Your Service

Veterans often present with a variety of physical and mental illnesses, including musculoskeletal injuries and chronic pain, mental health issues such as posttraumatic stress disorder (PTSD) and moral injury, traumatic brain injury, chemical and noise exposures, and infectious disease concerns. Medical assistants should be well informed about the range of veterans' health concerns, particularly PTSD, depression, and suicidality.[2]

"Veterans are at a high risk for depression, suicide, and other mental disorders. The VA offers telehealth visits with mental health professionals, and you could suggest that to a veteran if you suspect they're having issues [if your delegating provider authorizes you to do so]," says Dr. Felker. "Medical assistants may notice symptoms of PTSD in the veteran. In PTSD, there are three clusters of symptoms that might present including the re-experiencing cluster, which has the symptoms of nightmares, flashbacks, intrusive thoughts, and triggers. The medical assistant may not see these symptoms during the office visit. More likely they will see the hyperarousal cluster symptoms, which are when someone is stuck in 'fight-or-flight mode.' They might present as anxious, hypervigilant, and aware of everything. They startle very easily. They don't want anyone behind them.

"But the cluster that causes the most dysfunction … is the isolation cluster," says Dr. Felker. "People with PTSD tend to isolate and withdraw. They have difficulty making and maintaining relationships. They don't do well in crowds. If the veteran is not showing up for their appointments, they're not returning calls, and when asked a question, they immediately leave or run away; they isolate, withdraw, and disappear—these people need help. The symptoms of the illness lead them to just disappear, not be compliant, not go get their medications. This is not just being difficult; this is their illness."

Bogar worked in a urology office and encountered a veteran who was triggered by a procedure. "When we did a prostate biopsy, we used a 'biopsy gun.' The provider holds the device and pulls the trigger, and it makes a loud popping sound. The first couple of times when the provider pulled the gun, the patient jumped off the table. He said the popping sound took him back to Desert Storm. I showed him the mechanism and allowed him to pull the trigger to get used to the noise. This put him at ease, and we were able to resume the procedure. If the medical assistant can tell the veteran what to expect and then ask whether there's anything that might trigger or startle them, that's a good thing to do. Also, if I see a veteran having trouble sitting in a waiting room full of noisy people, I'll find a quiet location. You want to let them know that you see them and have their back."

"Sleep issues among veterans are also a problem," says Dr. Manning. "The probability of a veteran having sleep apnea is 40%. They're often very light sleepers. Researchers are starting to document something called an 'arousal index,' which measures the number of arousals or brief awakenings per hour of sleep, indicating the level of sleep fragmentation and potential sleep disturbances. If this is suspected, I would alert the physician so they can explore it with the veteran. However, be aware that it may be contraindicated to have some veterans do mindfulness training. I was in a session in which they asked me to close my eyes in a room full of people I didn't know, and I became very anxious because you would never do that when you're on duty."

Being in the military is also physically challenging. "A veteran might be in their 20s but have the body of a 60-year-old," says Dr. Felker. "Hauling a heavy pack, moving equipment, moving physically from place to place takes a toll. Don't assume that because a veteran is younger that they won't have the physical problems of someone much older."

In addition, veterans have often been exposed to toxins in the air and water depending on where and when they were deployed. In recent years, burn pits have emerged as one of the most widely recognized concerns around veteran health. Open-air burn pits were commonly used by the military in places such as Iraq and Afghanistan, and many veterans are dealing with the consequences of being exposed to the toxic smoke produced from burning chemicals, paint, human and medical waste, metal, petroleum and plastic products, rubber, munitions, and more.[4]

Research on the long-term health impacts of military burn pits is ongoing. However, in 2022, the VA formally acknowledged the presumed connection between burn pit exposure and nine rare respiratory cancers, which are now treated as service-connected disabilities. Burn pits are also believed to be linked to increased risk of death and various serious health conditions, including heart disease, asthma, chronic obstructive pulmonary disease, and more.[4]

"The VA has a long list of presumptive conditions—such as brain cancer, gastrointestinal cancer of any type, glioblastoma, head cancer of any type, kidney cancer, and lymphoma of any type—that if you served in certain areas, they assume your symptoms are a result of your service," says Dr. Manning. "There's a screening process through the PACT Act, which medical assistants should know about and can provide as a resource to patients."

The PACT Act, officially named the Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics (PACT) Act of 2022, expands and extends eligibility for VA health care for veterans with toxic exposures and veterans of the Vietnam War, Gulf War, and post-9/11 eras, and adds 20 more presumptive conditions for burn pits, Agent Orange, and other toxic exposures.[5]

Got Your Six

Medical assistants can shine when helping veterans coordinate their care with the VA, says Nancy Gourley, CMA (AAMA) who works at the Newton Medical Center, Family Practice Clinic in Valley Center, Kansas. "It is important to coordinate medical treatment with the local VA to avoid duplication of treatment with the private sector. Not all states have reciprocal relationships with one another, and, for instance, finding up-to-date vaccination records on veterans may be a challenge.

"The VA referral/authorization process is initiated from the veteran's primary care team at the VA who sends them for secondary or tertiary care within the local community," says Gourley. "If care isn't available locally, it may be necessary to send the veteran to a larger city where more resources are available. There may be a shuttle to help veterans with transportation to appointments outside their local community. My dad was in the service, and I found it helpful to keep a copy of his health records in a binder, so I could coordinate his care. Keeping the Durable Power of Attorney information current at the VA hospitals was extremely important—[the information] often needed to be updated every year. We personally had experience with multiple different VA hospitals and honestly, some were *very* good."

Bogar recommends picking up the phone and calling or even visiting your local VA. "Ask them, 'I'm trying to coordinate care for this veteran; can you help me?' " Check out the VA website, just to see what resources are available so you can offer tips to patients. If veterans need assistance, numerous organizations, including the VA, Navy-Marine Corps Relief Society, the American Legion, Veterans of Foreign Wars, and charities like Homes For Our Troops, offer relief and provide resources for financial hardship, housing, and other needs. Many veterans do not understand health care jargon and policies, and the medical assistant can help bridge that gap. ✦

Resources for Veterans

- Find care: https://www.va.gov/health-care/about-va-health-benefits/where-you-go-for-care/
- Get community care referrals and schedule appointments: https://www.va.gov/resources/how-to-get-community-care-referrals-and-schedule-appointments/
- Learn about airborne hazards and burn pit exposures: https://www.publichealth.va.gov/expo sures/burnpits/
- Read up on the Veterans Transportation Program: https://www.va.gov/healthbenefits/vtp/
- Learn about the National Call Center for Homeless Veterans. Call 1-877-4AID-VET. Veterans are also encouraged to call or visit their local VA medical center and ask for a homeless coordinator.

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

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Nicotine Addiction

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

Credit: 2.5 AAMA CEUs (gen/clin) **Code: 144267**

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. Replacement therapies include only prescription medications such as Zyban, Wellbutrin, and Chantix.

☐ ☐ 2. Exposure to second-hand smoke is greater among young people and individuals from lower socioeconomic backgrounds.

☐ ☐ 3. Nicotine is the only known cancer-causing chemical contained in tobacco products.

☐ ☐ 4. During the first half of the 20th century, smoking was considered generally safe and not harmful to health.

☐ ☐ 5. The 1964 report of the U.S. surgeon general provided evidence of a link between cigarette smoking and laryngeal and lung cancer.

☐ ☐ 6. Despite the marked decline in the percentage of the population that smokes, tobacco-related illnesses are still the second leading preventable cause of death.

☐ ☐ 7. The health risks of smoking are less for people who are otherwise healthy.

☐ ☐ 8. Smoking cessation plans should address the psychological, sociocultural, and physical aspects of tobacco addiction, not just the physical addiction aspect.

☐ ☐ 9. LGTBQ people are disproportionately affected by tobacco use.

☐ ☐ 10. Tobacco use is higher among people with mental illness than the general population, often because smoking is used as a coping mechanism.

T F

☐ ☐ 11. Tobacco dependence should be viewed as an acute disease, not a chronic disease.

☐ ☐ 12. Tobacco use is linked to diseases other than cancer, such as diabetes, stroke, and heart disease.

☐ ☐ 13. People who smoke and develop lung cancer sometimes experience stigma and feel shame and guilt because they feel that they are responsible for their cancer diagnosis.

☐ ☐ 14. Because native populations have a history of using sacred tobacco, they avoid using commercial tobacco.

☐ ☐ 15. Tobacco use is first recorded in 16th-century Europe.

☐ ☐ 16. Currently, a very small percentage (less than 3%) of high school students are using some form of tobacco product, including cigarettes, vaping devices, or e-cigarettes.

☐ ☐ 17. Tobacco is a consumer product that is legal, even though it results in the death of half of its users when consumed as directed.

18. Which of the following is linked to tobacco use?

☐ a. Crohn disease

☐ b. Chronic fatigue syndrome

☐ c. Rheumatoid arthritis

☐ d. Fibromyalgia

Veteran-Informed Health Care

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

Credit: 1 AAMA CEU (gen/admin) **Code: 144268**

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. Veterans who served overseas have a lower risk of respiratory diseases related to deployment because most other nations have lower levels of industrial pollutants than the United States.

☐ ☐ 2. Military culture has unique vocabulary, traditions, norms, and values.

☐ ☐ 3. Veterans' private sector health information is not always linked to their health records with Veterans Affairs.

☐ ☐ 4. There has been no verified correlation between veterans' exposure to military burn pits and illnesses such as respiratory cancers.

☐ ☐ 5. A veteran's unwillingness to comply with a provider's orders and pick up prescribed medication may be a manifestation of isolation cluster symptoms of posttraumatic stress disorder (PTSD).

☐ ☐ 6. As directed by the overseeing/delegating licensed provider, medical assistants are permitted to screen patients and inform the provider and other staff if a patient who is a military veteran is struggling with a life issue.

T F

☐ ☐ 7. The re-experiencing cluster of PTSD symptoms is likely to be witnessed during a veteran's practice visit.

☐ ☐ 8. The definition of a veteran is limited to individuals who have served in the military as a member of the Army, Navy, Air Force, Marine Corps, or Coast Guard.

☐ ☐ 9. The "arousal index" measures the number of brief awakenings per hour of sleep.

☐ ☐ 10. Veterans may have difficulty trusting civilian medical professionals because they are accustomed to working with military medical professionals.

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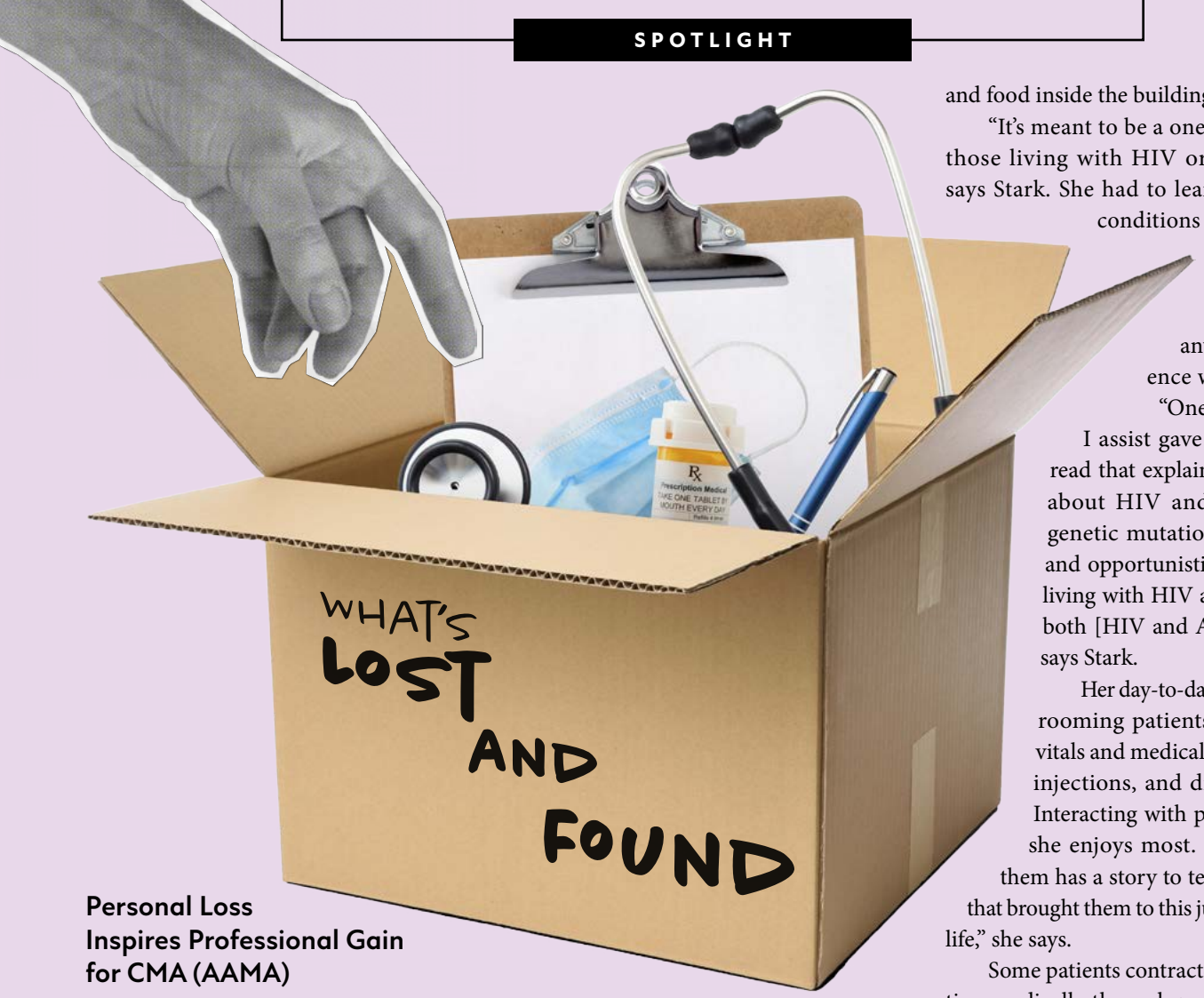

Personal Loss Inspires Professional Gain for CMA (AAMA)

By Cathy Cassata

As a child, Mindy Stark, CMA (AAMA), embraced her mom's interest in medicine. "She taught me to read the entire informational insert that comes with medication before taking it. I learned so much from that. She also watched medical shows like *ER* and *Grey's Anatomy*, so I was always interested in what people go through," says Stark.

As she got older, she considered going to nursing school. Instead, she worked as a store manager when she became a mom at 20 years old. "I had my second daughter at 21, so it was like having twins. I had to work and support my family, which meant I couldn't go to school," says Stark.

While raising her kids, she worked different jobs, including a 10-year stint at her local bank.

In 2013, Stark's mom passed away after living with chronic obstructive pulmonary disease and emphysema for years. "I knew she had left a life insurance policy for me, my two sisters, and my stepdad to split, but I didn't know how much it was," says Stark. "When I got the money from the insurance company, I knew she would be proud if I used it to go to school."

Stark enrolled in medical assisting school at 47 years old. After graduating in 2014, she worked in internal medicine for six months. Over the years, she gained experience in pediatrics, primary care, orthopedics, and neuropathy care before landing her current role at an HIV and hepatitis C clinic. In addition to medical and psychiatric treatment, the clinic offers patients housing and food inside the building.

"It's meant to be a one-stop shop for those living with HIV or hepatitis C," says Stark. She had to learn about both conditions on the job and on her own because she did not have any prior experience with either.

"One of the doctors I assist gave me a book to read that explained everything about HIV and AIDS, from genetic mutations, treatment, and opportunistic infections to living with HIV and living with both [HIV and AIDS disease]," says Stark.

Her day-to-day duties include rooming patients, taking their vitals and medical history, giving injections, and drawing blood. Interacting with patients is what she enjoys most. "Every one of them has a story to tell and a reason that brought them to this juncture in their life," she says.

Some patients contracted their condition medically through procedures like a lung transfusion, while others got infected due to intravenous drug use.

"We care for everyone with compassion and treat them regardless of how they contracted the disease. Even though they may [have an addiction], they are a person who deserves medical care, and we are trying to prolong their life," says Stark.

Because patients with HIV typically visit the clinic long term, she develops trusting relationships with them. Those seeking treatment for hepatitis C visit the clinic for about six months, and Stark prioritizes providing compassion throughout their journey. "I'm motivated to come to work every day and help patients through a difficult time in their life," she says.

As she reflects on her journey to becoming a medical assistant and her decade-long career, she is grateful for the path she took.

"It's never too late to pursue your dream," says Stark. "I know my mom would be so happy that I'm living it now." ✦

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