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 AMERICAN ASSOCIATION
OF MEDICAL ASSISTANTS.

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Medical Assisting Today

The Magazine for Professional Medical Assistants

The AAMA's New Microcredential

Learn How the CMA (AAMA), I.V.
Benefits Medical Assistants

Fall Fun

It's time to gather, connect, and make this fall unforgettable!

Fall is almost here, bringing with it the traditions we look forward to all year. For some, that means the return of pumpkin spice lattes; for others, me included, it means football season. And for medical assistants, fall brings something even more exciting: the return of our two favorite events—the AAMA Annual Conference and Medical Assistants Recognition Week (MARWeek).

September will bring us together in Reno, Nevada, for the 70th AAMA Annual Conference—and what a milestone it will be! Over four exciting days, we will have countless opportunities to learn, connect, participate, and share in the excitement through education sessions, networking, the House of Delegates, the Knowledge Bowl, and the Welcome and 70th Anniversary Celebration. Come ready to let your hair down, enjoy an evening of fun with longtime friends, and make a few new ones along the way.

While we are together, I hope you will take time to reconnect with medical assistants from across the country and make new connections during our morning networking breakfasts. Then, on Wednesday evening, please join me for the Presidents Banquet as we recognize our state society presidents, thank our outgoing Board of Trustees members, and welcome the newly elected leaders who will help guide us forward.

October gives us a meaningful opportunity to shine a bright light on the dedication, skill, and impact of medical assistants everywhere during MARWeek. This year's theme—Educated, Equipped, Empowered—reflects who medical assistants are and what they bring to health care every day. A big shout-out to the 2025–2026 Marketing Strategy Team and the AAMA Marketing Department for bringing this year's theme together.

How will you mark MARWeek? I love a good old-fashioned ice cream party, but no matter how you choose to celebrate, take time to recognize yourself and your colleagues who make a difference every day. Don't wait for someone else to recognize you—celebrate yourself, your team, and the profession we are proud to represent. Even a simple gesture can become meaningful recognition and remind others of the value medical assistants bring to patients, providers, and communities. Be sure to take pictures and tag the AAMA so we can share in the joy of your celebration.

So, who is ready to commemorate 70 years of AAMA history and gather in Reno for the 70th AAMA Annual Conference? I hope to see you there—ready to learn, connect, celebrate, and make new memories with friends from across the country.

Bring your energy, your smiles, and maybe even your party hat.

This is one anniversary celebration you won't want to miss!

Virginia Thomas, CMA(AAMA)

Virginia Thomas, CMA (AAMA)
2024–2026 President



AAMA® Mission

The mission of the AAMA is to empower medical assistants by advancing education, certification, advocacy, and scope-of-practice protection.



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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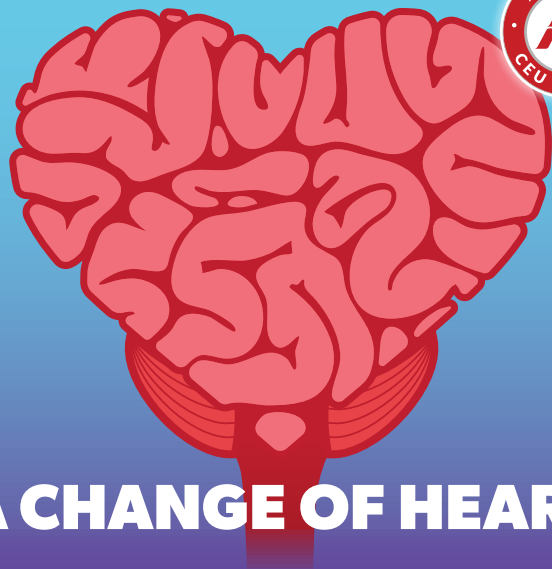
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Medical Assistants Matter

Get ready to cheer for medical assistants during Medical Assistants Recognition Week (MARWeek)! This year—and every year—we celebrate medical assistants as educated, equipped, and empowered professionals.

That is why we observe MARWeek during the third full week in October:

MARWeek: Oct. 19–23, 2026

MARDay: Oct. 21, 2026

The AAMA provides tools (i.e., products and downloads) to help you celebrate the professionals who are true partners in health care. Visit the AAMA online store to purchase clothing, tumblers, stickers, and more! You can also download complimentary posters, phone wallpapers, and virtual backgrounds.



AAMA Membership Reminder

Be on top of your dues—if you are hoping to serve as a delegate or alternate for your state society to the 2027 AAMA House of Delegates, be sure to pay your dues well ahead of the Dec. 31 deadline so that the AAMA is able to report your active status to your state.

Bonus!

Not a current member? When you join today, get membership all the way through Dec. 31, 2027.

Already a current member? Members who renew before the end of the year get access to a free CEU course! ♦

Updates from the Scholarship Road

In honor of last year's recipients of the esteemed Maxine Williams Scholarship, we checked in to see how they are doing on their journeys as medical assistants. Check out their stories on the AAMA website. ♦



Put Safety First in September

The Medical Assistant Partnership for Healthy Pregnancies and Families (MAP) strives to reduce and prevent fetal alcohol spectrum disorders (FASDs) by introducing and sustaining medical assistants' knowledge and practice behaviors.

September is FASDs Awareness Month, a great time to explore the MAP website and its resources, including the Walk and Talk products, which medical assistants can use—even during brief moments with patients—while walking from the waiting room to the examination room. Choose from scripts, posters, index cards, and more to help you and fellow medical assistants improve your interactions with patients. Visit the MAP website (FASDMap.org) for resources on these topics and more:

- Alcohol and Cancer Risk
- Pregnancy and Fentanyl
- Opioids and Naloxone
- Things to Avoid During Pregnancy
- Compassion Fatigue/Self-Care

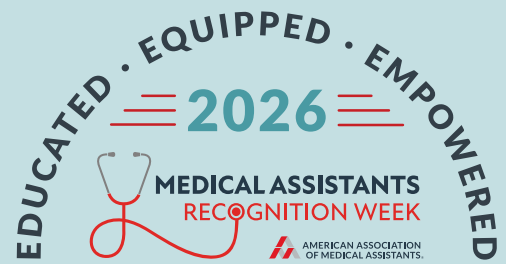
The partnership between the AAMA and MAP acknowledges the unique role medical assistants have in forming communication links between patients and providers and motivating patients to avoid or stop dangerous alcohol consumption. Take action this FASDs Awareness Month and learn more about promoting alcohol- and substance-free pregnancies through these great products! ♦

Earn Free AAMA CEUs While Learning about FASDs

Want to expand your knowledge of addressing substance misuse in clinical settings in honor of FASDs Awareness Month? Check out these free CEU courses provided by the Medical Assistant Partnership for Healthy Pregnancies in the AAMA e-Learning Center:

- *Stimulant Use and Reproductive Health Considerations* (1 gen/admin/clin CEU) *Available for free to all learners until October 6
- *Ethical Considerations and Effective Strategies for Preventing Excessive Alcohol Use* (1 gen/clin CEU) *Available for free to all learners until October 6
- *Cannabis Use in the Perinatal Period* (1 gen/clin CEU) ♦

Educated. Equipped. Empowered.



By Cathy Cassata

Every year, the third week of October brings a well-deserved spotlight on one of health care's most versatile and vital professionals—the medical assistant. This Medical Assistants Recognition Week is a time to pause and acknowledge all that medical assistants contribute to enhance medical practices across the country. From taking vitals and rooming patients to managing calls, refills, and administrative workflows, medical assistants do so much more than most people realize, and they do so with skill, compassion, and consistency.

We asked providers to share what medical assistants mean to their practices, and their words speak to something beyond job descriptions and workflow efficiency. They highlight partnership, trust, and an indispensable dedication that keeps health care functioning at its best. Their insight is a well-deserved tribute to every medical assistant who has ever made a difference.

Gratitude from Providers

Our medical group consists of 19 practices including family practice, pulmonology, cardiology, OB-GYN, mental wellness, and urology. Medical assistants are the glue that holds each practice together. Their clinical knowledge and administrative experience allow providers to focus on diagnosing and treating patients. Their flexibility enhances workflow efficiency, improves team collaboration, and helps ensure patients receive timely, high-quality care. To all our talented medical assistants, thank you for your dedication and professionalism, and for your willingness to step in and help with whatever

is needed. As a former medical assistant myself, I personally know your value.

Amy Sattler, BSN, RN

*RN manager of clinical quality in
Coldwater, Ohio*

At Onvida Health, we have over 200 medical assistants working across walk-in clinics, family medicine, oncology, mobile units, and specialty clinics. They are the backbone [of] supportive ambulatory care. Their ability to competently maneuver between front office tasks and caring for patients and families makes them dynamic. Our medical assistants always provide excellent patient care, even on the days that are challenging. I'm thankful for their innovative ideas to improve patient care and patient workflow, for always placing our patients' needs first, and for consistently being engaged and eager to learn. Above all, their kindness makes a positive difference in our patients' lives.

Elizabeth A. Jones, RN

*Clinical director for ambulatory pediatrics
in Yuma, Arizona*

I appreciate our medical assistants' ability to anticipate the needs of both patients and providers. They enhance the quality of care by recognizing details that may otherwise be overlooked. Working with an exceptional medical assistant makes me a better physician because we approach situations from different perspectives, and their experience working with multiple providers often brings valuable insight to my practice. In women's health care, patients often share very personal and sensitive concerns, and our medical assistants

help create an environment where they feel comfortable and supported. I'm grateful for their dedication to our practice, their teamwork, and the countless ways they help our days run efficiently.

Lydia Lormand, DO

*Obstetrician-gynecologist in Manchester,
Connecticut*

I oversee staff at both cardiology and vascular surgery practices, and I can say with complete confidence that we would not be where we are today without our medical assistants. They constantly balance clinical tasks, patient communication, and operational workflows, all while bringing professionalism, empathy, and a calm presence to a fast-paced environment. Medical assistants improve patient flow, increase access, and allow providers to focus on clinical decision-making. Their presence enhances efficiency, reduces wait times, and ensures patients receive timely, high-quality, and compassionate care. I am deeply grateful for the exceptional care they give our patients and the irreplaceable role they have on our teams.

Amber Brown

*Senior manager of clinic operations in Everett,
Washington* ♦

Read the
full article
online
for more
stories.





Donald A. Balasa, JD, MBA, ICE-CCP
AAMA Legal Counsel

The AAMA's New Microcredential

Learn How the CMA (AAMA), I.V.
Benefits Medical Assistants

The Certifying Board (CB) of the American Association of Medical Assistants® (AAMA) has announced that its new add-on microcredential in intravenous (IV) initiation, maintenance, and discontinuation for CMAs (AAMA) will be available in the coming weeks. Additional information and approved program listings will be available on the AAMA website. Only current CMAs (AAMA) will be eligible to obtain the IV add-on microcredential by passing a course in IV initiation and discontinuation approved by the CB. Current CMAs (AAMA) who successfully complete an approved course in IV initiation will be permitted to use the following designation after their name: “CMA (AAMA), I.V.” A medical assistant whose CMA (AAMA) is no longer current is not permitted to use the “CMA (AAMA)” or the “CMA (AAMA), I.V.” designations.

A Need for an IV Add-on Microcredential

One of my most important responsibilities as AAMA Legal Counsel is protecting the right to practice of CMAs (AAMA) and medical assistants by answering scope-of-practice questions. These questions are asked by employers, licensed providers, clinical supervisors, and medical assistants themselves from all American jurisdictions. By far the most frequent question I have received during the last 15 years is whether medical assistants are permitted to perform IV tasks. Licensed providers generally want to be allowed to delegate to knowledgeable and competent medical assistants working under their authority and supervision the performance of IV tasks—almost always initiating IVs and sometimes performing IV infusions. Medical assistants also have expressed an interest in performing IV tasks.

After years of hearing and analyzing the expressed desires of providers to delegate to educated and competent medical assistants the performing of certain IV tasks, especially IV initiation and discontinuation, I recommended that the CB consider creating an add-on microcredential for the CMA (AAMA) in IV initiation, monitoring, and discontinuation.

Professional Advancement: Career Ladders and Lattices

Survey results over several years from AAMA members—including CMAs (AAMA)—have indicated consistently that one of their strongest expectations is that the AAMA provide avenues for career advancement. This is often described as the AAMA offering opportunities for “career laddering” and “career latticing.”

These ladders and lattices can be clinical, administrative, a combination thereof,

Read more scope of practice topics via the AAMA blog:



Learn more about the IV add-on microcredential for CMAs (AAMA):



or in some other category. After years of answering emails from CMAs (AAMA) and other medical assistants who want to be delegated IV tasks, I came to the conclusion that students in and graduates of medical assisting programs accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) or the Accrediting Bureau of Health Education Schools (ABHES) (or equivalent programs) with an interest in career advancement in the clinical aspects of medical assisting would want to be able to perform IV tasks—especially starting an IV.

Interest in an IV Add-on Microcredential

My above conclusion is supported by survey data. In a 2024 survey sent to current CMAs (AAMA), two questions were asked. The following are the questions and the results of this survey:

Q1. If it were legal in your state for medical assistants to perform IV tasks, would you be interested in completing a course in IV therapy and technique?

Yes: 9,853 (95%)

No: 502 (5%)

Q2. Upon the successful completion of a course, demonstration of clinical competence, and passing an exam, would receiving an IV credential be of interest to you?

Yes: 9,714 (95%)

No: 543 (5%)

Will the IV Add-on Microcredential Result in More Graduates Choosing to Take the CMA

(AAMA) Certification Exam?

Although it is impossible to know for sure, I believe it is possible that the IV add-on microcredential for the CMA (AAMA) will result in a greater percentage of students in and graduates of CAAHEP- or ABHES-accredited medical assisting programs (or equivalent programs) who will choose to take the CMA (AAMA) Certification Exam so they will be eligible for the IV add-on microcredential. It is also conceivable that the opportunity to obtain the CMA (AAMA), I.V. will increase the number of aspiring medical assistants who decide to attend CAAHEP- or ABHES-accredited medical assisting programs.

How Many States Allow Medical Assistants to Initiate IVs?

There are four states (Florida, Maryland, Montana, and Washington) with specific statements in statute or regulation that authorize providers to delegate certain IV tasks to medical assistants. There are four other states in which IV tasks are being delegated to medical assistants based on statements from the state board of medical examiners or interpretations of state delegation laws. There are eight states whose laws do not allow medical assistants to perform IV tasks, and there are 34 states whose laws neither explicitly allow nor prohibit providers from delegating to medical assistants the performance of IV tasks.

The Existence of the CMA (AAMA), I.V. Could Cause More States to Legalize IV Initiation for CMAs (AAMA), I.V.

Bodies that accredit academic programs in a profession/occupation and private sector certification boards often revise their curriculum requirements and examina-

tion content outlines (respectively) when scope-of-practice laws are changed by state legislatures and state regulatory boards. However, this process can also work in reverse. That is, changes in curricular content by academic accrediting bodies and the content outline of private-sector certifications can lead to changes in statutes and regulations that expand the legal scope of practice for a profession.

I contend that the creation of the CMA (AAMA), I.V. could lead to changes in state law that would authorize providers to delegate certain IV tasks to CMAs (AAMA), I.V. The existence of a course in IV initiation approved by a testing body (i.e., the CB of the AAMA) with a certification accredited by the National Commission for Certifying Agencies should assuage any concerns of state legislators or regulators that the health, safety, and welfare of patients would be jeopardized by allowing appropriately educated and credentialed medical assistants to initiate IVs.

A New Type of AAMA Advocacy Will Be Needed

The advocacy role of the AAMA will change with the launch of the CMA (AAMA), I.V. add-on microcredential. Protecting the right to practice of CMAs (AAMA) and other medical assistants will continue to be paramount. However, the AAMA will also have to collaborate with provider organizations in urging state decision-makers to modify laws regarding the delegation of IV initiation to include CMAs (AAMA), I.V. ♦

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

Up to Code

Make an AI Policy for Your Classroom

By Pamela Schumacher, MS, Prosci, RYT

Generative artificial intelligence (gen AI) is reshaping the world. It not only helps educators streamline routine tasks, but students are using it every single day, for better or worse. Adopting it in the classroom requires clear guidance, thoughtful policies, and strong human oversight to ensure accuracy, fairness, and responsible use—especially when preparing medical assistants for real-world clinical and administrative work.

A New Classroom Algorithm

ChatGPT, a gen AI program that learns patterns and uses them to generate text, images, music, or code, was introduced in November 2022 and marked a major turning point in education. Suddenly, AI was available to everyone at the same time—administrators, educators, and students. Colleges did not have time to set thoughtful policies, and the initial response was to prevent the use of gen AI for any academic purpose.¹ But AI can also help educators teach in new ways.²

“Like many institutions, we had to adapt quickly as AI evolved and students began using it to complete their coursework. Our initial focus was on maintaining academic integrity while we evaluated the technology and its impact on teaching and learning,” says Christopher Adams, BS, MPH, CMA (AAMA), CPT (NHA), an educator in the allied health division of the School of Health Sciences at Central Penn College in Enola, Pennsylvania. “When I started using AI to improve my classes, I decided to develop policies for student AI use because I knew they were also using it.”

“Students are already using AI tools whether programs are addressing them or not. Without guidance, they are developing habits that they will carry into clinical practice. In health care education, those habits

have consequences beyond academics,” notes Dipu Patel, DMSc, MPAS, PA-C, ABAIM, the vice chair for innovation and a professor at the University of Pittsburgh in Pennsylvania.

Prompt Response

Establishing policies starts with educators becoming familiar with AI tools, taking time to experiment with these systems, and understanding what they can and cannot do.² Educators should create policies that foster students’ critical thinking, adaptability, and readiness for the future by adhering to principles such as the following³:

- **Transparency:** Tell students exactly how and when AI can be used for each assignment.
- **Consistency:** Avoid conflicts between school and department-specific policies.
- **Equity:** Recognize that not all students can access, afford, or understand AI tools without support. All students should have equal access to AI tools.
- **Adaptability:** Regularly review and revise the AI policy so that it evolves with the technology.

Lee Forest, MEd, assistant director for the Center for AI at Bridgewater State University in Bridgewater, Massachusetts, says educators can employ a variety of policies ranging from restrictive to open, depending on the class. Drawing in part from Leon Furze’s AI Assessment Scale,⁴ these could include the following:

- **No AI Use:** Ensures that students develop a thorough, personal understanding of core skills and knowledge entirely on their own. One trade-off is that it removes the opportunity to build AI literacy or practice working

alongside tools that are increasingly present in professional contexts. A risk is that there is no surefire way to enforce compliance.

- **Limited/Planning-Only AI Use:** Allows students to use AI for ideation—brainstorming, outlining, and synthesizing ideas—but emphasizes the importance of independently developing deeper insights and arguments. Encourages engagement with generative tools, helping students build AI literacy skills while avoiding the risk of off-loading cognitive effort to AI. The challenge is that the line between planning and doing can be blurry, and enforcement may be difficult.
- **Active/Integrated/Collaborative AI Use:** Permits AI use for creating a first draft and support with revisions. This strategy can also blur the line between what the student did and what AI created, and it is challenging to enforce.
- **Unrestricted/Full AI Use:** Places no limits on how AI is used but raises the bar—the final product must be *superior* to what either the student or AI would have achieved independently. This develops skills in directing and leveraging AI effectively. The challenge is assessment; it requires educators to evaluate not just the product but the quality of the human-AI collaboration, including the salience and evidence of the student’s academic voice and critical thinking.

“My original policy was no AI allowed, because I didn’t understand it well enough,” says Adams. “But I educated myself—took online classes and went to several conferences about the ethical uses of AI in education. Now, I include specific examples of how students can use AI for assignments and specific examples of how it’s being applied

AI Policy Examples

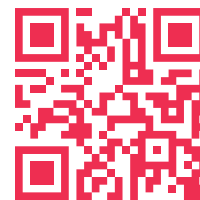
A repository of more than 200 sample classroom AI policies



AI in Academia: Policies, Guidelines, and Governance



Leon Furze's AI Assessment Scale for use in the classroom



in medical offices.”

IRL Preparation

Concerns about gen AI in higher education often center on academic integrity and the risk of misuse, but thoughtful policies and well-designed safeguards can significantly reduce those challenges.⁴

“Change happens at the speed of trust, and AI policy in education is no exception,” says Patel. “Don’t just drop an AI policy in the syllabus and expect students to understand it. Explaining the ‘why’ before the ‘what’ can really help. Whenever possible, involve students in developing the norms. A student who helped shape the policy is far more likely to hold themselves to it.

“Also, connect the policy directly to their clinical future,” she says. “Ask students, ‘What happens when an AI tool is wrong or you don’t have the reasoning skills to catch a mistake?’ That’s not a hypothetical situation, because it happens all the time in health care. Frame the policy as preparation for real-world practice rather than a restriction.”

Debugging Issues

After ChatGPT was released, AI content detection tools were developed, but they remain unreliable.⁵ “There is plenty of research showing AI detection tools do not work and this is an arms race you won’t win,” says José Antonio Bowen, PhD, FRSA, a senior fellow at the American Association of Colleges and Universities in Washington, D.C., and coauthor of *Teaching with AI*. “Detectors do *not* give you proof. At best, detectors provide a probability score that will

not hold up in court. Those scores demonstrate extreme vulnerability. For instance, a hybrid editing strategy can enable up to 88% of AI-generated content to evade detection successfully. AI detectors do not accuse students of cheating; the teacher does. Legally, you must be ready with proof.

“Also, using AI is not plagiarism. Plagiarism requires an author from which you copy. Every time you prompt an AI bot, you get a different and unique answer, so you cannot demonstrate an original that was plagiarized,” says Bowen. “The U.S. Copyright Office has ruled ‘the outputs of generative AI can be protected by copyright only where a human author has determined sufficient expressive elements.’⁶”

Adams has had fewer academic integrity issues since he has put an official policy in the syllabus, which he discusses in class and requires each student to sign. He also encourages students to talk to him about how they are using AI. “But I make it clear that if [they] misuse it, and I’m able to determine that [they] have, there’ll be consequences. The college has a structured academic integrity process that I refer to, but even that doesn’t deter all students because many think they know better than you.”

If he suspects a student has crossed a line, he runs the assignment topic through several free AI tools and compares that output to the student’s work. He has also reviewed enough AI generated writing that he often spots the familiar patterns immediately and does not always need a detector. If he suspects a student has flouted the policy, he handles it quickly: “I’ll show them why I think they may have misused the AI tool and

let them take it from there. If they admit to it, then we’ll talk about ways they can redo the assignment, with some point reduction.”

However, policies alone are not the solution, notes Bowen: “What’s needed is to rethink education so that students are learning the things that we want them to learn. We’ve been assuming that the essay or exam represents thinking and learning, but it was never actually measuring learning, and AI has exposed this. Rather than worrying about cheating, we should make sure that our students can do the things that AI cannot.” ♦

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Tele-ICUs Expand Nationwide

Intensive care units (ICUs) across the United States are using telehealth to fill care gaps through tele-ICUs. A tele-ICU is a hospital unit in which patient care is delivered remotely by physicians, nurses, or specialists. Up to one-third of ICU beds in the U.S. are in tele-ICUs, according to a study from the American Hospital Association.

Only some studies suggest that the technology can improve patient outcomes, reports NBC Chicago. However, there are no industry-wide regulations dictating the practice, so the quality, implementation, and reliability of these programs may vary greatly across hospitals.

As of May 1, 2026, critical care physicians are no longer physically present in the ICUs of a few Ascension satellite hospitals in Wisconsin, according to NPR. These physicians are available via video call to help nurses and on-site physicians who do not specialize in critical care.

While these facilities embracing telemedicine in ICUs offer an opportunity to expand and improve the health care received by patients, there may be risks of replacing in-person care in critical life-or-death moments.



Antidepressants and Pregnancy

In recent years, concerns about whether antidepressants cause harms to developing fetuses have grown.

A group of researchers has published in *The Lancet Psychiatry* the best evidence to date on links between both parents' antidepressant use before and during pregnancy and autism and attention-deficit hyperactivity disorder (ADHD) in their children. The large study found that for most antidepressants, exposure during either period ultimately had little to no association with the conditions once the authors considered other influential factors.

The evidence comes from a review and meta-analysis of 37 previous studies, which included data from over 600,000 pregnant women taking antidepressants and nearly 25 million pregnancies with no antidepressant use.

Depressive disorder affects more than 10% of pregnant women worldwide. Much of the conversation around potential risks has surrounded selective serotonin reuptake inhibitors, the most prescribed class of antidepressants.

Experts emphasize that untreated depression carries its own risks and that these findings offer reassurance to people who need antidepressant treatment during pregnancy.





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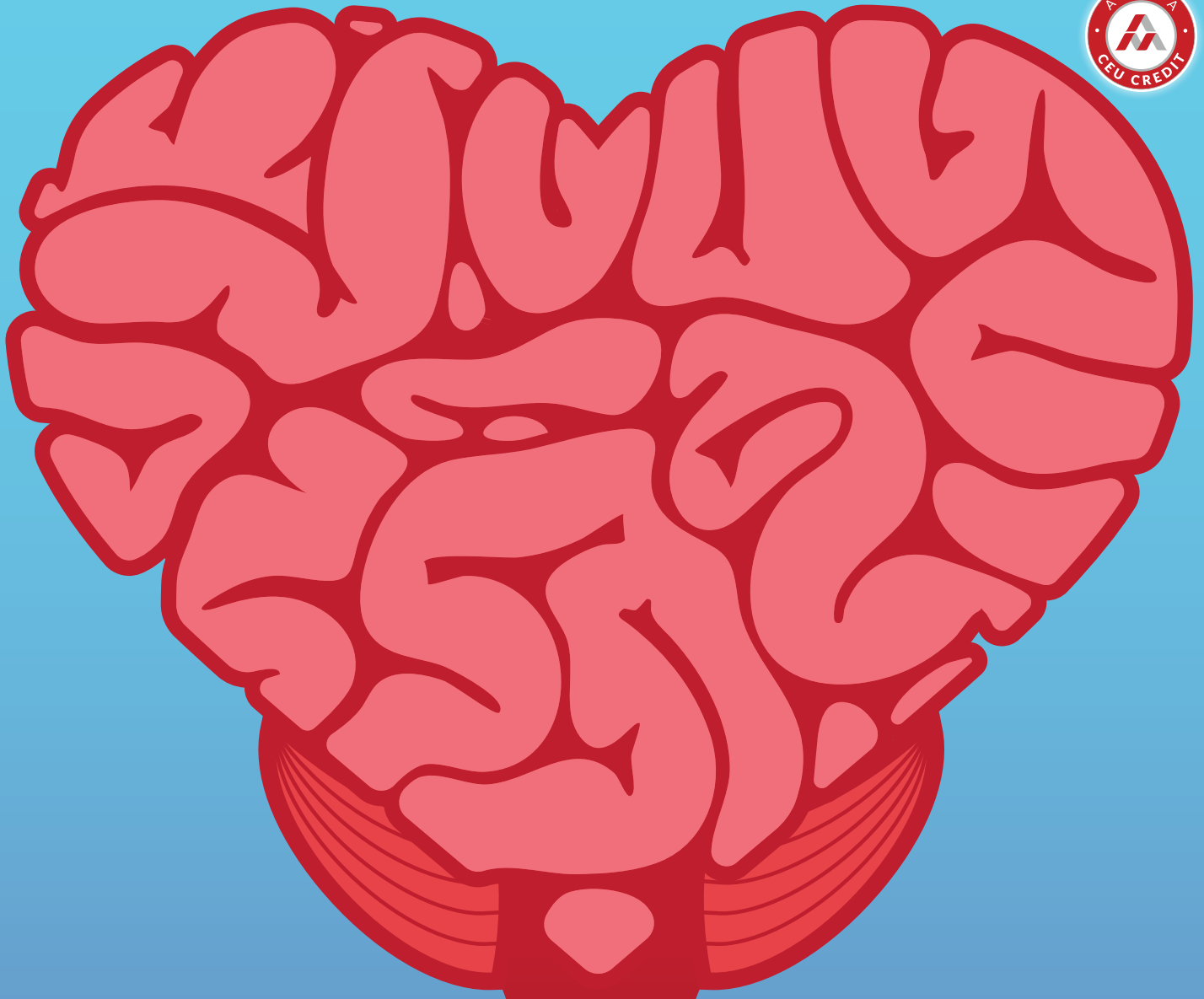
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A CHANGE OF HEART

How Cardiac Psychology Is Reshaping Cardiac Care

Cardiovascular disease is the leading cause of death in the United States, according to the American Heart Association (AHA).¹ For many people, it is also a chronic health concern, with conditions such as coronary artery disease, valve disease, heart failure, and arrhythmias affecting a person's physical health over the course of years.

Living with cardiovascular disease can also impose a toll on a person's emotional health, increasing risks for anxiety, depression, and psychological stress. Major depression affects an estimated 20% to 40% of patients with cardiovascular disease.² Further, as many as 65% of individuals who experience a heart attack (myocardial infarction) report symptoms of depression after the event.²

Cardiology care historically has largely focused on treating disease and physical health outcomes, with mental health concerns either underrecognized or treated as a separate concern. With the rise of preventive cardiology in recent decades, the treatment lens has widened to include the importance of addressing modifiable risk factors for heart disease. Yet even the AHA's Life's Essential 8 checklist for good health, which highlights eight key prevention categories (diet, exercise, blood pressure, blood sugar, cholesterol, weight management, sleep quality, tobacco use, and activity levels) does not mention mental health.³

Mind the Gap

In recent years, a focus has emerged on the links between mental health and cardiovascular disease. A 2021 statement from the AHA cites mounting evidence of a causal link between psychological health and biological processes that may contribute to cardiovascular disease.⁴ Notably, this causal relationship is also a reciprocal one. Psychological stress and mental health issues can be both potential risk factors for cardiovascular disease as well as a

complication of existing disease.

Today, initiatives among health systems to support a more integrated, collaborative care treatment approach toward mental health and cardiovascular disease are on the rise. For instance, at UW (University of Washington) Medicine in Seattle, mental health care services are now available for select cardiac patients through the Cardiac Resilience program. The new program began in late 2025 as a collaboration between the UW Medicine Heart Institute and the Division of Rehabilitation Psychology and Neuropsychology in the Department of Rehabilitation Medicine.

The Cardiac Resilience program currently serves two categories of heart patients: electrophysiology patients and adult congenital heart disease (CHD) patients.⁵ The former are patients with heart-rhythm disorders who have experienced CPR or implantable cardioverter-defibrillator (ICD) shocks. The CHD patients are adults with a history of heart surgeries from childhood.

"For patients with congenital heart conditions or who have had ICD shocks, we offer specialized psychological care to help them cope or adjust to their cardiac condition," says Tracy Herring, PhD, a rehabilitation psychologist with the UW Medicine Heart Institute. "This includes helping manage symptoms of anxiety or depression, as well as addressing the distress associated with living with a chronic medical condition. For instance, we can help with issues related to the psychological effects of defibrillator or ICD shocks, which can be traumatic. The goal is that we're not ignoring the mental health issues

in these patients. These cardiac conditions can affect how patients feel mentally, so it's important that we attend to those needs."

Notably, the Cardiac Resilience program integrates mental health care directly into cardiology services. This allows cardiologists to refer patients to Herring rather than to separate or outsourced mental health facilities or therapy providers. This prevents possible delays in access to mental health counseling but also aligns patients with a psychologist who is already working closely with the referring cardiology team.

For many CHD patients, Herring emphasizes that stress and fears about their condition are not uncommon. "In terms of congenital heart disease, these are adult patients who often have had their condition since birth," she observes. "There's often a lot of uncertainty for these patients. 'Am I going to need a valve replacement in the future? Is my health going to worsen or decline?' I think our role as psychologists fits really well with managing or supporting patients who are navigating uncertainty, future potential for more surgeries or interventions, and concerns about life expectancy."

Referred for Counseling

What happens when an eligible cardiology patient is referred for counseling? "When someone is first referred to me, I start with an intake to get a better sense of what their presenting concerns are," explains Herring. "From there, I collaborate with the patient to figure out what behavioral or psychological skills we can offer this patient. I think about it in terms of improving their

functioning and resilience [and] improving their ability to tolerate the distress that can come with living with this type of medical condition. I often use cognitive behavioral therapy and acceptance and commitment therapy to guide my work with patients."

"In terms of our focus, we try to help patients adjust their thinking from being unhelpful or catastrophizing, from worst-case scenario to more optimistic and help-

Living With an ICD

For patients diagnosed with ventricular arrhythmias, an implantable cardioverter-defibrillator (ICD) is a potential lifesaver. When detecting an abnormal heart rhythm, the battery-powered device delivers an electric shock or uses anti-tachycardia pacing to restore normal heart rhythm.

While medically necessary in high-risk patients, an ICD can also cause psychological stress. Up to 20% report symptoms of posttraumatic stress disorder after shocks or cardiac arrest. Along with other contributing stressors, experts agree psychological support for ICD patients can be an important treatment tool.⁹

ful,” says Herring. “This can influence how people feel physically and mentally, and that can then influence their behaviors. The goal of acceptance and commitment therapy is to increase psychological flexibility by helping people accept difficult thoughts and emotions in order to engage in value-directed living.

“Sometimes the focus is just on basic problem-solving too,” adds Herring. “A perk of my job is that I have more time to sit down with patients and identify the problem. So, you’re nervous about surgery? What can we do to support you in getting the information you need? What steps can we take that are concrete [and] action-oriented to get you [the] information you need to feel better about your situation?”

Herring notes that cardiac psychology is usually time-limited. “The goal for our clinic is brief therapy,” she says. “That can involve one session, or it could be six to eight sessions. It’s very much targeted therapy, meaning it’s focused on the cardiac issues. When people might need longer-term therapy, I will refer them to a therapist in the community. The good news is we can usually get a lot accomplished in a few sessions. It can be quite rewarding.”

Herring also works closely with the program’s three cardiologists to ensure the patient’s mental health needs are being met. The program uses brief patient surveys before each visit to quantitatively measure and track the patient’s psychological symptoms and progress over time.

While a newer program, the broader links between mental health and cardiovascular disease certainly frame the collaboration. “We’re seeing in the [clinical] literature a strong correlation or connection between mental well-being—just the level of distress a person experiences—and how one functions or how one is doing physically,” says Herring. “We know we cannot ignore the role that mental health and well-being play in people’s cardiac well-being or their

“We do not consider patients in our integrated clinic to necessarily have a psychiatric or mental health illness, but rather we acknowledge that all humans have some degree of psychosocial symptoms (such as anxiety and depression), and that complex cardiac conditions may worsen these symptoms from time to time.”⁵

—UW Heart Institute

cardiac functioning.”

In fact, these links are often a discussion topic in therapy, reports Herring. “I talk a lot with my patients about the mind-body connection and how they are deeply intertwined. Think just about panic attacks, for example; they can present as people who come into the [emergency room] thinking they’re having a heart attack. When we feel worse mentally, we’ll often feel worse physically. And, vice versa, if we help people feel better mentally, they’ll often notice that their physical symptoms or condition can improve. I believe cardiology is a perfect place for this work.”

As a collaborative initiative, UW Medicine’s Cardiac Resilience program underscores the idea that mental health care should be considered a normal or integral aspect of cardiology care. “Anything we can do to destigmatize mental health care is a win,” says Herring. “A line I like to use when I lecture is, ‘Just as I would refer you to a cardiologist for your heart health, I’m going to refer you to a psychologist for your brain health.’ We want to normalize mental health care as just another referral to improve your health. My goal is to help destigmatize mental health care and get people access to care who might otherwise be reluctant.”

Take a Beat

In October 2021, as a response to the COVID-19 pandemic and other soci-

“I know visits are short and primary care providers have a lot of patients they see in a day. But those extra 30 seconds it takes [for staff] to inquire [and] listen for any type of indicators that maybe this person is struggling from a psychological standpoint could send them on a totally different path in terms of their care. I think it can be a game changer.”

—Tracy Herring, PhD

etal factors, a national emergency in youth mental health was declared by the American Academy of Pediatrics and other medical organizations.⁶ Even now, a mental health crisis continues to significantly affect American youth.⁷

For young people, the psychological stress and pressures of growing up with CHD can potentially weigh even more heavily on their mental health and well-being.

Thanks to advances in medical treatment, today about 90% of CHD patients survive into adulthood and live full lives.⁷ But CHD patients may also be more vulnerable to struggles with anxiety, depression, and other challenges. Thus the psychosocial needs of these young patients must not be neglected, caution experts.

“It is essential to recognize mental health care and support as a core feature of the illness experience for young people with congenital heart disease,” says Melissa K. Cousino, PhD, a pediatric psychologist and director of the University of Michigan Congenital Heart Center Psychosocial and Educational Program (M-COPE) in Ann Arbor. “Children with even relatively simple forms of CHD have roughly 5 times greater odds of developing anxiety or depression compared to healthy peers. For those with more complex disease, such as single ventricle heart disease, the odds climb to 7 times higher. Two-thirds of those patients will experience a diagnosable mental health condition at some point in their lives.”

Notably, the mental health needs of younger cardiac patients can differ from those of adult cardiovascular patients. “What makes the pediatric and adolescent experience distinct from what we see in adult cardiovascular patients is the developmental context,” says Cousino. “Adults who develop heart disease have typically already navigated the formative milestones of childhood and adolescence. Young patients with CHD

are navigating those milestones while simultaneously managing a serious chronic illness. Most importantly, there is growing evidence that the relationship between psychological health and cardiovascular outcomes is bidirectional. Psychological distress doesn't just accompany heart disease; it can worsen it. Stress, anxiety, and depression influence inflammation, autonomic function, and health behaviors in ways that affect the heart and patient outcomes directly, including survival. Mental health care *is* CHD care.

"In my experience, young people with CHD have varying and understandable fears and concerns," notes Cousino. "For many, their worries or challenges are quite similar to their peers without heart disease—friends, school, relationships. [They also have] subset worries about upcoming procedures, the uncertainties surrounding their condition and course, and the impact of their condition on their daily lives and interests. Importantly, what I have witnessed most is the remarkable resilience of young people living with CHD. Their worries and concerns are often 'normal responses to the abnormal,' as I often say. Validation and support specific to this can be especially powerful.

"In terms of building resilience and improving well-being, young people with CHD need to be seen as a whole person, not a cardiac diagnosis," adds Cousino. "Validation of their experiences is critical. Providing them with opportunities to express their needs and preferences specific to their health care, medical communication, and decision-making is imperative. Some want to be very informed. Some prefer to know less. Supporting them in the way they best cope with such information is most helpful. For care teams specifically, the message I'd

"If you have anxiety, stress, and mental health issues, this involves your brain, and that's connected to the rest of your body and also to your heart. You can start out with no problems at all in your heart, but if you have constant anxiety and are so anxious that you overeat and don't exercise, this can increase [the] release of stress hormones—e.g., cortisol, epinephrine, and norepinephrine. If you chronically have those hormones turned on, that can raise your blood pressure. In turn, this raises your chances for coronary artery disease and also for a heart attack. And if you get a heart attack, this can cause even more stress. All of which reminds us of why we're focused on prevention and healthy living."

—David Thoele, MD

offer is this: psychological care cannot be an afterthought that happens only in crisis. It needs to be woven into routine cardiac care—normalized, not stigmatized, and accessible without a patient having to advocate for themselves to receive it."

A Vessel for Heartfelt Care

The mission and goals of the M-COPE program reflect the advances in treatment for CHD in recent decades.

"The M-COPE Program was formally established in January 2020 at the University of Michigan Congenital Heart Center at C. S. Mott Children's Hospital," says Cousino. "Its founding reflected a recognition that survival alone is no longer sufficient as a goal in [CHD] care. As surgical and interventional outcomes have dramatically improved, we've shifted our attention appropriately toward quality of life and building the infrastructure to actually deliver comprehensive psychosocial support within a cardiac setting.

"The impact of M-COPE has been tangible," adds Cousino. "Since its founding,

"Ideally, every cardiac team should have a member who specializes in stress and anxiety—a psychologist, social worker, or someone who recognizes the stress people go through. I spend a lot of time with my patients, and it's challenging because, as a doctor, sometimes your time is limited, especially for those who are doing procedures like surgeons or interventional cardiologists. But someone on the team should be doing this work—reaching out to help patients get through the stress and anxiety they may have while they're in our care."

—David Thoele, MD

outpatient cardiac psychology referrals have increased 2.5-fold. We've developed novel group and digital interventions that have reached patient populations who previously had limited or no access to mental health services within their cardiac care. We've also built a fellowship training model that is producing a new generation of cardiac psychologists—clinicians specifically trained to work at the intersection of heart disease and mental

health, which is itself a critical and underserved pipeline. What I'm most proud of is that M-COPE integrates research, training, and education into a single program so that what we're learning from our patients is informing the science, and what the science is teaching us is improving how we care for patients. That kind of feedback loop is essential."

As a practical resource, M-COPE also sponsors the WE BEAT program to support psychological well-being among its adolescent patients. "WE BEAT—which stands for Wellbeing Education Program: Breathe, Energize, Adjust, Thank—is a structured, evidence-based psychological intervention designed specifically for adolescents with heart disease," explains Cousino. "It was developed by a clinical psychologist with more than a decade of experience working with youth facing serious cardiac illness, and it draws on cognitive behavioral theory, mindfulness-based approaches, stress management and resiliency science, and positive psychology. The program consists of five group-based telemedicine sessions, each approximately 45 minutes long, delivered once a week over five consecutive weeks."

Notably, these efforts are also being studied toward the goal of improving evidence-based mental health care for young cardiac patients. "WE BEAT is currently being evaluated

in the largest and most rigorous psychosocial intervention trial ever conducted in adolescent congenital heart disease—a multisite pragmatic randomized controlled trial through the Pediatric Heart Network, funded by the National Heart, Lung, and Blood Institute. We are enrolling adolescents ages 12–17 with moderate or severe CHD across multiple sites. We are generating the kind of rigorous evidence the field needs to establish psychological intervention as a standard of CHD and pediatric cardiac care, not an optional add-on.”

While these achievements are impressive, Cousino says more work remains, much of which involves addressing systemic barriers in U.S. health care that limit access to care for populations in need.

“In terms of challenges and areas for growth, I’d be candid: we are still not reaching everyone who needs M-COPE services,” she says. “This is multifactorial. While stigma regarding accessing mental health services has declined in recent years, barriers to accessing such services remain. First, mental health insurance coverage remains limited for many patients. For some of our patients, they have medical coverage at our institution but cannot access our specialty mental health care services. State-funded programs for children with chronic conditions are not always inclusive of mental health services. Reimbursement for pediatric mental health care is very low in our country. As such, hiring and retaining the needed workforce to meet the needs of young people and their families is an ongoing challenge. Advocacy at the national, state, and institutional level, as well as institutional commitment to funding and sustaining programs such as M-COPE, is of utmost importance.”

Take the Pulse

In the day-to-day clinic world, cardiovascular medical care understandably involves some level of stress for many patients and families. After all, the function of the heart

Resources

Cardiac Resilience Program

UW Medicine



Congenital Heart Center Psychosocial & Educational Program (M-COPE)

University of Michigan Health



is essential to life.

“As a pediatric cardiologist, I just assume there’s a certain amount of anxiety and stress with the patients and families I see in my office or in the hospital,” says David Thoele, MD, a pediatric cardiologist with Advocate Children’s Hospital in Park Ridge, Illinois. “For those with very serious heart conditions, those cases can definitely be very stressful.”

As Dr. Thoele notes, CHD involves problems with the heart’s structure that are present at birth and prevent normal blood flow. These anatomical defects can involve a hole in the heart wall or blood vessel and heart valve issues. The defects vary from minor, asymptomatic issues to more serious, life-threatening conditions.

“If they’re very sick, some CHD patients

might be on a ventilator, or they are going through surgeries,” says Dr. Thoele. “Now, for the child, that’s going to cause psychological stress and anxiety down the road because that’s part of your human experience. We know that can have an effect later on. But in the short term, who is really stressed out are the parents and family, and they’re often quite stressed out.”

As a physician, Dr. Thoele tries to directly address the stress patients and families can experience at appointments. “In my experience, I think the most important thing to deal with this anxiety is first just to acknowledge it,” he says. “If a child has a more serious condition, I often find a lot of the family’s anxiety is because the condition didn’t get explained properly. They’re anxious because their doctor heard a murmur in their child and were told it could be a valve problem or ‘a hole in the heart.’ Often, I will try to just explain things in plain English, which can lower the anxiety.”

Taking the time to answer questions and clearly explain the clinical diagnosis can go a long way to relieve stress, says Dr. Thoele: “For instance, a patient may have a small hole in the heart called a *ventricular septal defect* or an *atrial septal defect*. Now, sometimes those are serious and do require surgery, but very often there is a congenital condition that just has to be followed infrequently in the clinic, meaning a visit every year or two. With these cases, I will ask the parents if anyone has ever explained what it means to have a hole in the heart. If they say

no, [and] it just sounds bad, I might use some analogies to explain it better. For example, I’ll explain how this is not like your car is going to fail, but rather instead of getting 40 miles to the gallon, you will get 37 miles to the gallon. But the car still runs. There’s also a very good chance this hole will close up and your child will never need surgery.

“I might also explain that the heart is not like a hole in a bucket where you start out with a full bucket of water, and after a while the water’s

“Rehabilitation psychology is a subspecialty of psychology. The focus is on working with people who are living with medical conditions and [disabilities]—physical as well as other [disabilities]. Often, our work is around issues related to adjustment to disability or a medical condition, which involves coping or adjustment to change and function. Traditionally, we would often see people with brain injury or spinal cord injury. Thankfully, we’re now well positioned to be in settings where people are living with any type of real medical condition. We also feel fortunate that our cardiology team at UW Medicine recognizes that our specialty pairs well with their patient population. It’s been a good collaboration.”

—Tracy Herring, PhD

leaking out and pretty soon you have an empty bucket,” adds Dr. Thoele. “With the heart, the hole does not leak out. In human beings, the middle of the heart has a wall going down the middle, and if there’s a little gap in the top part, that’s called an *atrial septal defect*, and the bottom part is called a *ventricular septal defect*. This just means [that] because the pressure’s higher on the left side than the right side, it makes the heart a little less efficient. But blood doesn’t leak out of the cardiovascular system. In fact, small holes don’t really have any effect at all. With larger holes, it could mean the child might not be gaining weight as well. And sometimes the child will need medicine or surgery. But often even the large holes will get better with time. I do a lot of these types of explanations, which I find helps with stress.”

As director of the narrative medicine program at Advocate Lutheran General Hospital, Dr. Thoele is also known to take a few moments with patients and their families to teach them breathing exercises and other techniques he uses to reduce their stress or anxiety.

Similarly, whether working in cardiology, primary care, or other settings, medical assistants can also play a valuable role in cultivating sensitivity for the psychological stress or mental health challenges patients may be experiencing.

“Since the COVID-19 pandemic, I think medical assistants and other health professionals are starting to recognize more fully the importance of mental health in our overall health,” says Emily Brewer, CMA (AAMA), a southeastern Michigan-based medical assistant whose 15-year career includes experience in family medicine and cardiology settings. In their patient interactions, medical assistants can help normalize a focus on mental health care as an aspect of health that can and should be discussed without stigma or embarrassment, suggests Brewer. Doing so might lessen the likelihood these issues are ignored or not addressed in a timely way.

“As medical assistants, it’s important that we validate patients [and] that we don’t just shrug off their concerns or things they might be telling us,” says Brewer. “It is so

important for medical assistants to take detailed notes and observations when talking with patients and to note not only what a patient is saying, but also what we are seeing while they’re talking. Too often we try to rush without making observations. I think there are things patients say that can get overlooked because we only have a certain amount of time.”

Brewer speaks not only from experience working with patients. “About a year and a half ago, I was diagnosed with supraventricular tachycardia after spending my whole life in normal sinus rhythm,” she reports. While personally relating to patient experiences with psychological stress, over the years Brewer has also seen multiple patients who had heart attacks who were experiencing significant stress in their lives. “We also know about ‘broken heart syndrome’—literally cardiomyopathy caused from stress and/or grief,” she observes. “I think we always have to look at how stress and our mental health affect our [physical] health.”

In fact, the AHA describes stress-induced cardiomyopathy, which medically is known as *takotsubo cardiomyopathy*, as an overt example of a heart condition in which psychological stress can cause an immediate adverse effect on heart function.⁴ The condition involves a temporary weakening of the left ventricle, which is the heart’s main pumping chamber. Most cases of *takotsubo cardiomyopathy* occur in the older female population (i.e., ages 58 to 75).⁸

In today’s stressful world, health professionals must be cognizant of the links between mental well-being and cardiovascular disease. This entails not only recognizing the ways our behaviors and lifestyle habits are affected by psychological stress, but also how mental health intersects with the body’s physiology and biochemistry.

While evidence of these mind-body links and their consequences has been known for some time, there is growing recognition in medicine of the need for a more holistic, resilience-focused treatment approach for patients with cardiovascular disease. ♦

The CE test for this article can be found on page 26.



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Top Banana

Bananas are one of the most convenient and affordable fruits, and they're also incredibly nutritious. Whether you eat a banana for breakfast, as a snack, or in a smoothie, bananas offer numerous health benefits that make them an important staple in any diet. Here are some of the top reasons to add them to your diet, according to Verywell Health and Cleveland Clinic.

- **They're full of potassium.** Potassium can lower your blood pressure by helping your body get rid of excess sodium.
- **They support digestion.** Bananas are rich in fiber, which is crucial for digestion.
- **They increase energy.** Due to their high carbohydrate content, bananas can help boost your energy levels.
- **They are gentle on the stomach.** Bananas are recommended when you're sick because they are easy to digest.
- **They can help with muscle recovery.** The magnesium and potassium in bananas can help reduce muscle cramps and soreness related to exercise.
- **They're rich in antioxidants.** Bananas contain antioxidants that can help protect your cells from damage.
- **They're delicious!** Bananas are a tasty alternative to processed snacks.



Work It Out

After a long day at work, it's easy to bring stress home with you. Whether you've been dealing with deadlines, meetings, emails, or all of the above, you need a physical and mental reset. Here are some simple habits from Calm and Talkspace that can help you unwind throughout the evening:

- **Engage in physical activity.** Physical exercise (e.g., stretching, jogging, walking, or playing a team sport) can improve your mood and reduce stress.
- **Limit screen time.** Reduce your exposure to screens, especially for work emails or news.
- **Write down what's on your mind.** Journaling can help get work thoughts out of your head and relieve stress and anxiety.
- **Engage in fun activities.** Reading, cooking, gaming, watching a movie, or grabbing dinner with a friend can remind you that there is more to life than just work.
- **Try deep breathing.** Deep breathing can reduce blood pressure, lower stress levels, and promote a sense of calm.
- **Take a shower or bath.** The warmth of a bath or shower can ease muscle tension and calm the nervous system after a difficult day.
- **Listen to calming music.** Audio distractions can shift your focus away from the workday.

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SEPTEMBER

Pain Awareness Month

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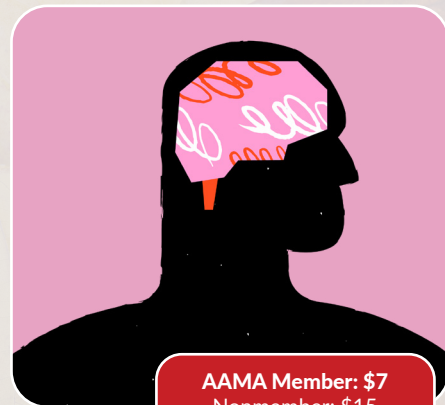
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ADHD Awareness Month

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Small Patients,

BIG REACTIONS

What Medical Assistants Must Know About Pediatric Allergies

By Brian Justice

In 2024, almost 30% of children in the United States were diagnosed with at least one of three allergies: seasonal, eczema, or food. Allergies occur when the immune system mistakenly reacts to a normally harmless substance, such as pollen, pet dander, or certain foods. Exposure to that substance can trigger symptoms affecting the skin, nose, eyes, lungs, or digestive system.¹

Triggers vary, but the most common also include airborne particles, insect bites, medications, dust mites, and more. A family history of allergies or asthma can also indicate the likelihood of a child developing allergies.²

Notably, the percentage of allergies in children, especially food allergies, has risen over the last several decades.¹ One report states that such allergies increased 50% from 1997 to 2011, and another reported a 50% increase from 2007 to 2021. Among those

children, 42.3% have experienced severe reactions, with approximately 4 in 10 of them requiring emergency treatment.³

Tiny Triggers

"Allergies in general are on the rise, and a lot of it is attributed to environmental factors and some to lifestyle," says Manisha Relan, MD, an allergist and spokesperson for the American College of Allergy, Asthma, and Immunology. "There is also a strong genetic predisposition to allergies, so they are often inherited. We've also changed what we eat, especially with more processed foods."

Among children with allergies, seasonal allergies are the most common, affecting a little more than 20% of them. Eczema is next at almost 13%, followed by food allergies at 5%.¹ Common food allergens for children include milk, eggs, peanuts, wheat, soy, tree nuts, and shellfish. Allergies may also

be triggered by penicillin and other medications, fragrances, metals, or rubber that cause contact dermatitis.²

"Allergies and asthma are highly associated," says Frank Rando, CMA (AAMA), a clinical research associate at the University of Arizona Health Sciences Center. "When some kids get allergies, and depending on their severity, they can also develop an asthmatic exacerbation, a form of what's called allergic asthma, or asthmatic symptoms as a result of exposure to allergens in the environment or their diet."

"Climate change has lengthened the pollen season and caused higher pollen counts," adds Susan Laubach, MD, of Latitude Food Allergy Care in San Diego and an executive committee member and spokesperson for the American Academy of Pediatrics. "In areas with more pollution, the pollens concentrate on particles in the air and cause more severe symptoms."

A DOSE OF HOPE

Researchers are studying new ways to reduce the risk of severe reactions in children with food allergies. One of the most promising treatments is omalizumab (Xolair), a medication approved by the FDA in 2024 for adults and children age 1 and older with food allergies.

In a clinical trial, nearly 67% of children and adolescents who received omalizumab were able to tolerate the equivalent of about 2.5 peanuts without a moderate or severe allergic reaction, compared with less than 7% of those who received a placebo. Similar results were seen for milk, egg, wheat, cashews, walnuts, and hazelnuts. Although patients must still avoid foods they are allergic to, the medication can help reduce the risk of severe reactions when they accidentally consume them.⁶

Researchers also compared omalizumab with oral immunotherapy, a treatment that gradually exposes patients to small amounts of allergenic foods. In that study, 36% of participants receiving omalizumab were able to tolerate peanut protein and two other food allergens, compared with 19% of those receiving oral immunotherapy.

Researchers found that many participants receiving oral immunotherapy stopped treatment because of allergic reactions or other side effects, while no participants stopped omalizumab because of treatment-related allergic reactions. The findings suggest that both treatments can increase tolerance to food allergens, but omalizumab may be easier for some patients to tolerate.⁷

A Telling Reaction

Allergy symptoms depend on the organ system involved. Seasonal and respiratory allergies can cause nasal congestion, itching and discharge, sneezing, and coughing. Allergic conjunctivitis causes red, itchy, watery eyes. Skin symptoms include eczema, hives, and itchy welts. Asthma-related symptoms include coughing, wheezing, and shortness of breath.⁴ Food-related allergic reactions can cause hives, vomiting, difficulty breathing, or throat tightening that can even become life-threatening.¹ However, diagnosis should not be based on symptoms alone. It also requires a detailed history, physical examination, and, when appropriate, allergy testing.²

“Medical assistants should recognize symptoms such as hives, itching, swelling of the lips or face, difficulty breathing, wheezing, coughing, dizziness, and signs of anaphylaxis,” says Emily Martinez, a medical assistant with ACCESS Community Health Network in Chicago. “This experience reinforces the importance of early recognition of symptoms, clear communication among health care staff, and educating families on prevention and emergency response.”

Evaluation begins with a detailed med-

ical history, including the child’s symptoms, possible triggers, and family history of allergies or asthma, followed by a physical examination. Allergists may then use skin or blood tests, elimination diets, or medically supervised oral food challenges, depending on the suspected allergy.²

The most common allergy test is a skin-prick test, in which small amounts of suspected allergens are applied to the skin. A raised, red, itchy bump may indicate sensitivity to that substance. Other testing methods include intradermal or patch testing. Blood tests may be used when skin testing is not practical or when a child cannot stop medications that could affect the results. Elimination diets and medically supervised oral food challenges, in which a child is gradually given larger amounts of a suspected allergenic food while being closely monitored for signs of an allergic reaction, are performed in a medical setting equipped to manage allergic reactions if they occur.²

Nothing to Sneeze At

The top priority in caring for children with allergies and their families is their overall well-being. Children with allergies typically miss a week of school every year—and some

miss up to a month due to anxiety and severe reactions. Altogether, allergies and asthma cause a total of 12 million missed school days annually.⁵

“Kids are not adults,” says Rando. “Children are very sensitive to a lot of things. They’re unique organisms with very specific anatomical and physiological differences, and we need to treat them like kiddos.”

Reducing anxiety is crucial, especially since allergy testing may involve needles or multiple skin applications. “I use a calm and friendly approach, explain each step before it happens, encourage questions, and provide positive reinforcement,” says Martinez. “Distraction techniques such as conversation, toys, or deep breathing can help children feel more comfortable.”

Add to all that the emotional burden on families, and the financial stress when parents or caretakers must take time off from work.

“The most important thing,” says Dr. Laubach, “is to move away from fear-based counseling to empowering kids and families with information so they can effectively avoid their allergens, recognize symptoms, and feel confident.” ♦

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A SPECTRUM OF CARE

Meet the
Unique Needs of Patients
with Fetal Alcohol Spectrum
Disorders

By Sandra J. Gonzalez, PhD, LCSW

Improving care for individuals with fetal alcohol spectrum disorders (FASDs) requires careful attention to how care is delivered in everyday moments, including intake, instructions and after-care summaries, follow-up scheduling, and conversations with caregivers. Many individuals with FASDs feel rushed, misunderstood, or judged in medical environments. Medical assistants are uniquely positioned to influence these experiences.

LIVED EXPERIENCE

When individuals and families describe living with FASDs, a fairly consistent picture emerges—one that goes beyond symptoms and diagnoses and speaks directly to how patient care is experienced. Recent qualitative work highlights that FASDs shape daily life in very concrete ways: people describe ongoing challenges with relationships, employment, housing stability, and navigating complex systems, alongside a persistent undercurrent of stigma.^{1,2} These lived accounts are consistent with quantitative findings showing significant impairments in adaptive functioning, including communication, social skills, and indepen-

dent living, even among individuals with average intellectual ability.³

FASD affects people's lives daily, influencing everything from school to independence and mental health.² Individuals themselves are often acutely aware of these difficulties. Caregivers consistently describe both the emotional weight and the practical burden of care, particularly when trying to access diagnosis and support in systems that are often fragmented or under-resourced. In fact, one recent study noted that obtaining a diagnosis can be difficult due to "lack of training, knowledge, and inadequate professional support," leaving families to navigate much of this on their own.⁴

Within health care specifically, these broader challenges show up in ways that are easy to overlook but deeply consequential. Adults with FASDs frequently describe feeling dismissed or judged, especially when symptoms are misinterpreted as noncompliance or a lack of motivation or effort. Difficulties with memory, processing speed, and executive functioning can make it hard to follow complex instructions or keep up in fast-paced clinical encounters, especially in busy, overstimulating environments.^{1,2} Thus,

navigating health care systems that require scheduling, referrals, and follow-up without support can feel overwhelming.²

Across studies and lived accounts, individuals clearly articulate what actually helps. Feeling understood is not a courtesy; it is foundational. People talk about wanting providers who slow down, communicate clearly, and meet them where they are.¹ When that happens, engagement shifts. Care is no longer something to endure but something that feels accessible. In contrast, stigma or misunderstanding reinforces the same barriers seen elsewhere: disconnection, frustration, and disengagement.^{2,3} For health care professionals, the takeaway is straightforward but crucial: respect, patience, and clear communication are not just interpersonal skills; they are clinical interventions that directly shape outcomes for individuals and families living with FASDs.

DEFINITION

FASDs is an umbrella term used to describe a continuum of conditions resulting from prenatal alcohol exposure. These effects range from mild learning and behavioral differences to profound cognitive difficul-

Life Stage	Common Presentations	Implications for Medical Assistants
Infancy and Early Childhood	Infants and toddlers with FASDs often experience significant difficulties with self-regulation, including problems with sleeping and feeding; heightened sensitivity to noise, light, or touch; high irritability; difficulty being soothed; low birth weight or failure to thrive; and frequent infections early in life.	In pediatric settings, medical assistants can support families by validating caregiver concerns, helping track developmental milestones, and reinforcing early referrals to diagnostic and support services. A calm pace and predictable handling can reduce stress for both the child and caregiver.
Preschool and Late Childhood (e.g., up to 12 years old)	As children grow, neurological differences are often misinterpreted as behavioral problems. Common concerns include intense tantrums or meltdowns, hyperactivity and impulsivity, motor and language delays, difficulty with transitions and changes in routine, and sensory overload in busy environments.	Medical assistants can help by documenting behavioral patterns, coordinating referrals, and supporting caregivers during visits. Reinforcing to the care team that repeated mistakes reflect impaired learning from experience, not defiance, can reduce stigma and inappropriate discipline.
Adolescence	Adolescence often brings increased vulnerability. Youth with FASDs may experience academic failure, particularly in math; social misunderstandings and peer conflict; difficulty understanding abstract concepts such as time, money, and risk; increased mental health challenges; and heightened susceptibility to negative peer influence.	During this stage, medical assistants play a critical role in facilitating referrals to behavioral or mental health services for screening and ongoing support, encouraging collaboration with school-based services such as individualized education plans or legally required accommodations, and involving caregivers or trusted adults to reinforce structure and safety across settings.
Adulthood	Adults with FASDs often report significant challenges in health care settings, including difficulty managing appointments and medications, misunderstanding medical instructions, sensory distress in busy clinics, poor judgment or safety awareness, and multiple co-occurring medical and mental health conditions. Adaptive functioning may worsen in adulthood, even when IQ scores fall within the typical range.	For medical assistants working with adult patients, recognizing FASD-related needs is essential for improving adherence, safety, and trust. Structured communication, written instructions, and a non-judgmental approach can significantly improve follow-through and patient experience.

ties. FASDs are solely caused by prenatal alcohol exposure. FASDs include several conditions, such as fetal alcohol syndrome (FAS), partial FAS, alcohol-related neurodevelopmental disorder, alcohol-related birth defects, and neurobehavioral disorder associated with prenatal alcohol exposure.⁵ FAS is the most involved of the diagnoses across the spectrum and is characterized by three distinct facial features. FASDs are often described as invisible disabilities because many individuals do not have physical features that are commonly associated with FAS, yet they experience substantial neurobehavioral challenges. In fast-paced health care environments, this invisibility can easily lead to incorrect assumptions about behavior and intent.⁶

FASDs affect how the brain processes information, regulates emotions, manages sensory input, and organizes behavior. A defining feature of FASDs is variability. Individuals often show uneven developmental profiles, with areas of relative strength alongside significant challenges. A patient may speak fluently and appear confident while struggling to understand instructions or remember the next steps. Another may follow information during a visit but be unable to recall it later. Because these differences are not always visible, they are frequently misunderstood.

FASDs affect individuals across the lifespan and across all backgrounds. While much of the literature has historically focused on children, increasing attention is being

paid to adolescents and adults with FASDs, many of whom encounter health care systems that are not yet designed with their neurodevelopmental needs in mind.⁴ By understanding FASDs as neurodevelopmental disabilities, medical assistants can help reduce stigma, improve care coordination, and foster more equitable health outcomes. Further, understanding how FASDs affect individuals at each stage of life⁷ can help medical assistants tailor communication, expectations, and support.

EXECUTIVE FUNCTIONING

Executive functioning deficits are among the most disabling aspects of FASDs. *Executive functioning* refers to cognitive processes that

SENSORY PROCESSING AND THE HEALTH CARE ENVIRONMENT

For many individuals with FASDs, sensory processing differences significantly affect health care experiences. Bright lighting, loud noises, crowded waiting areas, and unexpected touch can quickly overwhelm the nervous system. A blood pressure cuff tightening or a sudden change in routine may trigger anxiety or shutdown rather than cooperation. Medical assistants can reduce distress by explaining each step before it happens, maintaining a calm and steady tone, and offering simple choices that give patients a sense of control. These adjustments help regulate stress and support smoother clinical encounters.

support planning, organization, impulse control, working memory, and learning from experience. These impairments affect an individual's ability to plan and organize tasks, remember multistep instructions, manage time and appointments, learn from past consequences, and shift attention from one task to another. As a result, patients with FASDs may fully intend to follow medical recommendations yet struggle to do so consistently. This is not because of a lack of motivation or concern, but because their brains cannot reliably sequence, retain, and apply information over time.⁸

Medical assistants can play a critical role in reducing these barriers. When instructions are broken into small, concrete steps, patients are better able to process and act on information. Written or visual reminders provide external supports that compensate for memory challenges, while calm repetition of key points, delivered without judgment, reinforces understanding. Checking comprehension using teach-back methods allows medical assistants to confirm clarity and adjust communication as needed. When expectations are aligned with cognitive capacity, patients are more likely to succeed, adherence improves, and health care interactions become more effective and less frustrating for everyone involved.

SOCIAL AND EMOTIONAL DIFFERENCES

Individuals with FASDs often experience differences in social and emotional processing that extend well beyond what might be labeled as behavior problems. They may miss social cues or nonverbal signals, appear overly familiar or intrusive, and have difficulty under-

standing boundaries or recognizing danger. Many are eager to please and easily influenced, which can place them at heightened risk in social situations. These neurological differences increase vulnerability to exploitation, abuse, and legal involvement. In health care settings, they can also contribute to misunderstandings with staff when behaviors are misinterpreted as intentional or inappropriate.

Medical assistants can play an essential role in reducing harm and supporting safer interactions. Maintaining professional warmth while setting clear, explicit boundaries helps create predictable and respectful encounters. Avoiding sarcasm or abstract language reduces confusion, while allowing extra time for responses supports processing and regulation. When appropriate, involving trusted caregivers or advocates can further enhance understanding and safety. Crucially, these behaviors are neurological, not deliberate, and responding to them with clarity and respect promotes more effective and compassionate care.

CO-OCCURRING CONDITIONS AND WHOLE-BODY HEALTH

FASDs are associated with high rates of co-occurring conditions that affect both mental and physical health. Individuals with FASDs commonly experience anxiety, depression, attention-deficit/hyperactivity disorder, substance use disorders, and sleep disturbances. Many also have metabolic, cardiovascular, immune, hearing, or vision-related conditions that require ongoing monitoring and care. Despite this, health care systems too often focus narrowly

on behavioral symptoms, overlooking the multisystem health needs that shape overall functioning and quality of life.^{9,10}

Medical assistants can help promote more comprehensive and effective care by supporting routine screenings, observing and tracking patterns over time, and identifying unmet needs that may not surface during brief provider encounters. By recognizing that physical and mental health concerns are often interconnected for individuals with FASDs, medical assistants play a key role in ensuring that care addresses the whole person rather than isolated symptoms.

CREATING FASD-INFORMED HEALTH CARE ENVIRONMENTS

Health care environments can either support regulation and understanding or unintentionally increase stress for individuals with FASDs. Adults with FASDs frequently describe health care environments as difficult to navigate. Using clear, concrete language and avoiding medical jargon helps reduce cognitive overload, especially when instructions are given one step at a time. Visual supports and teach-back methods reinforce understanding without embarrassment.

Sensory considerations also matter. Minimizing noise and visual clutter when possible, offering quieter spaces, and explaining what will happen before it happens can significantly reduce anxiety. Consistent, relationship-based care—which includes greeting patients warmly, validating lived experience, acknowledging stress without judgment, and following through reliably—builds trust over time. Small, intentional adjustments like these can meaningfully reduce barriers to care and improve patient engagement.

PERSON-CENTERED AND STRENGTHS-BASED APPROACHES

Historically, FASDs have been described primarily in terms of deficits. Increasingly, research and lived experience point to the importance of recognizing strengths as a foundation for effective, respectful care. A strengths-based approach offers a more balanced perspective by recognizing abilities alongside challenges. This approach

acknowledges qualities such as creativity, empathy, honesty, perseverance, a desire for independence, and the capacity for meaningful relationships. This perspective does not minimize challenges; instead, it supports dignity, motivation, and more effective intervention. The model can be reinforced by intentionally noticing and naming patient strengths, encouraging autonomy in small but meaningful ways, supporting goals identified by the patient, and avoiding deficit-focused or labeling language. When strengths are recognized alongside support needs, health care interactions are more collaborative, and outcomes are more sustainable.

TRAUMA-INFORMED CARE

Many individuals with FASDs have experienced trauma, including within health care systems. These histories shape how health care settings are perceived and can strongly influence trust, regulation, and engagement. Trauma-informed care emphasizes safety, predictability, and respect.

Trauma-informed care begins with non-judgmental communication and an awareness that past experiences may affect current behavior. Explaining what will happen and why helps reduce anxiety, while respect for autonomy supports a sense of control. Medical assistants who remain attentive to potential triggers and validate patients' lived experiences help shift health care encounters from sources of stress into places of safety. Consistent trauma-informed practices foster trust, improve cooperation, and support more effective care over time.

NAVIGATING SYSTEMS

Health care systems are complex, particularly for individuals with executive functioning challenges, and navigating multiple appointments, referrals, and services can quickly become overwhelming. Medical assistants play a key role in helping patients with FASDs move through these systems more successfully.

Serving as a consistent point of contact (when possible) helps reduce confusion and build trust. Supporting appointment scheduling, reminders, and follow-up reduces the risk of missed care, while assistance

with referrals helps ensure connections to needed services. Coordination with behavioral health and social service providers strengthens continuity, and involving caregivers or advocates when appropriate adds an additional layer of support. When health care systems work together rather than in isolation, outcomes improve, and the burden on patients and families is reduced.

REDUCING STIGMA

Stigma remains one of the most significant barriers faced by individuals with FASDs and often begins with how behaviors are interpreted in health care settings. Stigma often enters care through language and assumptions. Labels such as “noncompliant” or “difficult” can obscure the neurological realities of FASDs and influence how future providers interpret a patient's behavior.

Medical assistants can help reduce stigma by documenting functional needs rather than judgments, using person-first language, and approaching behaviors as signals of unmet support needs. Educating team members about FASD-related challenges helps shift understanding across the care team. Every interaction shapes whether patients feel safe, supported, and willing to engage in care.

THE ESSENTIAL ROLE OF MEDICAL ASSISTANTS

Medical assistants serve as frontline advocates for individuals with FASDs, often shaping how health care is experienced from the very first interaction. Their role extends beyond clinical tasks to include observation, communication, and advocacy across systems.

By noticing patterns others may miss, setting the tone for respectful and supportive encounters, and helping patients understand and follow through with care plans, medical assistants reduce barriers that can otherwise derail care. Bridging gaps between providers and services while consistently upholding dignity in everyday interactions helps transform health care from another obstacle into a source of stability and support. When medical assistants adapt communication, environments, and expectations accordingly, the impact reaches far beyond the exam-

ination room and contributes meaningfully to health equity for an often-overlooked population. ♦

The CE test for this article can be found on page 27.



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Cardiac Psychology

Deadline: Postmarked no later than **November 1, 2026**

Credit: 2.5 AAMA CEUs (gen/clin) **Code:** 145837

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 | T F |
|---|---|
| <p>☐ ☐ 1. In 2021, the American Academy of Pediatrics and other medical organizations declared a national emergency in youth mental health, but this emergency has ended.</p> <p>☐ ☐ 2. One of the key prevention categories in the American Heart Association's checklist for good health is mental health.</p> <p>☐ ☐ 3. Electrophysiology patients are patients who have a history of heart surgeries from childhood.</p> <p>☐ ☐ 4. Cognitive behavioral therapy is a technique that can be used in counseling cardiology patients.</p> <p>☐ ☐ 5. A small hole—called a <i>ventricular septal defect</i> or an <i>atrial septal defect</i>—in the heart of a child will sometimes close up as the child grows.</p> <p>☐ ☐ 6. Cardiovascular disease is the third leading cause of death in the United States.</p> <p>☐ ☐ 7. Because of the varying needs of patients, cardiac psychology is not time-limited.</p> <p>☐ ☐ 8. Children with relatively simple forms of congenital heart disease have roughly 5 times greater odds of developing anxiety or depression compared to healthy children.</p> <p>☐ ☐ 9. The mental health needs of younger cardiac patients can be much different from those of adult cardiovascular patients.</p> <p>☐ ☐ 10. A hole in the heart causes blood to leak out of the cardiovascular system.</p> <p>☐ ☐ 11. Congenital heart disease can cause psychological distress, and psychological distress can worsen congenital heart disease.</p> | <p>☐ ☐ 12. Evidence suggests that mental health issues and high stress levels can increase the likelihood of cardiovascular disease.</p> <p>☐ ☐ 13. State-funded programs for children with chronic conditions such as heart disease usually include mental health services.</p> <p>☐ ☐ 14. Stress-induced cardiomyopathy is an example of a heart condition in which psychological stress can cause an immediate adverse effect on heart function.</p> <p>☐ ☐ 15. Congenital heart disease involves problems with the heart's structure that are present at birth and prevent normal blood flow.</p> <p>☐ ☐ 16. Insurance reimbursement for mental health care for children is high in the United States.</p> <p>☐ ☐ 17. Research has shown that 65% of individuals who have experienced a myocardial infarction have stated that they had depression symptoms after the heart attack.</p> |



FASD Patient Care

Deadline: Postmarked no later than **November 1, 2026**

Credit: 1 AAMA CEU (gen/admin) **Code:** 145838

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

- | T F | T F |
|---|---|
| <p>☐ ☐ 1. People with fetal alcohol spectrum disorders (FASDs) often have impairments in adaptive functioning, even those who have average intellectual ability.</p> <p>☐ ☐ 2. Fetal alcohol syndrome is the most involved of the diagnoses on the FASD spectrum and is characterized by three distinct facial features.</p> <p>☐ ☐ 3. Executive functioning refers to cognitive processes that support planning, organization, impulse control, working memory, and learning from experience.</p> <p>☐ ☐ 4. Clear communication by health care professionals directly shapes outcomes for people with FASDs.</p> <p>☐ ☐ 5. FASDs can be caused by environmental factors such as air pollution.</p> <p>☐ ☐ 6. Medical assistants working with adult FASD patients can help them considerably by recognizing their FASD-related needs.</p> <p>☐ ☐ 7. A diagnosis of an FASD is not difficult to obtain because of the growing awareness of FASD among professionals.</p> | <p>☐ ☐ 8. Labeling behaviors of patients with an FASD as “difficult” or “noncompliant” is one manifestation of stigma.</p> <p>☐ ☐ 9. Using teach-back methods to help patients with an FASD understand the instructions of a licensed provider has been shown to be ineffective.</p> <p>☐ ☐ 10. Some people with FASDs have problems following complex instructions because of their difficulties with memory and mental processing.</p> <p>☐ ☐ 11. People with FASDs may have difficulty understanding boundaries or recognizing danger.</p> <p>☐ ☐ 12. Trauma-informed care is characterized by nonjudgmental communication and an awareness that past experiences may affect current behavior.</p> |

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By Cathy Cassata

Marsha L. Benedict, CMA-A (AAMA), BSA, was working as a dental assistant when she learned about medical assisting. “My cousin worked at a plastic surgeon’s office, and they needed someone to help answer phones and schedule appointments, so I started working there,” she says.

Soon after, her cousin learned about the American Association of Medical Assistants® (AAMA), and they attended a local chapter meeting together. Benedict began volunteering to take photos at chapter events. She was quickly inspired to pursue a career in the field and began studying for the CMA (AAMA)® Certification Exam with a group of aspiring medical assistants. “We would get together at lunch hour or at night to study. We all passed the exam,” says Benedict.

From there, her involvement in the AAMA grew. She became president of her local chapter—Oakland County—and president of the Michigan Society of Medical Assistants. While in this role, she also advised Blue Cross Blue Shield of Michigan and

Medicare for Michigan when they developed their updated procedure manuals.

She expanded her impact by getting involved at the national level, serving on committees, and attending board meetings in Chicago. “After attending my first AAMA Annual Conference in Houston in 1982, I was hooked,” she says. Since then, she has missed only three national conferences, attending most as a delegate.

In 2001, she served on the AAMA Continuing Education Board (CEB), which she remained on for seven years, two of which she served as chair. “I loved the CEB; that was so much fun and wonderful,” says Benedict. “I’m invested in education, medical assistants keeping up with their CEUs, and offering good opportunities for them to do so.” In 2007, she served as AAMA Vice Speaker of the House.

As her volunteer work grew, so did her medical assisting career. After working for years in part-time roles at different specialties, Benedict moved into education: first teaching the administrative side of medical assisting at a technical school and then accepting an adjunct position at Baker College in Flint, Michigan.

In 2007, she became the associate dean and program director of the medical assistant program at Baker College. She also volunteered countless hours traveling to help other programs earn CAAHEP accreditation. “This was a highlight of my life to meet other faculty and program directors

and help them with accreditation,” she says. “My many years as a surveyor helped me understand the process.”

When Benedict relocated to Florida in 2004, she continued her mission, working as an adjunct educator at Indian River State College before retiring from teaching in 2016. However, she continued to make an impact on the field. She served as president of the Florida Society of Medical Assistants for almost three years and chaired the 2023 AAMA Annual Conference in Orlando. Currently, she chairs Florida’s state conference committee and sits on the AAMA’s Marketing Strategy Team and Membership Development Strategy Team.

She understands the profession is changing and that today’s medical assistants prefer to work, learn, and volunteer differently. She embraces the changes with grace. “You have to evolve with the times,” says Benedict. “The younger group might not want to go to meetings and meet people that way, so we have to think about what they want. They like to [stay home] and do a Sunday morning CEU, so that’s what we have to give them.”

What stays constant is her unwavering drive to promote the profession. “I have a great passion for medical assisting,” says Benedict. “People ask why I stay involved even though I’m retired. I tell them that I’ll keep doing my best to make sure medical assistants get the respect they deserve.” ♦

A HELPING PAW

South Carolina State Society Comes Together to Support Animals in Need



By Kelli Smith

In 2024, when Crissy Taylor, CMA (AAMA), started her most recent term as president of the South Carolina Society of Medical Assistants, she decided to take her lifelong passion for animals and channel it into a community service campaign that would make a difference across South Carolina. “Animals have always been my love, especially dogs and cats,” says Taylor.

The campaign is called Paws for a Cause, and its goal is to work with humane societies, shelters, and rescues across South Carolina to provide them with the necessary items—such as cat and dog food, beds, toys, and towels—that are crucial to taking care of animals in need.

The community service campaign started in Anderson, South Carolina, near where Taylor resides, with the no-kill shelter Anderson County PAWS, which depends on donations. With the shelter often at or near capacity, Taylor felt that it was the perfect place to focus the state society’s attention through donations. “It would be good if we could all go in and adopt an animal, but that’s not always something that we can do. But we can help keep them healthy,” explains Taylor.

Taylor felt that, while charitable causes that help people are crucial, during her presidency she wanted to direct her focus toward animals, a population that can be forgotten or deprioritized when it comes to philanthropy. “A lot of people focus on the different organizations for people. ... But a lot of people don’t think about the happiness that an animal can bring us,” explains Taylor.

Pet Project

In the past, the South Carolina state society has had other community service efforts that have helped other populations in need throughout the state. “We have donated to others, like homeless shelters,” details Taylor. “I’ve been state president three times. So, this last time when I [became] state president, [Paws for a Cause] was what I wanted us to do for that year.”

The Paws for a Cause campaign is ongoing for the South Carolina state society, whose president always chooses a community service project to carry out during their term. While Paws for a Cause started with Taylor, who was the South Carolina state society president from 2024 to 2025, it was continued by Patty Licurs, CMA (AAMA), CPC, when she became president in 2025. This year, the current president, Lisa Kianos, CMA (AAMA), is also choosing to continue the community service campaign.

While the campaign started with Anderson County, it spread across the state with the donations of various South Carolina local chapters. “We had each chapter gather stuff to take to their local humane society,” explains Licurs. “And then at the end of the year, we asked them to bring stuff to our state conference as well. And [Taylor] had a car full of stuff that she took to the Anderson [County] Humane Society. So, it was really successful for that. We continued it on to my presidential year.”

While Paws for a Cause was developed with a love of animals in mind, it also aligns well with the South Carolina state soci-

ety members’ roles as medical assistants. “Medical assistants like to help care for people in any way. So, taking care of animals is just branching off from that,” explains Licurs.

The South Carolina state society has had a special devotion to community service and carrying out philanthropy for a long time. “I think that South Carolina is very committed to our communities, especially with the charities that we have done,” says Licurs. “The president is the one who picks the charity. And that’s something that we want to continue doing every year. We just think it’s very important to reach out to our community.”

For other state societies and local chapters who want to carry out similar kinds of community service campaigns, Licurs has some advice. “The easiest thing that we did is we just asked [local chapters] to donate to their local humane society. That way we’re reaching out to humane societies all throughout the state,” explains Licurs. “So that was the easiest thing: to start with your chapter. And then we had just a big [event] at the end of conference for a statewide [initiative]. But we asked each chapter to submit pictures and what they did each meeting. ... Just decide on what charity you want to contribute to. And then we just went from there.”

Fur the Greater Good

While starting the Paws for a Cause campaign was a special experience for Taylor, certain moments stood out to her as par-



ticularly moving and gratifying: “When you take the whole truckload of stuff to distribute and see the people so excited to help you bring it in and let you take and actually give it to the animals throughout their facility. That is what was most memorable: to see the look on those puppies’ faces and those kittens [because] they just had something to play with. That made it all worthwhile,” says Taylor.

Taylor feels that, as public servants, all medical assistants should aim to make this kind of impact on their communities. “I think it makes a better medical assistant if they’re willing to give their time for free to ... do [what they can] to help others.”

She reflects on her passion for animals and how they serve people in countless ways: “I think that animals ... seem to bring the best out of us. It makes us want to live and be better people. ... To me, that helps humans with their health care.” ♦



Donations for Paws with a Cause were collected at the 2025 SCSMA conference.

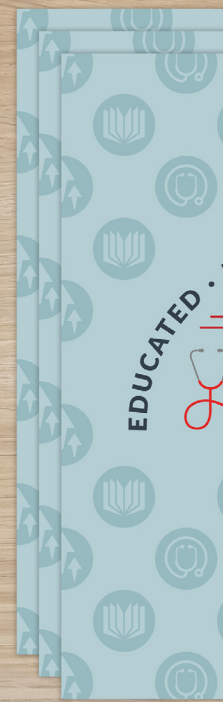
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