

# GSA Reporter

Vol.2 No.3 Spring 2005

Group on  
Student Affairs  
**GSA**



## Greetings From the National Chair

*Peter Katsufraakis, M.D.,  
M.B.A.*

Based on previous formal and informal statements I've made to our community, I suspect many of you are aware of my interest in mentoring. I'd like to take this opportunity to share my thoughts on why I think this is important to us all, and how I see mentoring playing out in the lives of our GSA community members.

I expect we all share the experience of having at least one person in our lives who has served as a shining example of a guide, counselor, role model, or teacher. Often these individuals are most effective, and their impact most memorable, when their guidance combines direction in both our personal and professional lives. We could spend hours discussing a precise definition of "mentor"; for now, I propose that a mentor is a wise, experienced, and trusted counselor, who is an exemplary role model, and who engages in enduring active guidance and maturation of a more junior individual that encompasses both professional and personal domains of the protégé's life. I still recall advice received years ago from two such individuals.

Unlike many of my students, I did not know from the time of my early childhood that I wanted to be a physician; this realization came to me much later. I recall a conversation I had as a college sophomore with my best friend's parents, a physician and his wife. I was home from college that weekend, and though my friend was away at school I stopped by to visit Kate and Roland. I trusted them as adolescents often trust their friends' parents (not yet having matured sufficiently to trust my own parents!). In discussing possible career paths, Kate said, "Pete, you should be a doctor.

You're smart, you're good at science, and you like people." Roland agreed, elaborating on his rationale, comparing my values and abilities with his own, and providing specific advice about how to pursue this goal. I left that night with a head full of ideas, the seeds of my career taking root, benefiting from the informal advice I today would characterize as mentoring.

What makes a good mentor? Perhaps a better question is: What makes a good mentoring relationship? The ideal mentor is someone who is empathic, mature, self-confident, resourceful, and willing to commit the time and energy to another's development. A good mentor should also be able to offer effective guidance, stimulate and challenge the protégé, encourage self-realization, and foster growth. The person seeking mentorship should be proactive and take the initiative to establish the relationship. He or she should also be respectful, organized, responsive to the mentor's guidance, and demonstrably appreciative of the mentor's gifts of time, energy, and concern. The relationship has reciprocal, tangible benefits for both parties, and is characterized by: regular, enduring contact; generous, sensitive, and honest exchange of knowledge, values, and beliefs; and, consideration of both personal and professional development.

How do these concepts apply in our roles as medical school staff and faculty? Obviously, each of us has experience and knowledge to share. Typically, one of our formal job responsibilities is to share our expertise with our students; such service for our students often constitutes the bulk of our day. Although our official job responsibilities may not encompass the personal and professional development of our colleagues, those of us who have accepted such a role can attest to the exciting challenges and gratification associated with serving as a mentor. Thus, envisioning yourself in a new role and assuming responsibility for

enhancing the skills, knowledge, and judgment of your colleagues can provide an exciting professional challenge.

Similarly, despite years or decades of experience, it is the rare individual who has nothing to learn from others. I suspect we all can identify within ourselves abilities or knowledge we would like to acquire or enhance. With just a bit of effort, I suspect we can also identify others in our environment who might serve as coach, advisor, or mentor in our development. Or if such individuals seem to be in short supply, other GSA colleagues (regional chairs, GSA committee members, national officers) can certainly identify capable and willing guides for our development.

In summary, we all have experience to share and the potential to be mentors, as well as benefit from others' guidance. Actively and consciously developing one's own skills and abilities is a path to continued professional and personal success and happiness. Sharing one's experience enriches our community, benefits others, and solidifies our own life's lessons. For "Eriksonians," mentoring provides a path to generativity and escape from stagnation. As we look to spring and summer, the end of one school year and planning for the next, I hope you will spend a moment or two thinking how others' knowledge and experience might increase your effectiveness, and how you might share the lessons you've learned with those following behind you.

NOTE: For those with greater interest in this topic, Dr. Katsufraakis will be conducting a workshop on mentoring at the June 9-12 Joint Student Affairs/Careers in Medicine Professional Development Conference in Orlando, Florida.

*Dr. Katsufraakis is associate dean for student affairs at the University of Southern California Keck School of Medicine, and GSA national chair (2004-2005).*

## Careers in Medicine Update

### New MSPI Assessment and Salary Data have Arrived

Careers in Medicine (CiM) has added two new features to the Web site to assist your students with career planning. *The Medical Specialty Preference Inventory (MSPI)*, 2nd edition, by George Zimny, Ph.D., is a 150-item interest inventory that provides overall preference scores for 6 major medical specialties (internal medicine, family medicine, pediatrics, obstetrics and gynecology, surgery, and psychiatry), and factor scores on 38 specific areas of practice. These specialty preference scores and factor scores can be compared to each specialty, thereby allowing the student to match their preferences to those specialties containing similar characteristics. Users will receive a score report that provides interpretive information; an MSPI manual will be available soon. To access the new MSPI instrument, log in to the CiM Web site and click on the "Self Assessment" option on the menu, then choose "Interests."

Additionally, new physician compensation data are available, from the Medical Group Management Association, that adds to the existing salary information. CiM now has compensation information for both clinical faculty and practicing clinicians in many medical specialties and subspecialties to assist medical students in their career exploration. The new salary information can be found on the Specialty Pages. Career in Medicine staff are very excited about these new features and look forward to receiving your feedback.

### 2005 Joint Student Affairs/Careers in Medicine Professional Development Conference: Preparing for Tomorrow

**June 9-12, 2005, at the Omni Orlando Resort in Orlando, Florida**

Careers in Medicine is co-sponsoring a professional development conference this summer with the Group on Student Affairs (student affairs). This conference will provide you with an opportunity to consult with your peers and experts about the "hot topics" in student affairs and career development issues that affect you and your students. Program highlights include plenary sessions on "Proactive Living: Where Achievement Begins," with renowned career development speaker Doug Manning, and "Is a Physician Workforce Shortage Looming? Evidence, Implications and Options," with Edward Salsberg, the director of the Center for Workforce Studies. Other topics include career advising for students underrepresented in medicine, medical student debt and specialty choice, navigating the residency application sea, building your CiM program, innovations in CiM, and many more. The complete program and registration information can be found on the AAMC meetings Web site at [www.aamc.org/meetings](http://www.aamc.org/meetings). We hope to see you there!

### Osteopathic Medical Schools Invited to Participate in Careers in Medicine Program

The AAMC has submitted a proposal to the American Association of Colleges of Osteopathic Medicine (AACOM) offering access to the Careers in Medicine Program to all osteopathic medical schools. Under the terms of the proposal, which has received a favorable reception from the AACOM Board, each school will be provided with CiM Student Guides and Advisor Manuals for their students and advisors, full access to the CiM Web site, and invitations to CiM training workshops and professional development conferences, following the same guidelines as

### GSA National Officers, 2004–2005

#### Chair:

Peter K. Katsufraakis, M.D., M.B.A.  
Associate Dean for Student Affairs  
University of Southern California Keck  
School of Medicine

#### Chair-elect:

Patricia J. Metting, Ph.D.  
Associate Dean for Student Affairs  
Medical College of Ohio

#### Vice-chair:

Dwight Davis, M.D.  
Associate Dean for Admissions &  
Student Affairs  
Pennsylvania State University College of  
Medicine

member-medical schools. The services will be provided to all osteopathic schools for a nominal fee to cover the cost of development, preparation, and distribution of these materials. A number of osteopathic schools have already indicated interest, and they will be contacted by AAMC in the coming months to create working agreements and make arrangements for accessing the program. This opportunity is especially critical in light of the transfer of the GlaxoSmithKline Pathway Evaluation Program to the CiM Program, and will allow osteopathic medical schools to continue to provide career-planning services using the comprehensive, up-to-date tools and resources available from CiM. We are looking forward to working with our osteopathic medical school colleagues.



## News from the GSA-MAS National Chair

*James L. Phillips, M.D.*

It is a pleasure to report that the GSA-MAS Strategic Plan has been completed. The GSA-MAS Coordinating Committee and GSA Steering Committee have adopted the plan. The strategic plan was included in the February 2005 AAMC governance meeting agendas. Lily May Johnson, manager, AAMC Division of Diversity Policy and Programs, presented the plan at both the Council of Deans and Council of Academic Societies, February 2005, meetings for information. The mission statement is as follows:

“As medical educators, the mission of the MAS, a professional development group within the AAMC, is to improve the health of our diverse nation, through leadership, service, research and collaboration, with an emphasis on the value that diversity brings to medicine and the health of the nation. The MAS pursues its mission by assisting academic medical institutions, organizations, MAS members, and other individuals in carrying out their responsibilities for:

- Educating physicians and scientists who will be culturally proficient;
- Promoting racial and ethnic diversity in medicine;
- Developing innovative ideas for faculty development and for curricular changes in undergraduate and graduate medical education that address the diversity of our nation; and,
- Addressing community service outreach and research training with respect to racial and ethnic health and healthcare disparities.”

Within the plan, four strategic initiatives were developed, each with several goals and assigned objectives.

The initiatives are:

1. Promote racial and ethnic diversity in the physician workforce and medical education.
2. Develop diverse leadership to change the face of medicine.
3. Develop reciprocal communications among MAS Representatives, MAS Officers, the AAMC, and external organizations that address minority issues.
4. Increase collaboration within the AAMC as an organization.

To start the plan, and facilitate achieving the goals and objectives, six implementation teams (Recruitment and Outreach, Professional Development, Information and Dissemination, Data, Research and Publications, and Awards) have been established to work on their assigned objectives. The team leaders are members of the GSA-MAS Coordinating Committee, and they discussed their “teams” at the GSA spring regional meetings, and recruited members for their teams.

The GSA-MAS Coordinating Committee will give progress reports at its regular meetings (thrice annually). As with any strategic plan, in addition to receiving the above reports, the plan will be reviewed at regular intervals and revised appropriately.

In addition to the two subcommittees of the GSA-MAS Coordinating Committee assigned to this project—one each for Phase One and Phase Two, we also acknowledge the fine support and continual review of the plan when the subcommittees presented the various iterations to us. Working hand in glove with us throughout, were the members of the AAMC Division of Diversity Policy and Programs (DDPP), to whom we express our sincere gratitude.

*Dr. Phillips is senior associate dean and professor of pediatrics at the Baylor College of Medicine, and the GSA-MAS national chair.*

## Save The Date

116th AAMC Annual Meeting  
Minority Student Medical Career  
Awareness Workshop  
and Recruitment Fair  
November 5, 2005  
Washington, DC

Sponsored by: AAMC Group on  
Student Affairs-Minority Affairs Section  
(GSA-MAS)

AAMC Division of Diversity Policy  
and Programs

Recruitment table registration will be  
mailed late summer, and information  
will be available at a later date at  
[www.aamc.org/students/minorities/medicalcareerfair.htm](http://www.aamc.org/students/minorities/medicalcareerfair.htm).

**“As I See It”**

“As I See It,” highlights the views and opinions of GSA admissions, student financial assistance, minority affairs, student affairs, and student records representatives on the various “hot topics” that relate to their roles.

This column will initially seek out opinions on a specific topic from your representatives to the GSA national committees, and then request all GSA representatives to share their views and opinions on the same topic via the GSA listserv—GSALIST (when sending your views to the listserv, type “As I See It” in the subject line). A sample of opinions from the GSA listserv will appear in the next issue of the *GSA Reporter*.

**“Should Debt Management Education Be a Required Component Throughout the Medical School Curriculum?”**

*Michael Jacobson*

The AAMC Working Group on Student Educational Costs and Debt recently presented its final report, which raises several issues and makes recommendations concerning the growing problem of student debt incurred during medical school. The majority of this report’s recommendations were directed towards AAMC member institutions, urging (1) increased accountability and transparency in setting tuition, (2) increased predictability for future tuition increases, (3) development of methods to halt the trend of high tuitions contributing to decrease in the racial and socioeconomic diversity of the physician workforce, and (4) attempts to analyze and decrease the wide variability in costs of attendance of member medical schools. A fifth issue with a set of associated recommendations, however, was directed, at least in part, towards the responsibility of medical students in understanding and controlling their debt, namely the development of “required, ongoing educational activities to help medical students understand and master the financial aspects of their medical education, both while in school and in practice . . .” The specific recommendation calls for medical schools to “mandate [the participation of students] incurring educational debt in educational activities regarding financial, debt, and loan management at multiple points in [their curricula] . . .” [in a manner which is] “. . . appropriate to the year of medical education in which the student

is enrolled.” The committee justifies this recommendation by stating, “To date, these educational activities at most schools are usually voluntary, infrequent, inconsistent in quality and content, and easy to avoid, with understandably variable results.”

I agree that there are some powerful arguments for a required curriculum in debt management. Given the complexity of the subject, most students probably never truly understand how, or who, sets their school’s tuition, the factors that determine their financial aid package, or the true cost of their loans, given the confusing practices of interest capitalization, grace, deferment, and forbearance. In addition, because financial aid packages bundle money earmarked for tuition together with money for living expenses, it is quite easy to feel as if one is being paid a salary to attend medical school, conveniently in semi-denial that the funds must eventually be paid back with significant interest. The true cost of the daily latte, or even the trip abroad taken during elective time off, rarely receives notice from most medical students. Finally, students under stress to learn gross anatomy or survive their general surgery clerkship do not have much time, energy, or desire to deal with these issues. Perhaps, if certain areas of the medical curriculum could be pared down to allow dedicated time for the debt management curriculum, it would yield higher sophistication on these issues. The aspect of designing the information in a way that matches students’ needs during each year of matriculation could prove tricky; however, the committee’s recommendations do call for AAMC to develop a standardized curriculum specifically geared towards the needs of each class.

While I do agree with the general notion that greater knowledge about debt management would benefit medical students, I must admit that I cringed when I first heard about adding to the already very full curriculum. For over one hundred years in the United States, medical school has been comprised of four years of training; however, the complexity and sheer number of facts taught in the curriculum has exploded, even compared to the last decade. Any additional material, especially that which does not directly involve basic science or medical principles, should be added only after carefully considering its absolute necessity; and, I am not sure I am convinced that debt management training would meet that criterion. According to the committee’s report, at least 15 percent of all medical students in the U.S. are lucky enough to graduate with no educational debt at all. Such an addition to the curriculum is clearly unnecessary for these students. Furthermore, even for students who do incur large debt, the majority of the debt they carry is effectively out of their control (i.e., tuition and fees). The part of the financial aid package the medical student can control is living expenses, which are highly variable, depending on age, marital status, geographic location, previous employment and savings, as well as personal spending habits. With all due respect to the GSA Committee on Student Financial Assistance (COFSA) and the MD<sup>2</sup> (Monetary Decisions for Medical Doctors) for materials they have kindly developed, my sense is that few, if any, students will truly change their spending habits or ability to live on a smaller budget based on information presented in the curriculum unless they are already motivated enough to have found the information themselves on the AAMC Web site.

Beyond my doubts concerning the necessity of debt management training, my greatest criticism of the committee’s findings and recommendations is that they do not take into account the high costs of applying to medical school as a source of personal debt. According to a recent analysis performed by B.J. Gordon, Ellen Julian, and Gwen Garrison (representing AMCAS, MCAT, and Student and

Applicant Research) that was presented at the last GSA Committee on Admissions (COA) meeting, successful applicants to medical school submit more applications, spend more on AMCAS, and were more likely to have taken an MCAT prep course than non-successful applicants. Although there are currently no AAMC data available to track how applicants fund these and other costs, such as secondary application fees and travel to interviews, it seems clear that this money must come from either family, personal savings, or credit card debt. My own sense is that for an increasingly prominent set of applicants, whose families are unwilling or unable to fund their medical school applications, credit card debt – secondary to application fees – represents a significant fraction of personal debt carried during medical school. Students in this group would include many older, “non-traditional” students entering a second career, as well as students coming from an economically disadvantaged background, and many students underrepresented in medicine. Because student financial aid will not directly cover application fees, students carrying credit card debt originating from the application process are then more likely to borrow up to the limit from their financial aid while in school in order to make minimum payments. This represents an additional stressor and distraction during a time of intense study that a required course in debt management would do little to alleviate.

There are no quick or easy fixes to the problems of medical student debt, but the task force’s analysis of the problem and set of recommendations are a good starting point. As the task force suggested, today’s medical students, who are used to an ever-increasing standard of living, should be expected to take responsibility for managing their own debt. But, before jumping to mandate required debt management courses, we need to consider whether it would have any more than a token effect on the overall problem. Perhaps, a more efficient use of our financial aid officers’ expertise would be providing required courses for the university administrators and state legislators charged with determining our tuition and fees.

*Mr. Jacobson is a fourth-year medical student at the University of Washington, Seattle, and OSR Liaison to the GSA Committee on Admissions (COA).*

### **Should Debt Management Education Be a Required Component Throughout the Medical School Curriculum?**

*Ted Williams, Ph.D.*

The ever-increasing cost of a medical education has created a very real concern for medical students, residents, and the medical education enterprise. Recent data from the Association of American Medical Colleges (AAMC) show that the average level of indebtedness for medical school graduates from public medical schools is \$104,385. The indebtedness of a graduate from a private medical school is \$133,357. During the 2004-2005 academic year, the average tuition for medical students attending public institutions increased by 8.7 percent for residents, and 7.9 percent for non-residents compared to the 2003-2004 academic year. The average tuition for private schools increased by 4.4 percent for residents, and 4.3 percent for non-residents during the same period. Suffice it to say, these statistics bear witness to the ever-increasing cost of a medical education.

After medical school graduation, the average housestaff stipends nationwide are: PGY1-\$39,800; PGY3-\$43,442 and PGY5-\$47,146. As is evident, upon graduating from medical school with an average debt load of \$104,385 to \$133,357, stipends for residents are only marginally sufficient to sustain a rather Spartan lifestyle.

Aside from the general financial burden imposed by rising medical school tuition on medical students, there is also the disparate impact on those socioeconomically, disadvantaged students. Examination of racial statistics impacting the ability to pay shows that black families in the United States have a median income that is 63 percent of the median white family income. According to the U.S. Census Bureau data, this figure has remained essentially unchanged for nearly three decades. Census Bureau statistics also show that 13 percent of all 18- to 24-year old,

college-age black youths come from families with incomes below \$10,000. This is more than seven times the level for white youths in the same age bracket.<sup>1</sup> If one looks at an income threshold of \$25,000, which is still well below the median income in the United States for both blacks and whites, one finds that 30.6 percent, almost one-third, of all youth come from families with incomes below \$25,000.<sup>1</sup>

Most individuals have some knowledge concerning the very large income gap between black and white families. However, family income differences are only part of the financial burden that almost all black families face in sustaining their children through the college years. Usually the large economic cost of completing college is paid from two sources: family savings and disposable income.<sup>2</sup> U.S. Census Bureau 2000 statistics showed that the median net worth of black families in the United States was less than one-tenth of the median net worth of white families.<sup>1</sup> The latest statistics from the Census Bureau show that financial wealth (i.e., money in banks, stocks, bonds, and the like), which could be used to pay for a college education is almost nonexistent in the black family. According to Census data the median net worth for black families with these types of assets was only \$1,166. For whites, the median asset value was about \$22,566.<sup>3</sup> Thus, one can readily see that there is a huge gap between both income and wealth between black and white families in the U.S.

Although one may agree that blacks operate at severe financial disadvantages in terms of servicing their college debt, one might try to make a case for the compensatory effects of scholarships to black students. According to a 1994 study by the General Accounting Office, scholarships for blacks and other minorities amounted to only four percent of all scholarships in the United States.<sup>3</sup> These data would suggest that scholarship money has a negligible impact in moderating, between black and white families, the ability to service the cost of a college education.

In view of the aforementioned statistical information, it would not take a huge leap of faith to envision a disparate impact of medical school indebtedness on blacks, as

well as other medical school graduates from groups underrepresented in medicine. I believe that debt management becomes an odious reality to these students upon entry into medical school. The majority of “those underrepresented in medicine” do not enjoy the financial wealth of their majority counterparts. Therefore, they must devote considerable time and effort toward developing viable strategies that will allow them to financially survive medical school and still be able to service medical school indebtedness. I feel that this is an avenue wherein medical schools can and should be more involved.

Should debt management education be a required component throughout the medical school curriculum? Unequivocally, yes! All medical students, especially “those underrepresented in medicine,” who lack the financial resources, should be constantly apprised of the need for debt management during medical school, and beyond. This can be readily accomplished by introducing “Debt-management Seminars” throughout the four-year medical school curriculum. All medical students should be made aware of debt loan accumulations, and viable options to service those debts, upon graduation from medical school.

In view of the possible disparate impact of medical school indebtedness on those students underrepresented in medicine, the crying need to increase the number of these students in medical school, and the ever-increasing debt load of our medical school graduates, medical schools have an obligation to keep all students well informed on the efficacious management of medical school debt. The pursuit of any other pathway reflects a disservice to the medical students, their families, and society.

<sup>1</sup> U.S. Bureau of the Census, “Household Wealth and Asset Ownership”; 1998 and 2000, “Current Population Reports”; Series p-70, No.88

<sup>2</sup> Cross, T. Winter, 2003/2004. The Journal of Blacks in Higher Education, “The Good News That the Thermstroms Neglected to Tell,” No.42 pp-81-92

<sup>3</sup> Information on Minority-Targeted Scholarships United States General Accounting Office. B-251634, January 1994

*Dr. Williams is associate vice president for diversity and equal opportunity, University of South Florida; associate dean for diversity initiatives, professor of biochemistry and molecular biology, University of South Florida College of Medicine; and, AAMC GSA-MAS national chair-elect.*

### “As I See It” Dual/Combined Degree/Baccalaureate/MD Programs

*Reader’s response:* I enjoyed reading the winter 2005 issue of GSA Reporter. I think the new feature, “As I See It,” is a valuable addition to this publication. Any opportunity that we have to share our views on the current “hot topics” benefits us all, as well as the GSA.

I’d like to react to the column that Delores Brown published regarding Combined Baccalaureate/MD Programs. I share many of the thoughts that Delores expressed, especially the mixed feelings with regard to the benefits of selecting students directly from high school for these programs.

Her observation about the increasing pool of outstanding applicants through the traditional application pathway warrants our consideration. However, I wish to point out that the assumption made in the column is that acceptance to baccalaureate/MD programs must be directly from high school. Her points about the impact that these programs have on the undergraduate experience deserve serious consideration.

Northwestern was certainly one of the pioneers in this arena in the early 1960s. At Robert Wood Johnson, we did not begin our baccalaureate/MD program (which is joint with Rutgers University) until 1988. When we developed our program, we looked at the existing models (with special attention to the Boston University model), and we made the decision to not admit students directly from high school. Rather, the application process occurs at the end of the sophomore year at Rutgers. By this time, students have had an opportunity to explore

their interests a bit, and decide if medicine really is their desired career path.

Additionally, we have the opportunity to evaluate data from their first two years of college. These data are not just academic data, but rather we place great emphasis on leadership and maturity. Our program is designed to allow students to have two (or more) years of concurrent undergraduate and medical schoolwork. It is designed to allow students, who have interests (perhaps outside of science and medicine), to pursue these interests by giving them the time and the freedom to do so.

I agree with Delores that rigorous outcomes research is warranted to determine whether the intended goals of these programs are being achieved. I will, however, contribute to the anecdotal database by saying that over the 16 years of our program’s existence, while we have not had a “perfect” record (less than two percent attrition), many of the students in our program have assumed leadership positions in our medical school, many are characterized by the faculty as exactly the types of students who make teaching fun; and, they consistently are over-represented among our AOA students.

As we move forward in the continuing evaluation of our programs, I would suggest that medical schools look at multiple models of how baccalaureate/MD programs can be structured.

David Seiden, Ph.D.  
Associate Dean for Admissions and Student Affairs  
Professor of Neuroscience and Cell Biology  
UMDNJ-Robert Wood Johnson  
Medical School

Select responses, from the GSA listserv (GSALIST), will be published in the July issue of the GSA Reporter. Some comments may be edited for clarity and length.

## 2005 Match

The 2005 Main Residency Match is now history, and it can best be characterized as “steady as she goes.” More positions were offered and more matches were made than ever before; however, the match rates for most categories of applicants and the fill rates in most specialties held steady, with little variation from 2004.

This year, the overall match rate for all applicants was 78 percent, up 1.2 percent from 2004. U.S. seniors fared considerably better, however, with a match rate of 93.7 percent. The number of seniors, who submitted rank order lists, was 14,719 – up 110 over last year and the highest number since 1986. The number of seniors, who matched to PGY-1 positions, grew by 226, and 86.2 percent matched to one of their top three choice programs.

This year’s Match offered 21,454 PGY-1 and 2,558 PGY-2 positions, an overall increase of 308 positions from 2004. The fill rates for PGY-1 and PGY-2 positions were 92.1 percent and 92.5 percent, respectively, varying less than 1 percent from last year. Dermatology, Emergency Medicine, General Surgery, and Orthopaedic Surgery remained highly competitive, filling at least 80 percent of their PGY-1 positions with U.S. seniors, and more than 95 percent of positions overall.

In other news, the Association of Academic Departments of Otolaryngology has announced that, beginning next year, Otolaryngology programs will move from the San Francisco Matching Program to the NRMP’s Main Residency Match. The move was prompted by a change in the Residency Review Committee’s accreditation requirements that allows Otolaryngology programs to assume responsibility for the PGY-1 year of training.

*Mona Signer, executive director-designate, NRMP, and AAMC assistant vice president*

## GSA Reporter: GSA National Committee Reports

- The Committee on Admissions completed work on the GSA recommendations for criminal background checks for applicants accepted to medical school. These recommendations were approved by the GSA Steering Committee in January 2005 and presented for consideration at the February 2005 AAMC governance meetings. The AAMC Executive Council tabled the recommendations until June 2005, when they will be considered again. In the interim, Barbara Gordon and Bob Sabalis are preparing a survey regarding criminal background checks to be distributed in May 2005 to all admission officers; they are also conferring at the GSA regional spring meetings with admissions representatives from those schools currently requiring criminal background checks.
- The Committee on Student Records finalized its “Guidelines for Maintaining Active and Permanent Student Records,” which were approved by the AAMC Executive Council in February 2005. “Active records” are those of students who are currently enrolled or on an approved leave of absence. “Permanent records” are those of students who are no longer enrolled due to graduation, dismissal, withdrawal, or death. “Records” can either be hard copy or electronic. The guidelines document can be downloaded from the GSA Resources and Publications Web site at: [www.aamc.org/members/gsa/resources.htm](http://www.aamc.org/members/gsa/resources.htm) (scroll to Student Records).
- The Committee on Student Financial Assistance is developing a Resource for Financing Medical Education, a merger of “(MD)2: Monetary Decisions for Medical Doctors” and “Financial Education and Wellness” (FEW) (formerly “Financial Wellness for Medical Students”). An introductory brochure is being mailed to all Financial Aid representatives and pre-health advisors.
- The Committee on Student Affairs has completed its “Recommendations for Student Healthcare and Insurance Programs” document, which was approved by the AAMC Executive Council in February 2005. This document represents the culmination of an 18-month-long collaborative effort by the Committee on Student Affairs and the OSR Administrative Board. These recommendations complement the “GSA Recommendations Regarding Health Services for Medical Students” document first published in 1992. Both documents can be accessed on the GSA Resources and Publications Web site at: [www.aamc.org/members/gsa/resources.htm](http://www.aamc.org/members/gsa/resources.htm) (scroll to Student Affairs).
- The GSA-Minority Affairs Section (GSA-MAS) has completed its Strategic Plan and is currently working on implementation plans. The Strategic Plan, which can be accessed on the GSA Web site at: [www.aamc.org/members/gsa/](http://www.aamc.org/members/gsa/) (scroll to Hot Topics), identifies four priority areas on which the GSA-MAS will focus its attention and efforts in the future.

## AAMC Calls for Modest Increase in Medical School Enrollment

Association Adopts New Position on Physician Supply

Concerned that America may experience a physician shortage in the next few decades, the AAMC recommended that enrollment in U.S. medical schools be increased 15 percent by 2015. Assuming that schools respond to the AAMC’s recommendation, the result would be an increase of about 2,500 M.D. graduates per year.

For more information, go to [www.aamc.org/newsroom/press-rel/2005/050222.htm](http://www.aamc.org/newsroom/press-rel/2005/050222.htm) for the February 22, 2005 Press Release.

## GSA Meetings of Interest

### 2005

#### June 9–12

Joint Professional Development  
Conference  
For Student Affairs Officers and  
Careers in Medicine Liaisons  
Orlando, FL  
[www.aamc.org/meetings/groups/  
gsacim05/start.htm](http://www.aamc.org/meetings/groups/gsacim05/start.htm)

#### September 17 – 19

Minority Faculty Career Development  
Seminar  
Georgetown University Conference Center  
Washington, DC  
Information: Lily May Johnson  
([lmjohnson@aamc.org](mailto:lmjohnson@aamc.org))

#### November 5–10

AAMC Annual Meeting  
Washington, DC

### 2006

#### April 2–5

Spring GSA/GSA-MAS/OSR National  
Meeting  
Philadelphia, PA

---

#### CALL FOR SUBMISSIONS

Group on Educational Affairs (GEA)/  
Group on Student Affairs (GSA), the 44th  
Annual Research in Medical Education  
(RIME) Conference and the Innovations  
in Medical Education (IME) Exhibits

During the 116th Annual Meeting  
November 4–November 9, 2005  
Marriott Wardman Park and Omni  
Shoreham Hotels, Washington, DC

For information on submission  
types and deadlines, go to  
[www.aamc.org/members/gea](http://www.aamc.org/members/gea)

## GSA Reporter

2450 N Street, NW  
Washington, DC 20037

The GSA Reporter is published three  
times annually by the Section for  
Student Affairs and Programs of the  
Association of American Medical  
Colleges.

#### Associate Vice President

Robert F. Sabalis, Ph.D.

#### Editor

M. LaVerne Shanklin

For additional copies, contact the  
Section for Student Affairs and  
Programs at 202 828 0494.