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Exhibit 1:
Transcribed Interview of Dr. Aamir Hussain

COMMITTEE ON THE JUDICIARY,

U.S. HOUSE OF REPRESENTATIVES,

WASHINGTON, D.C.

INTERVIEW OF: DR. AAMIR HUSSAIN

Friday, July 18, 2025

Washington, D.C.

The interview in the above matter was held in room 6400, O'Neill House Office Building, commencing at 2:25 p.m.

Appearances:

For the COMMITTEE ON THE JUDICIARY:

[redacted] PROFESSIONAL STAFF MEMBER

[redacted] DEPUTY DIGITAL DIRECTOR

[redacted] CHIEF COUNSEL FOR ANTITRUST,

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[redacted] MINORITY CHIEF COUNSEL AND SENIOR ADVISOR

[redacted] MINORITY SENIOR COUNSEL

[redacted] MINORITY INTERN

[redacted] This is a transcribed interview of Dr. Aamir Hussain. Chairman Jordan has requested this interview as part of the committee's oversight of the adequacy and enforcement of U.S. antitrust laws as it relates to competition concerns in the medical residency market. Will the witness please state your name for the record.

Dr. Hussain. Aamir Naveed Hussain.

[redacted] On behalf of the committee, I want to thank you for appearing here today and answering our questions. The chairman also appreciates your willingness to appear voluntarily. My name is [redacted] and I am with Chairman Jordan's staff. I will now have everyone else from the committee who is here at the table introduce themselves as well.

[redacted], professional staff member, House Judiciary Committee.

[redacted] with Chairman Jordan's staff.

[redacted] law clerk.

[redacted] with Chairman Jordan.

[redacted] with Ranking Member Raskin's staff.

[redacted] Ranking Member Raskin and also Ranking Member Jerry Nadler's Antitrust Subcommittee.

[redacted] with Ranking Member Raskin's office.

[redacted] with Chairman Jordan's office.

[redacted] I'd like to now go over the ground rules and guidelines that we will follow during today's interview. Our questioning will proceed in rounds. The majority will ask questions first for one hour, then the minority will have an opportunity to ask questions for an equal period of time if they choose. We will alternate back and forth until there are no more questions and the interview is over. Typically, we take a short

break at the end of each hour, but if you would like to take a break apart from that, please just let us know.

As you can see, there is an official court reporter taking down everything we say to make a written record, so we ask that you give verbal responses to all of our questions. Please try not to nod, anything of the like. Verbal responses would be great. Do you understand?

Dr. Hussain. Yes.

[redacted] So the court reporter can take down a clear record, we will do our best to limit the number of people directing questions at you during any given hour to just those people on the staff whose turn it is. Please try and speak clearly so the court reporter can understand, and so the folks down at the end of the table can hear you. It is important that we don't talk over one another or interrupt each other if we can help it, and that goes for everybody present at today's interview.

We encourage witnesses who appear before the committee to freely consult with counsel if they so choose. It is my understanding that you are appearing here today without counsel. Is that correct?

Dr. Hussain. Yes.

[redacted] Thank you. We want you to answer our questions in the most complete and truthful manner as possible, so we will take our time. If you have any questions or if you do not understand one of our questions, please let us know. Our questions will cover a wide range of topics, so if you need clarification at any point, just say so. If you honestly don't know the answer to a question or do not remember, it is best not to guess. Please give us your best recollection, and it is okay to tell us if you learned information from someone else. Just indicate how you came to know the information.

If there are things that you don't know or can't remember, just say so and please inform us who, to the best of your knowledge, might be able to provide a more complete answer to that question.

You should also understand that although this interview is not under oath, that by law, you are required to answer questions from Congress truthfully. Do you understand that?

Dr. Hussain. Yes.

[redacted] This also applies to questions posed by congressional staff in an interview. Do you understand this?

Dr. Hussain. Yes.

[redacted] Witnesses that knowingly provide false testimony could be subject to criminal prosecution or for perjury or for making a false statement under 18 USC section 1001. Do you understand this?

Dr. Hussain. Yes.

[redacted] Is there any reason you are unable to provide truthful answers to today's questions?

Dr. Hussain. No.

[redacted] Finally, I'd like to make note that the content of what we discuss here today is confidential. We ask that you not speak about what we discuss in this interview to any outside individuals to preserve the integrity of our investigation. For the same reason, the marked exhibits that we will use today will remain with the court reporter so that they can go in the official transcript and any copies of those exhibits will be returned to us when we wrap up.

All right. That is the end of my preamble. As I understand it, our witness has prepared a statement. We will begin by allowing you to read the introduction to that

statement, and then we will enter the full statement into the record as exhibit 1.

Dr. Hussain. Thank you. Dear committee members and staff, my name is Aamir Hussain. I am a board certified dermatologist. It is my honor and privilege to assist our esteemed representatives in addressing the national physician shortage.

The crisis affecting America's healthcare system is deeply personal to me, as I witnessed death and devastation on an unimaginable scale during the first wave of the COVID-19 pandemic in New York City in March 2020. As a newly graduated doctor at Northwell Health in Long Island, one of the Nation's top five hardest hit hospitals, I saw our healthcare system stretched beyond its limits. To meet overwhelming patient demand, we transformed auditoriums and cafeterias into makeshift COVID wards. We promoted medical students into practicing physicians, and doctors from specialties such as rheumatology and radiology untrained in critical care medicine were recruited to manage these new hospital units. This experience exposed a stark reality of our physician shortage projected to reach up to 124,000 by 2034.

In Maryland, represented by subcommittee Ranking Member Jamie Raskin, the patient to physician ratio is worsening, with some areas reporting over 2,000 patients per primary care doctor. Similarly in Ohio, represented by House Judiciary Chair Jim Jordan, rural counties face ratios as high as 3,000 to one leaving families vulnerable when emergencies strike. This ratio is even worse for specialties such as dermatology.

In the next pandemic, would you want yourself or a loved one to face a situation where no doctor is available? Even outside a crisis, the shortage affects us all. As a new parent with a one-month-old baby, I can't imagine the terror of needing a doctor in the delivery room and finding none available.

I am a physician with a master's in public policy from the University of Chicago. I currently practice dermatology in northern Virginia, focusing on high-quality patient care

while advocating for healthcare policy reforms. I have written extensively on these issues for major publications, including the New York Times, The Hill, and The Baltimore Sun drawing on my expertise to highlight systemic flaws in medical education and healthcare delivery.

My experience as a resident physician in the MedStar Georgetown combined dermatology residency program combined with my policy expertise provides me with unique insight into the urgent need for reform. The solution is simple: Eliminate the artificial cap on physicians and unleash the potential of thousands of medical students eager to serve their fellow Americans. Thank you.

[Hussain Exhibit No. 1

was marked for identification.]

[redacted] Wonderful. We will now introduce the full written form of the statement into the record as exhibit 1. The clock now reads 2:32. We will start the first hour of questioning.

EXAMINATION

[redacted]

Q Thank you, Dr. Hussain. I'd like to start by talking a little bit about your background, your educational experience, and your experience in residency. Could you tell us where you attended college as an undergraduate student?

A Undergraduate was at Georgetown University in D.C.

Q And where did you attend medical school?

A University of Chicago.

Q Could you describe some of your academic achievements during your undergraduate or medical education?

A As an undergraduate, I majored in political science. I have a BA in

government from Georgetown University with a minor in religious studies of theology, and I'm also on the premed track. I graduated with a summa cum laude, and I -- directly after college I attended the University of Chicago where I graduated from medical school in 2019, during which I also obtained a master's in public policy from the Harris School of Public Policy.

Q Following medical school, you sought employment as a resident physician, correct?

A That is correct.

Q Could you define medical residency?

A Medical residency is a training period that occurs after graduating medical school, where you are a practicing physician under the supervision of an attending physician, and your goal is essentially to provide patient care while also learning and studying and gaining experience that you will be able to use when you finish residency and become an attending physician yourself.

Q And why did you decide to pursue a residency position?

A It was not really a choice in the sense that in order to become a licensed physician in most -- pretty much all States in the country, you are required to finish a ACGME or accredited residency program in order to be eligible for board certification and/or to practice medicine as an attending.

Q In addition for board certification, it's a requirement for State licensure as well?

A In most States, I think that is correct, yes.

Q Can you -- could you describe why that is the case, why is residency a prerequisite for board certification and State licensure?

A The goal of residency is to create a -- almost like an apprenticeship model

similar to the old medieval style where there was essentially a fixed amount of positions for a specific career. So, for example, in the middle ages, there might be a shoemaker's guild. There was, like, an agreement on what, like, a good quality shoe might be, so the master craftsman would essentially allow people to study under them, and once they had demonstrated the ability, they were able to become a member of that guild and be able to do the same career.

That same model has essentially evolved as how medicine is done where graduating medical students are now under the apprenticeship model of a group of senior physicians with expertise. Their goal is to learn the practice of medicine, and then once they demonstrate some competence, they join the group of seasoned physicians and can now pass that on to the next generation.

[redacted] Medical residency is a form of employment, correct?

Dr. Hussain. Correct.

[redacted]

Q In the process of applying to medical residency, could you describe that process generally, and kind of your particular experience walking through it.

A Yes. When medical students are finishing medical school, they have to pass a series of board exams. The USMLE, U.S. medical licensing exams. Once you have passed two of these, the step one and the step two exam, you are eligible to apply for a residency, which means that you are able to practice as a physician. During your fourth year of medical school, you'll be asked to identify which specialization you would like to pursue, and you will look for programs that offer residencies in that specific specialty, and then draft a list of programs and submit a unified application through the National Residency Matching Program, the NRMP, and based on those applications, programs will review your credentials, select you for an interview.

After interviewing that variety of programs, you will then be asked to rank the programs in order of most to least preference, and programs will do the same for applicants. And at the end of that process, there will be an algorithm which matches programs to applicants in a one-to-one ratio and there will be essentially no room for changes after that point but, like, limited exceptions.

Q So moving to your particular experience, kind of working through the application process, what factors did you consider when you were deciding which residency programs to select?

A So, I first decided to specialize in dermatology. That was through a series of research projects I'd undertaken and my personal interest. After selecting dermatology, there is actually a separate process where you have to complete first year of a general medicine residency, which is when I was in New York during the pandemic, and then complete a 3-year residency in a specialization. For dermatology, you have to apply to both positions at the same time during fourth year medical school. So I drafted a list of internal medicine preliminary programs that I would apply to, and then a separate list of the dermatology programs.

In practicality for dermatology, given the competitiveness, I applied to essentially all 100 or so residency programs that were available, and I received about 15 interviews total and I ranked those 15 programs in order from most to least preference, and then I was assigned by a physician on the match day in March.

BY [redacted]

Q You just testified that you applied to 115 programs. Is that correct?

A The exact number I don't recollect, but that is in the realm of the ballpark.

Q Why did you apply to such a large number of programs?

A The challenge is that there is essentially no way for applicants to know

where they would be competitive. Programs are not very transparent on their selection criteria. They may not list their score cutoffs or other criteria that they select applicants, so it enormously maximizes your chance of attaining a residency. It is essentially in your interest to apply to as many programs as possible.

Q How much time would you say you spent during that application process?

A Are you referring to the physical application or the travel or the other aspects of it?

Q Both the applying, the travel, and the interviewing, all components of it.

A That will be challenging to determine. I'd say each application, I would say 100 just to keep it easy to calculate. Each application probably took at least one hour to write because of all the essays and some programs require, like, separate essays similar to applying to colleges, and some of them also require an in-person interview, and some of them have a phone interview if there's travel involved. Although, I will say some of that has changed since the pandemic. Now many programs have shifted to a virtual interview for some applicants. However, I did write an article after my completion of this process that estimated the average applicant probably spends about 7- to $8,000 on this entire process, and that includes travel, volunteer rotations in a different medical school as well as the cost of actually applying to the programs.

BY [redacted]

Q So in other words, your experience is not abnormal. A lot of other applicants spend this amount of time and this amount of money?

A That is correct, yes.

Q In this calculus, what role did salary play in kind of your preferences of residency positions?

A It essentially had no impact, because the salaries are not meaningfully

different among the residency programs. There is some slight differences depending on quality of -- essentially, the cost-of-living adjustments. So, for example, New York has a higher cost of living adjustment than, like, rural counties in other parts of the country. However, that wasn't a major factor in selecting the programs.

Q If there was difference, a difference in the salaries, would that have probably become a factor in your calculation?

A I think it would have. I was pretty much applying to places where I was comfortable, so mostly major cities. However, there is a big shortage of physicians in rural areas, and if there is a salary difference, like, significantly for those areas, I think myself and other applicants would be more likely to select them.

[redacted] What factors lead to this level of uniformity in resident salaries?

Dr. Hussain. There is -- it's difficult to say exactly. However, part of it is the fact that there is a database of programs by the American Medical Association called a FREIDA. The actual acronym I have to look up what it stands for, but essentially posts the residency salaries in the various States, and hospitals are able to use that database to determine what is considered reasonable salary, and they will not differ significantly from those agreed-upon rates.

BY [redacted]

Q So in other words, they're looking at the salaries of their competitors to create kind of uniformity in salaries?

A Correct.

Q To secure a residency position, you entered the National Residency Matching Program, or NRMP, often referred to as the match, correct?

A Yes, that's correct.

Q Can you generally describe the match process specifically within the kind of

broader application process.

A So the match is the last phase of the application. Once applicants have received interviews, those are the programs that they are going to place into their preference ranking, and there is a deadline by which applicants have to rank all their programs, and also the programs have to rank their list of applicants. I've had experience on both sides of this being an applicant and then later being on the admissions committee, which I'm happy to discuss.

However, once that -- those preferences are locked, these go into an algorithm that is run by the NRMP which essentially creates a best response algorithm. It's a game theory algorithm that was actually awarded the Nobel Prize many years ago in order to essentially maximize the overall utility for everyone entering this. If there's any kind of discrepancy, the tendency is to go towards the applicant with certain exceptions.

However, if applicants apply together as a couples match, there is, like, a married couple trying to match with the same program, there may be some discrepancies, but the overall goal is to make it so every applicant receives their highest possible rank, and every program also receives their highest possible rank.

Q Did you attempt to secure a residency position outside of the match?

A I did not.

Q Why not?

A I did receive a position through the first round of the matching program, and after that I was asked to sign a contract committing myself to that position, and I did so.

Q Before you even entered the match, did you make any efforts to determine whether or not there were positions outside of it?

A I did not.

Q And why not?

A The vast majority of accredited programs are run through the match, and especially with dermatology. I can't think of a single program that would not be running through the ACGME.

Q Are other specialties the same way? There aren't very many --

A You may find some exceptions with very, very high-demand specialties, such as family medicine or primary care. However, these are not common knowledge. You'd have to do extensive searching outside of the databases.

Q So in other words, medical students are essentially required to enter into the match to gain employment in an accredited residency program?

A That is correct.

Q Why is it important to access an accredited residency program if you're a doctor coming out of medical school?

A The first step is that we want to ensure that the quality of physicians is good. I mean, everybody needs medical care. We want to make sure that people are practicing safe, effective, evidence-based medicine. So in order for applicants to be assured that they're getting the proper training, that accreditation is very important.

Q And again, you ultimately secured a position in the Georgetown University dermatology residency program, correct?

A Correct. I did my first year of training at the Long Island Jewish Medical Center in Northwell Health and then my specialization was at Georgetown.

Q Could you describe your experience applying for both programs through the match.

A So, yes, the programs are slightly different, so for the initial preliminary internal medicine, that required a -- I applied to maybe 30 to 40 programs total, and some of them were in cities that also had a dermatology residency just for practical purposes.

I didn't want to have to move after one year. Eventually, I did have to do so, because I obtained my first position in New York, second position in D.C.

After submitting our first round of applicants for the internal medicine, we had a series of interviews throughout September to December of that year, and then for dermatology interviews, they occurred from about November to February of that same calendar year.

Q So dermatology, you said before, is a competitive specialty, correct?

A Yes.

Q How did that affect your approach to applying to and ranking programs in the match process?

A For dermatology, it required a lot more investigation into each program. If there were specific essay topics that they required or if there's specific supplementary applications, there's no centralized database for this despite there being, like, a centralized match, so I would have to go through every single program individually, look at their website, look at what they require, and then ensure that I was submitting things correctly to those areas.

And that -- that application process for dermatology was far more time consuming because the chance of obtaining a position is much lower than for internal medicine, and therefore, it seemed based on discussions with my advisors and other mentors that applying to more programs would increase your chance of getting a match position.

Q In your estimation of the kind of -- you said previously that you applied to 100 programs.

A Roughly, yes.

Q If -- in a free market, do you anticipate that you would have applied to that many programs taking kind of account of actual there?

A I don't believe so, and the reason is that you would assume that in a free market the programs would be more transparent with what they were requiring. So, for example, if there's a program that required someone with a public policy degree, I would be applying for that program. However, if they wanted someone with an MBA, I would not have applied because I would not be a good candidate.

In the current system, there's not even, like, score cutoff, so based on my exam score -- in many countries, actually, this is how they determine residency. They say that if you don't have above a certain score, you should not even apply to this program. You're going to get instantly rejected.

So currently, programs don't even offer, like, kind of basic ways to filter, so therefore, students are basically applying to, like, every single program.

Q When you applied for both the internal medicine position and dermatology, did you include in your ranked-ordered list less competitive specialties at all?

A I did not.

Q Are you aware of some folks including -- if they're applying to a competitive specialty, also including less competitive specialties in the rank-order list?

A Yes. That is quite common.

Q And why do folks do that?

A They know that if they're unable to match in their preferred specialty, they will not be able to -- very unlikely they will be able to secure a matched position outside of the match, so they essentially hedge their bets. It's similar to when students apply to college, they might apply to a safety college, because if they don't get into their top choice, they still have a back-up option. Otherwise, they won't have anywhere to go.

Q So in other words, it isn't necessarily their preference, but it's to ensure that they don't go unmatched all together.

A That's correct.

Q To participate in the match, you were required to sign and agree to the match participation agreement, and the rules contained within it, correct?

A That's correct.

[Hussain Exhibit No. 2
was marked for identification.

BY [redacted]

Q So we'll have a copy of that agreement for 2025. This is a copy of 2025 Match Participation Agreement for applicants which lays out the rules of the match hiring process. It will be marked as exhibit 2. You can take a moment to familiarize yourself with the document if you'd like. Once you have a second to do that, we'll turn to page 10. If you'll let me know when you're ready.

A Yes, I'm ready.

Q So on page 10 of the agreement, at the bottom of the page under the header, "before the rank order list certification deadline and/or the start of SOAP offer rounds," it reads, "Applicants may voluntarily communicate their interest to a program or programs. However, applicants may not solicit verbal or written statements from a program or programs implying a commitment to rank the applicant." Do you see those words?

A Yes.

Q So in other words, does this language prohibit applicants from negotiating with employers to secure an employment commitment in your understanding?

A I would say that this creates a lot of ambiguity in the process. The challenges that as a student, we were told that you are allowed to ask the program -- tell a program that you are interested in going there, but any response you receive you

should essentially not treat it as anything legitimate. There's been horror stories where students were given a message from a program, interpreted it as a commitment to employment, essentially bought a house or downpayment in that area, ended up not matching in that program, and then having a financial problem afterwards. So the problem is that students don't have a direct communication. They're kind of given guidelines, but programs also have their own set of guidelines that prohibit that direct communication.

Q And because of this rule against commitments to rank an applicant, an applicant, for example, can't go to a program with the strength of a competing offer in hand and ask for a salary increase, because they already have that competing offer. Is that --

A That is correct, yes.

Q This language also means that applicants are, in practice, barred from negotiating employment terms such as salary and benefits since they cannot secure employment commitment before participating in the match. Is that right?

A Yes.

Q How did the match agreements rule limiting negotiations affect you personally when you were applying to residency programs?

A It's similar to how you described it, because they -- it's impossible to determine how secure your position was at other programs. So if I had a commitment from, like a lower-ranked program, I would have been able to go through a, you know, higher-ranked program and show them this offer and potentially be able to negotiate an increase if they desperately wanted an applicant.

I always use the example of colleges because it seems the most similar where, for example, students may receive a financial aid offer from a certain college, and if they take

that offer to another college, they may be able to negotiate a slightly higher increase in their financial aid. Using that same logic for salaries is just not possible in the current system here.

Q You mentioned earlier that you're on an admissions committee?

A Yes. For during residency, I was on the Georgetown admissions committee.

Q So how did this restriction on negotiations affect even a residency program's ability to get, you know, their most preferred applicant?

A Yeah. It's extremely challenging and we routinely have this discussion where we would see a student with, like, off-the-charts board scores, off-the-charts research, phenomenal publications, and we were aware of our program's reputation and ranking compared to other similar programs, and our number one discussion would be that we want to rank this applicant highly, but we're almost certain that they're going to another program just given, like, their preferences, given their abilities, and it was very difficult to get a direct commitment from applicants.

I remember having the conversation with them that if they were committing to stay in D.C. that would increase their chances of matching. However, even within D.C. there's still three or four other residency programs. So we had that kind of limitation where we were unable to determine who is truly interested, and who is just applying, similar to myself, who applied to, like, all 100 programs.

Q So in other words, it kind of creates this kind of fog, ambiguity, in the process where both parties in the hiring decision don't really know where the other person stands.

A Correct, yes.

Q So based on your experience, how do you think this rule, this reality affects the medical residency hiring market as a whole?

A It makes it very challenging in both for applicants and for programs. As applicants, especially if they have severe financial restrictions, or they have specific preferences that they would like addressed in their employment, they're unable to guarantee that those preferences would be met, and programs also have a challenge where they're unable to fill kind of ad hoc labor shortages.

Like, for example, in my residency program, we had a few residents leave the program voluntarily for personal reasons. One person actually passed away unexpectedly very tragically, and that happened during the middle of the academic year, and programs were unable to fill that void in their workforce until the next calendar year. So that restriction kind of prohibits normal ability to fill labor shortages, and actually applicants that may not have matched, we're still not able to take those new positions until the next academic year.

[redacted] So because of this rule, there are greater labor shortages within the medical residency market, correct?

Dr. Hussain. Yes.

[redacted] You're mentioning kind of the issues with filling residency positions that become vacant all of a sudden. Are there any other factors that restrict kind of the movement of residents between programs that you're aware of in the market?

Dr. Hussain. There are abilities for residents to transfer to a different program. That has happened. However, it is extremely challenging, and it would not be as simple as, you know, you can resign from one position and seek offers elsewhere. When you sign this commitment, you're essentially committing to the three or four or how many years of residency training, and it's more of an exception than a rule that you would have to demonstrate some kind of hardship while you're willing to transfer to another program.

[redacted] What makes it so challenging to transfer between programs?

Dr. Hussain. There is a set number of residency positions that are funded every year, so in order to transfer to another program, both programs essentially have to negotiate where one program is losing that funding for a resident, and the other program needs to have excess funding available to take that extra resident, and then the program that's losing a resident needs to have an ability to fill that position somehow, and most programs aren't willing to make that effort because they are essentially losing a worker in that process.

[redacted] If you were able to negotiate leveraged competing offers from other residency programs, do you think that would have affected the employment terms you ultimately received, specifically your salary?

Dr. Hussain. I believe so, yes.

[redacted] In what way would it have affected it?

Dr. Hussain. I believe that programs that had specific preferences for the type of applicant they want. So for example, I applied to certain programs in the D.C. area because of my language skills. I was able to speak to Spanish-speaking patients, Portuguese-speaking patients, and that ability, there was only three or four residents in our program of 12 that had that ability, so that would have been able to -- potentially, I was able to negotiate for certain terms, like I want to work at this hospital, I want to not have a need for an interpreter, you know, certain kind of even detailed things like that would have made it easier for me to ask for those things.

And also the program if they needed someone who needs to fill a specific role, like, you know, we need a patient, you know, physician that speaks a specific language or needs to work in a specific skill set, they can ask for an applicant that has those characteristics.

BY [redacted]

Q So do you believe that your -- speaking about your kind of salary, for instance, in particular, that would have increased if you were able to kind of negotiate those positive characteristics that you have?

A Yeah. I believe by focusing on other aspects besides just the match, what I was forced to kind of write into my application, if I had additional opportunities to discuss the programs, I think it would have been possible to negotiate the salary increase.

Q So in that sense, do you believe that the match and its rules against employment negotiations lead to lower salaries for residents?

A Yes.

Q Do you believe that they also result in more wage uniformity between residents?

A Yes.

Q Do you believe that they contribute to worse working conditions for residents?

A Yes.

Q And in what way do they contribute to that?

A It's kind of similar to the issue with the salary. There is a requirement that all residents at the same post-graduate level be paid the same salary at the same institution. So, for example, a surgery resident might be working 80 hours per week. That's the official limit, although in practice, they may work more than that and not report it, so they may be making the same salary as a radiology or dermatology resident working potentially half those number of hours. So those surgery residents essentially feel like they're doing more work for same or less salary than their colleagues in the same hospital.

[redacted] You said that residents often work more than the official cap number of hours that a resident's allowed to work. Is that correct?

Dr. Hussain. That is correct, yes.

[redacted] Do you believe that's fairly common throughout the market?

Dr. Hussain. Yes.

BY [redacted]

Q Do you think removing restrictions on employment negotiations would benefit residents?

A Yes.

Q What effect would it be have on resident salaries?

A I believe they would increase because -- rather increase them or residents would gain commensurate other benefits. For example, increased PTO, increased sick leave, other modifications to their contract.

Q What effect would it have on the wage uniformity among residents?

A I believe their wages would be more -- there would be more discrepancy among the wages.

Q And why would that be the case?

A So the situation I described above, programs that need a certain speciality in high demand may be willing to pay more for that specialty, or if they know that certain specialties are working very high hours, even if they can't match the salary, they may give them additional benefits in other ways that currently they're not allowed to do.

Q And then finally, what effect would removing those restrictions have on resident working conditions?

A It's likely that they would improve working conditions. However, it's a speculation.

Q Would removing the match or its rules against employment restrictions aid in addressing the concerns of resident unions, including those -- you know, we've discussed of low and uniform wages as well as poor working conditions?

A It's possible that it would affect it, but it's difficult to say.

Q And why is it difficult?

A Some of the other issues, simply removing the match is a good step, but it's not the only solution. There's the issue of, like, geographic distributions where rural areas need a higher demand of physicians directed to other areas, and the unionization efforts are more driven by fewer exploitation by the hospital systems, and the match is not really the main driver of that. However, it does contribute.

Q So if we could turn to page 20 of the document under the header, "binding commitments," 10.0 binding commitments. It says, "Upon conclusion of the match and SOAP, matched applicants, one, are in a binding commitment with the program and must accept an appointment as matched or offered." Do you see those words?

A Yes.

Q That means that residency applicants are required to accept whatever position they receive at the match. Is that right?

A Yes.

Q Applicants are required to accept the position even if they're paired with their lowest ranked program, for example?

A Yes.

Q Or in a position in a speciality that they do not prefer?

A Yes.

Q And they are required to accept the position even, you know, for example, if it's hundreds of miles away from where they prefer to live, right?

A Yes.

Q In your experience, how does the binding nature of the match affect residency applicants, particularly those who did not get a match they prefer?

A For those who did not match, it creates an incredible amount of stress on the student. I remember during medical school, there was a week where the medical school admissions committee would send out a coded message to the students saying that basically, did everyone match, or did I lose one person not match. If I lose one person did not match, the office would essentially shut down. They told students to, like, bring almost, like, a mental health support person with them and they would help them navigate the Supplementary Offer and Assistance Program, the SOAP, because it was very stressful. Essentially, they would have to call every single program that had an open position and the dean of the medical school would essentially have to negotiate directly with that program in order to have an applicant get accepted.

There was only maybe 3 or 4 days during that period between the Monday of match week where positions are announced, and the Friday where matches are finalized, so students that do not obtain a position have a very limited amount of time and a very stressful period in order to secure a position.

And in those situations, it tends to, unfortunately, follow that students with a -- coming from a higher ranked medical school are more essentially like faculty connections are able to secure those positions because they know which programs are looking for certain applicants.

Q For residents who do match, but they match with a program that's not, you know, in their top few -- in the rank order list in the top few spots, how does the binding nature of the match affect those applicants? If they match with a program they didn't really prefer, but they're bound by the match agreement, how does that play out in your

experience?

A In general, the same challenge where students may be very stressed or have, you know, other mental health stressors, anxiety, depression potentially. A lot of times there is married couples that as I can discuss in future, but further, the one exception to the best response algorithm in the match is actually the couples match where there's a possibility that the couples will actually not get their top ranks, even if the programs also rank them that way, so you may have students that choose to match separately from their partner, and those partners may end up in opposite parts of the country. That creates a lot of stress and it can create tension on marriages. It can create tension with people that have children, because one parent may not be present all the time, so it's definitely a tremendous amount of stress.

Q The next line there, it reads, "Applicants with a match or SOAP commitment who seek a concurrent year position absent a waiver or deferral from the NRMP shall be presumed to have violated this agreement." Do you see those words?

A Where is that listed?

Q It's under -- so under "binding commitments," and then 1A.

A Oh, yes, I see that.

Q In other words, applicants participating in the match are prohibited from seeking a residency position outside of match process.

A Yes.

Q In your experience, how does this prohibition affect residency applicants and their freedom of choice in particular?

A It limits their ability to negotiate, because once they have secured a match position, they're essentially bound to that program. They're not able to seek additional offers, and potentially, even slightly better offers they're not able to commit to those,

because if they try to use that offer to seek a different one, they'll have violated their agreement.

[redacted] Did this restriction increase the market power held by the match?

Dr. Hussain. Yes.

BY [redacted]

Q How so exactly?

A Essentially all medical students that wish to become a licensed or employed physician are essentially forced to go through this process, even though technically they are -- they have alternatives to the system, it's the vast majority of accredited programs that use this process, so any student that tries to go outside the match is definitely going to have either direct problems in terms of securing a position because of State regulations, unlicensing, and board certification, or they will just face challenges from their medical community, because people who go outside of the match are looked down upon for not having completed the ACGME accredited position.

Q If a resident resigns or is terminated from a program, do they have to reenter the match to find a new position?

A I am actually not familiar with that position, but I would assume so.

Q And you discussed kind of difficulties with transfers earlier on. You know, if a resident does have to go through the match process, once they are removed from their position, can you explain how that would kind of -- what effect that would have on the resident trying to transfer from one position to the other.

A So can you clarify that one more time?

Q We can actually move down further on the same page under the header 11, waiver or deferral of match results. We can move to the third line there starting with the words, "Neither applicants." It says, "Neither applicants nor programs may release

each other from a matched position or an offer accepted during the SOAP. A waiver or deferral of the matching of the binding commitment may be obtained only from the NRMP." Do you see those words?

A Yes.

Q So applicants and residency programs in effect are not allowed to reject a pairing once it is made, even if both parties would prefer to reject it. Is that right?

A That's correct.

Q Do you know of any residency applicants who wanted to defer or waive their residency pairing but were unable to do so because of this NRMP rule?

A I don't personally know anyone that did this.

Q Is there an instance when you were part of the admissions committee where you wanted to defer from having an applicant or waive the agreement and you were not able to do so?

A But we had a -- it never came up directly, but we had discussions about whether applicants, for example, wanted to start a family and take leave, how that -- what time period they would be taking the leave, so to create less strain on the other residents, as well as when we had residents either voluntarily resign or leave the program. However, we would be able to fill that position during the academic year, and the conclusion was that there was no way to do so during the academic year. You essentially had to petition the NRMP to add an additional position for the next academic year, and then wait for that position to be filled.

Q Was that kind of bureaucracy, how did that affect your calculation of what would benefit your program the most in that situation?

A It was a challenge, because the program was really desperate for more residents. We were essentially covering three major hospitals with sometimes one or

two physicians. Very unsafe for patient care, and residents knew that having more workforce would alleviate some of those concerns, but it was very challenging to get those concerns addressed through the NRMP. And even when residents essentially brought up some of those concerns, the solution was simply to just petition the NRMP for more residents, and that would take several years to occur.

Q Let's turn to page 23 of the agreement. At the top of the page it says, "At any time before the match results are released, the NRMP may withdraw an applicant from the match or SOAP, and without first affording an opportunity for a hearing if the NRMP believes it has credible evidence that, one, the applicant has violated the terms of this agreement, and two, absent such summary withdrawal, the integrity of the match is in jeopardy." Do you see those words?

A Yes.

Q In other words, the NRMP can withdraw a residency applicant from the match for a violation if the integrity of the match is in jeopardy. Is that your understanding?

A In the NRMP believes that is the case, yes.

Q And if a residency applicant is withdrawn from the match, they are effectively withdrawn from the medical residency hiring market?

A Correct.

Q Can you describe how being removed from the match would impact a residency applicant's professional career and path to becoming a licensed board certified physician?

A So in the initial period, it would force them to essentially be unemployed for one year, or they'd have to seek a position at a very late stage in the hiring market. They would have a very difficult time finding a position for the next academic year. If

they were to enter the match again the subsequent year, they would have essentially like a black mark on their application, and we did actually review applicants during the admissions committee that had either failed to match, or for some reason, had not entered the match in the previous year, and even if the rest of the application is perfect, it still creates kind of a doubt whether this is a credible applicant. And even if the applicant has really done nothing wrong themselves, the fact that they've not been able to go through the match definitely creates a barrier to them entering the hiring market.

Q Do you have a sense of what might be viewed as jeopardizing the integrity of the match?

A It's very vague. It's difficult to see what the NRMP would consider that. I would assume that it means that the applicant tried to get, like, a firm commitment from a program outside of the agreement and essentially violate that guidance that was -- we discussed in the previous section.

[redacted] To your knowledge, do most teaching hospitals view the failure to match as a black mark in subsequent match hiring processes?

Dr. Hussain. Absolutely, yes.

[redacted] Are you familiar with any other market in the United States where trying to get a binding commitment would result in a black mark on a prospective employee?

Dr. Hussain. No.

[redacted] Let's turn to another document. This is a document that was produced to the committee from Stanford. The title of the document is Match Day 101, How Does the Medical Residency Match Work, and it's Bates numbered Stanford 75. Take a moment to familiarize yourself with the document. I'll ask some questions about some of its content.

Dr. Hussain. Okay. I'm ready.

[Hussain Exhibit No. 3
was marked for identification.]

BY [redacted]

Q On page 2 at the line that begins match day might towards the top of the page.

A Yes.

Q It says, "Match day might sound like a combination of the Oscars and one of Harry Potter's sorting hat ceremonies, but it's the result of an algorithm to create the ideal pairings between tens of thousands of applicants and residency programs." Do you see those words?

A Yes.

Q Do you believe that the match algorithm always creates the ideal pairings between tens of thousands of applicants in residency programs?

A I do not.

Q What factors could contribute to less than ideal pairings in the medical residency hiring market?

A So the first one which I alluded to is actually explicitly stated by the NRMP, which is the couples match, and where it basically -- applicants that are applying as a couple, so it doesn't have to be a married couple. It can be, you know, people that are interested in being in the same place. The applicants are not always guaranteed their ideal placement, and same with the programs. So that specific situation can lead to unideal pairings.

And there's other situations where as mentioned, students are applying for specialties where they may not have a preference because they know that if they don't

secure their primary preference, they may completely go unemployed. And as a senior resident, kind of counseling medical students, I often told them this guidance that medical schools will kind of pressure you to match somewhere. They may not -- you may not get the exact position that you want, but medical schools will often tell students that if they're not competitive for a certain specialty, they should not even try applying.

Q Referring earlier to our discussion of salary, and how it wasn't a factor to you, could it also be that if salaries, you know, were not as uniform and increased dramatically, then the pairing that you ultimately had through the match could be different and could be, you know, in a sense, less ideal than what you could have gotten through a free market with a higher salary.

A Correct. I believe that if there was more discrepancy in salaries, you would see a different distribution in how students chose their program as well as their specialty.

Q So given all that, from your experience, how does the match process compare to market competition and in creating ideal pairings?

A It definitely suppresses the market competition, because essentially, you're forcing students into a one-size-fits-all system, where every specialty, with a few exceptions which we can go over, most of them have to follow this exact same pathway. Even where you have specialties that are in severe shortage, such as pediatrics, and specialties where you can argue that there's too many applicants and there are certain specialties that are kind of in the middle where they have an appropriate number of students, but even in that case, the students aren't matching in places that would be best for them professionally or personally, and the match, because it's such a uniform way of applying, students don't have the ability to find more personalized areas where they could apply, pre -- that would fit more with their interests.

Q How does the match compare to market competition, specifically in ensuring

that applicants receive fair employment terms, like salaries and benefits, and so on?

A Students are basically forced to sign the match agreement for any program they go to, so they're not really allowed to negotiate any specific terms.

Q So on the same page under the header, What History Tells Us, it reads, "The modern residency match originated in the 1950s to tame an increasingly chaotic system. Hospitals competing to hire the best medical students were offering positions earlier and earlier, sometimes locking in students who were only halfway through medical school. When rules were made to limit offers to the fourth year, programs began pressuring students to accept and reject offers on shorter and shorter deadlines, sometimes within 12 hours of an offer being sent by telegram. Hospitals scrambled to hire the top students while students tried to delay their decisions until they had all offers on the table." Do you see those?

A Yes.

Q Does this mean the match was created so hospitals did not have to give early offers to medical students?

A The issue was the match was designed to solve this specific problem where the -- this problem still exists where you have a small number of students that are, like, very, like, highly qualified. They're absolutely the best type of students. So every hospital, every program is trying to compete for that small group of people, and the issue is that, you know, programs can only -- students can only accept one offer, so the best student in our class may have 20 offers. The lowest-ranked student may have zero, but essentially that top student can only go to one program and that bottom student is not going to go anywhere, so the goal of the match was initially to kind of address this issue where everybody who goes through the program, or matching program, will ideally get one position, and this top performing applicants will maybe have more selection, but you

won't have this distribution problem where you're only giving the offers to, like, the small group of the top-performing students.

Q Was the match created in your view to give hospitals the potential employers collective power in the -- of the labor pool?

A I know that wasn't the intent of the match, but I think that's how it's currently being used.

Q And could you explain how it's currently --

A The same issue exists now where hospitals that can go through the extensive bureaucracy to create a residency, those are some of the most wealthy institutions that have a lot of support, and those same institutions are not able to recruit the top performing applicants, whereas as I stated before, there's a lot of rural hospitals, smaller community areas where they definitely benefit from having a residency available, but since they don't have the resources to go through the accreditation process and the ACGME requirements, they're not allowed to accept students into those programs. So essentially these rich and well-resourced hospitals are able to have a monopoly on that market of recruiting the best applicants.

[redacted] So instead of having to compete for the best applicants by providing higher wages or better employment terms, they now just exclude their competitors. Is that correct?

Dr. Hussain. That is correct.

BY [redacted]

Q And specifically, the rich, well-resourced hospitals, you know, are able to not compete as hard against the rural kind of smaller programs, right?

A Correct. They don't have much incentive to change their behavior because they're currently the only ones that are allowed to have a residency program due to the

cap owner requirements by the ACGME.

Q And so kind of in that sense, the match is created to kind of protect, you know, residency programs from themselves in the sense that it's created so they don't have to compete as hard and push residents as hard as they otherwise would have in a free market.

A I'm not sure that's the best way I would say it. I think the way I would characterize it is that residents are in an interesting position where there's actually a Supreme Court case on this topic where there are basically workers that also study rather than students that also work. It's kind of a nuance, but it determines their eligibility for certain taxes and how programs are structured.

The reason the match or the way the ACGME is structured now is that residents are workers that are in a very unique position where they have to become physicians, so there are certain restrictions on what they can and can't do in order to train the best physicians. The issue is that the match is so uniform that they're unable to change, based on realities on the ground, so if there is a hospital that desperately needs more -- a more workforce or more residents, they're not able to immediately address that shortage because of the kind of requirements that are in place.

Q So, in fact, that is a free market system as opposed to the match would give power back to the students to move more freely?

A Yes, students as well as kind of the lower resource hospitals as well.

Q In your view, is a centralized hiring algorithm necessary to address the issues of early offers and time-bound acceptance requirements that we discussed earlier?

A Yeah. I think the -- this was a real problem in the sense that they then used the term here, but it used to be called "exploding offers." It sounds bad, but essentially it was, like, they would give you literally 12 hours to accept the offer, and that put an

insane amount of stress on students.

However, I will say that as a student applying, this happens with interviews. There are programs that will say you have to accept this interview offer within 12 hours. So that program, the problem isn't really solved by the current system, because there's such limited positions that are available in the match that students are essentially competing for those same positions. Even though this exact problem doesn't exist anymore, there's now other problems that are being created because of this uniformity.

Q In your opinion, could replacing the match with a deadline for residency offers and acceptances effectively address some of these issues in a less restrictive way?

A I believe so, yes.

Q And could you explain how it would do so.

A The current system for college acceptances and medical acceptances seems like a reasonable place to start. Most of them have kind of a reasonable deadline by which students have to submit application. Their scores have to be in. The admissions committee have time to review the applications, and they're able to distribute offers to students, and then there's usually a uniform date where they have to either give a deposit or commit to that program, and then the academic year starts as scheduled.

There is kind of room for students to negotiate financial aid offers, or other terms that they may prefer. In different schooling systems where there is not really a contract, you're not getting paid for those things, but financial aid is probably the most similar you'll get because you are able to negotiate certain aspects of that area. And currently medical -- college and medical school followed this one system and then residency follows a completely different system, and it's not unreasonable to assume that the similar system could work in the residency market.

Q In your experience, is aggressive competition from employees or employers,

rather, unique to the prematch medical residency market, or is this commonplace in other markets as well?

A I only have experience with this market that I haven't spoken to colleagues. I don't think this is true of any other market.

Q In a sense, you know, in markets for law students or business students or employees, employers aggressively compete for the applicant that they deem most preferable, right?

A Yes, that's correct.

Q And so in a sense, competition like that is ubiquitous in kind of a free market?

A Correct, yes.

Q You know, based on your experience as a medical student and a researcher, how would introducing competition affect the resident employment market?

A The best aspect of it would be that programs would get more flexibility on how they could select students, and as well as what kind of workforce they're trying to create. The current system, the problem is that there is basically a uniform system where students take their step one, their step two residency recommendation letters, their grades for medical school are all funneled into that same system, but because there's a lack of objective criteria, for example, one of our exams, the step one exam is now pass/fail, so now there's only really one objective exam, which is the step two, and most schools don't offer clinical grades anymore after the pandemic, so students are basically having one objective exam, and they're forcing residencies to rely on kind of other metrics that don't necessarily correspond to clinical care.

So, for example, a number of researched publications. I mean, I published a lot of research, but it doesn't really correlate to my ability to be a physician. But when

there's a limited amount of metrics, the programs are basically forced to use them.

However, if there was a free market, then you would have programs that are research-focused that could basically set -- potentially could set a minimum number of publications, or they could be aggressively recruiting students that have a Ph.D. or other researched focused applications.

However, other programs that, for example, serving underserved community that recruit people that speak the language of that community or have an experience in healthcare policy or reform, and it would just allow programs to be more transparent with how they select students. They also allow students to target their application towards specific programs.

I'm using the metaphor again, but again, for colleges, most colleges are pretty transparent with the kind of student they want to recruit, and students are able to kind of tailor their application accordingly to those places.

Q Let's turn briefly to page 4 of the document. Now, at the bottom of the page under the header "match day by the numbers," it reads, In the 1952 residency match, just 6,000 students applied for 10,400 positions. Do you see that?

A Yes.

Q In other words, in the first match, the supply of 6,000 residency applicants was lower than the demand of 10,400 physicians, right?

A Yes.

[3:23 p.m.]

BY [redacted]

Q In a free market, what effects does a low supply of employees and a high demand of employers have on employee wages?

A Logic States that it would cause the wages to increase because the employers are competing for a very limited supply of applicants.

Q So by eliminating competition between residency programs and prohibiting residents from negotiating employment terms, the Match has allowed residency programs to pay lower salaries than they otherwise would based on the statistics from 1952?

A That seems logical, yes.

Q All right. So turning briefly back to page 3. At the bottom of the third page, it says, and in the last paragraph, "in this year's match, students applying to pediatrics residencies submitted an average of 44 applications and those applying to surgery residencies submitted an average of 70 applications."

Do you see those at the very bottom there?

A Yes.

Q You know, you discussed that you, for dermatology, submitted roughly, you know, a hundred applications. Is it expensive to submit a large number of applications like this?

A Yes, it is. The average -- the cost is kind of tiered, but roughly 75- to $80 per application. So if you multiply that by 70, you're talking maybe like 6- to $700 just for the application fees.

Q And in addition to the application fees, is there a separate fee for the NRMP Match Rank Order List as well?

A I have to check on -- I'm actually not familiar with that.

Q In your experience, why do residency applicants in some specialties submit, you know, 70 or more applications?

A There's several explanations. One option is that there is basically not enough positions for the number of applicants. So, for example, for dermatology, which I know the best, there's roughly 75 percent of students every year are going to secure a Match position. So students are trying to increase their chance of matching by submitting more applications.

The other explanation possibly is that the specialty is more competitive overall. So students that are not as competitive as an applicant, for example, they have lower grades, lower board scores, they may need to apply to what we would call like, quote, safety programs in order to increase their chance of matching.

Q Let's move back to page 4. Starting at the paragraph right below the picture, it reads, "A program can't call a student and say, 'We're planning to put you down as No. 1. Are you going to put us down as No. 1?' [redacted] said. Such communications are considered a match violation."

How does this restriction on communication -- we discussed it a bit earlier, but how does this restriction on communication affect the number of programs that an applicant applies to?

A It increases the number that they have to apply to because there's essentially no way to guarantee that they're receiving an offer from that program. The one exception may be -- and we can go over this later, but for ophthalmology or for urology, they use a separate matching program that's separate from the main Match. And in these situations, programs are very much aware that students are basically ranking like one or two programs.

But in general, most students are -- if they get -- even if they get a communication like this, they're essentially told to disregard it because it's not considered like a binding contract.

Q Now, moving down to the next line, it states, "By early February, students and programs submit their ranked lists to the National Residency Matching Program, which runs the data through the algorithm -- and then the wait begins.

"On the Monday before Match Day, students are notified by email whether, but not where, they have matched. This allows those who have not matched to quickly apply to unfilled positions over the next few days in what's known as the Supplemental Offer and Acceptance Program."

Are you familiar with the Supplemental Offer and Acceptance Program, or SOAP?

A Yes. We had discussed it before, yes.

Q Could you briefly describe the SOAP process?

A So what happens is, on the Monday prior to the Match, the Friday it's referencing, programs are notified of -- if they have filled all their positions, and students are notified whether they match to a residency program. They're not told where or what type, even what specialty, just that they have matched or not matched.

And at that point, there is a window where programs are allowed to fill their unfilled spots, essentially ad hoc, through a traditional interview process. They're allowed to call applicants directly. They're allowed to make offers kind of on the spot to applicants. And applicants have basically limited time window to accept those offers. And there's usually a time window of 3 to 4 days, after which those all have to be finalized.

And after that, programs that do not fill their positions essentially have to take the hit on not having a position there. And same with students that don't have a Match

position.

And then on Friday, that's when all the positions are certified, and that's when they're stating that students are notified and programs are also notified by the specifics.

Q Do you have any concerns with the SOAP process and its effect on the market?

A Yeah, absolutely. It's a big challenge, because it's a very limited window, as I was mentioning, and it definitely gives preference to students that have more resources. And essentially, it's a very stressful process that doesn't create the best way for students to select offers.

For example, a student may have applied to a surgery residency. They didn't match to a surgery residency. Now they have a offer of a 1-year surgery residency, which is not a full residency, or they could switch to family medicine or pediatrics and do a 3-year residency. So they're having to make these life-changing decisions about their career prospects in a very narrow window, like 1 or 2 days, without -- and a lot of times they do have these kind of like time-limited or exploding offers where a program will say, I'm on the phone right now. If you don't commit to me, I'm giving the position to somebody else.

And those limits on what the Match can or can't do, those all go out the window with the SOAP, and it's basically taking advantage of the most vulnerable students at their most vulnerable period.

Q And that compressed timeframe is a product of the fact that the Match exists in the first place, that there has to be -- that the timeframe is compressed because the Match is sorting the rest of the applicants on the front end?

A It's absolutely artificial, because the algorithm, it says that -- they submit the data through the algorithm, and then the algorithm itself only takes several hours to fully

match all the applicants. It's actually unclear why they wait 3 weeks. In those 3 weeks, students could put a offer on a house. They could be negotiating for their rent or whatever they need to do to get a position. And the same with hospitals can essentially figure out their employment situation.

But there's this artificial 3-week period and then an even more artificial 2- or 3-day period just for the SOAP program. And that exists because of the NRMP guidelines.

Q And that compressed timeframe, that does not benefit the residents, correct?

A Correct.

Q But in a sense, it may benefit residency programs?

A Yeah, it absolutely benefits programs, because they know that they have all the leverage in terms of they can take advantage of these students when they have very limited offers.

And, I mean, programs do have an issue where if they don't fill the position, then they have the issue I mentioned where they have to wait a year to fill the position. But essentially, if they know that they have a somewhat good quality position, they can really get the absolute best out of whatever resident they select.

Q Do all applicants that are unable to match find positions through the SOAP?

A They do not.

Q Do all residency programs that still have positions after the Match fill them through the SOAP?

A They do not.

Q Let's turn to page 5 briefly here. At the top of the page, it reads, "81.1 percent: The overall percentage of applicants -- including international applicants -- who matched last year, though rates vary among specialties, ranging from

rates in the 60 percent range for plastic surgery and orthopaedic surgery, to above 97 percent for pediatrics, emergency medicine, and internal medicine."

Do you see those words?

A Yes.

Q If 81.1 percent of applicants match, that means that 18.9 percent of applicants fail to match with a residency program, right?

A That is right.

Q And in specialties like plastic surgery, as much as 40 percent fail to match, correct?

A Correct.

Q Can you describe what it means for a residency applicant to fail to match?

A Basically, they are not able to have a guarantee of employment for the next year. And for especially some of these high-ranking specialties, there's a very limited number of positions in any cycle. There's really no guarantee that they will be able to get a position at all, because the next year, as I mentioned, they will have this black mark where they didn't match for whatever reason. And just simply, there's not enough positions for the number of applicants available.

So any student in these competitive fields that doesn't match, they're not able to get employment for that year, and even their future employment is in doubt, just given that they have this kind of black mark against them.

Q How would allowing programs to recruit and hire residents outside the Match affect the doctor shortage in the United States to these types of applicants?

A It would alleviate some of the shortage because programs would be able to make more ad hoc decisions. So, for example, the situation I encountered at Georgetown where there's one resident covering three hospitals, if they realize that

there's a labor demand to cover a specific unit or hospital, they would be able to fill that position fairly quickly because, for example, dermatology usually runs in the 70 percent range for students that have been able to get a position. So, again, 30 percent do not. And if there's a need for an additional position, they would be able to recruit from that 30 percent or from really anybody that was interested in that field at an ad hoc level to fix those shortages.

And that would be the same for hospitals that are in high-demand geographic areas, where they may -- there are some hospitals that, for example, don't have a dermatology person on staff at all. But if they needed a dermatology person, they could essentially recruit someone and then go outside the Match to fill that position. This is all hypothetical. But those situations are not even possible under the current system.

Q And to be clear, if an applicant fails to match, that doesn't mean that they are an unqualified person to be a doctor and to treat patients. Is that correct?

A Correct. I mean, the only major qualification to be a physician is to essentially finish the step licensing exams and to graduate medical school. There may be differences in the quality of their grades or their application, but the fact that they don't match is not itself indicative of their quality as a applicant.

As an admissions person, I routinely had to counsel students who are very upset with their abilities. And sometimes when we have someone not match, there's sometimes a clear reason. I can tell them, like, you should work on this for next year. You should work on your interview skills. You should work on this. But occasionally, I've had very tough conversations where I told them, I honestly can't understand why you didn't find a position. There's just simply not enough positions for the number of people.

And that's the most crushing thing I've felt, because these students, like, really

want to be a dermatologist or be a physician, and the only reason they can't do it is just there are simply not enough positions for the number of people.

Mr. [redacted] So often, very qualified individuals do not match simply because there is a lack or shortage of positions within the market. Is that correct?

Dr. Hussain. Yes, that's correct.

[redacted] All right. I think we're about at an hour, so we can go off the record.

[Recess.]

[redacted] We will go back on the record at 3:47 p.m. Eastern Time.

EXAMINATION

BY [redacted]

Q Just to reintroduce myself, I'm [redacted]. I'm with the minority. I'm joined by my colleagues [redacted] and [redacted]

A lot of the questions we're going to ask are going to be on the same topics the majority was asking you about.

A Sure. Yes.

Q It might be similar questions but just phrased differently, so I apologize in advance if you've already touched on the subjects.

I wanted to go back through your educational background just a little bit more. So you went to Georgetown, right, for undergrad?

A Yes.

Q What did you study in undergrad, again?

A I was a government major and a theology minor.

Q And then from there, you went to University of Chicago for two degrees, right?

A Yes.

Q And what were those two degrees?

A M.D. and a Master's of Public Policy.

Q Okay. And then you went from there on to your residency?

A Yes.

Q And residence first at Northwell Health, right?

A Yes, for 1 year.

Q Okay. And what was that specialty or what were you doing as your residency there?

A That was a general internal medicine preliminary year.

Q Okay. And then you went -- finally came back to the great place of the D.C/Virginia/Maryland area, right?

A Yes, for Georgetown. That was 3 years dermatology specialization.

Q So 4 years total of residency?

A Correct, yes.

Q Okay. During any of your studies, did you study economics or anything like that?

A Yes. The Public Policy Master's was the main place where I studied that.

Q And what was the extent of your economics studies in public policy?

A We had a core curriculum of macro and micro introduction to economics. We actually had a workshop specifically on the Match algorithm. And I focused on healthcare economics specifically during that period.

Q Okay. Did you study any law classes when you were doing --

A I had some law classes during my government degree during undergrad. I had a few public health law classes and one actually on marriage law equality.

Q Gotcha. Anything on antitrust? Did you study antitrust?

A Antitrust, I did not.

Q Have you done any research on antitrust?

A For this presentation I have done some reading, yes.

Q So for preparation?

A Preparation, yes.

Q Okay. Have you done any formal publications or research on economics?

A On economics, I have some publications from medical school and residency, kind of broad, like healthcare-related, like workforce trends, and like cost of care.

Q Okay. What about on the Match or anything?

A Match, yes. I have a document about the specific challenges facing dermatology applicants, like the number of applications they have to send, the cost of them applying, as well as some op-ed pieces arguing that we should extend the number of residencies.

Q So how long have you been prac -- is it practicing medicine? I'm using legal terms here, practicing.

A Yeah.

Q How long have you been practicing medicine?

A So as an attending physician, it's been 2 years. And then since finishing medical school, it was 2019, so now it's been 6 years.

Q Do you consider yourself practicing medicine after graduating from medical school?

A I consider residency to be practicing medicine, yes.

Q Okay. Let's focus a little bit on the dermatology piece. As a dermatologist -- actually, what's an attending physician? I don't even know what that means.

A It is someone that's finished residency.

Q Okay, okay. So as a dermatologist, what is like the most frequent procedure or common procedure that you had to perform as a dermatologist?

A So it's probably more -- if I explain it like the type of complaints that we see or like types of conditions. So we see a mix of -- skin cancer screenings are probably our number one, like, reason people come into the office. And for that, in order to determine if a lesion is cancerous, we do a skin biopsy. That's probably the number one procedure that we perform.

Q So how did you learn how to do a skin biopsy? Walk me through that process.

A During medical school, I was observing of residents and attending physicians performing a shave biopsy. And then during residency, I had the opportunity to perform one under the supervision of another person. And I was given feedback on the performance, and then I was allowed to do them solo as I gained more experience.

Q So let's break that down a little bit. So you get to residency, right. And you said you had the opportunity to perform one, a biopsy, under the supervision of somebody else?

A Yes.

Q Okay. Before you performed that under supervision, how did you know what to do?

A They had a skilled workshop where we were given the shave biopsy tools with a practice, either a practice skin or like a, you know, banana or orange or some other fruit. And we were instructed to kind of perform the procedure, and then they would give us feedback on the depth of the biopsy and the technique that was used. And once we were able to demonstrate we were able to do that, we were allowed to do it on a

patient.

Q So before you even walk in this workshop, I mean, you just literally walk in and get a scalpel. You don't like have any reading or anything like that?

A Yeah, we were required to read the biopsy technique ahead of time as well.

Q Right. So you were given materials to read?

A Yes.

Q And then you read them, right?

A Yeah, we read through the materials. We had a skilled workshop where we were asked to apply the written material and then given feedback on the skills workshop. And then, based on that, we were allowed to do the procedure.

Q Did you ask questions at all after reading the materials before coming into the skills workshop?

A I did, yes.

Q And who answered those for you?

A This was the program director for the residency.

Q And this was here at Georgetown?

A Yes.

Q And then you go into the skills workshop, you get the scalpel, the materials to perform a biopsy on a banana or something like that, right?

A Yes.

Q Okay. So while you're doing that, describe to me again the environment of you performing this skin biopsy on a banana.

A We had a large group. It was like a large table similar to this. We were all given a station to work with, and we were given the tools. And then they were telling us -- they would basically draw like a practice, like, skin cancer lesion and ask us to take a

sample as if we would in a clinical setting. And then we were given feedback on how that was done.

Q And so once you get the feedback, do you do it again until you kind of perfect it?

A Yeah, until the senior physician determines that that's like the adequate way to do the procedure, then you're allowed to do it on a real person.

Q Did you receive feedback when you did it on the banana the first time?

A Yes.

Q Did you do it -- what was the feedback you received, let me ask you?

A I did it adequately on the first attempt, so I was allowed to do it on a person.

Q I want to be like you when I get older.

What about some of your peers, did some of them get feedback and have to do it over again?

A Maybe one or two of them, but majority of people after the second attempt were able to do it.

Q Okay. So you go from there, from performing on the banana, then you're able to perform on a person, right?

A After a banana it was like a fake skin. We get like a custom -- whenever you finish, most residencies give you like a cadaver-type skin, and you can perform procedures on that before you go on to a real person.

Q Okay. So you get a fake skin. Is this fake skin like something that Georgetown had to purchase?

A Yes.

Q Okay. And so they're purchasing these fake skins for the residents to be able to perform this practice biopsy. Is that correct?

A Yes.

Q And then you perform the biopsy, again, with an attending physician, I'm assuming, overseeing you?

A Yes. And we basically let them, the patient that was doing -- that was getting the procedure up front that this is a teaching hospital, this is a resident who's learning how to do this procedure. Is it okay with you if they perform it? If the patient agrees, then we're allowed to do it.

Q Why do they tell these folks it's a teaching hospital?

A Because the patients know that their care will -- it'll just essentially be more time delayed. Because the way it works is they will come in for a visit, the nurse will kind of collect the vital signs and their basic information.

A resident physician will see the patient first. And then a resident will tell the attending physician what the kind of synopsis of the case is and what they plan to work on. And then the attending physician will go back in the room with the resident and then together the team will develop a plan.

So it basically adds an additional step to the process. So some patients will complain that, oh, the care is taking too long. But the reason is because the attending is giving the resident feedback about the case before they can move forward.

Q I guess I might be a little philosophical here, but is there an educational component? Is that why they say that it is a teaching hospital?

A Correct, yes.

Q Okay. And what's that educational component?

A Part of it is the direct feedback that you get from -- when you present the synopsis of the case to the attending physician, they tell you their kind of guidelines on how they would address the patient's concern. And then there's also the direct

educational experience where like you're performing a procedure under the supervision of another physician.

Q So you start performing these procedures on, I'm assuming, like real patients, right, at Georgetown?

A Yes.

Q And you have your attending physician there to train you or to oversee, to make sure you're doing it properly. Is that right?

A Yes.

Q How long does this process play out where you're kind of doing those processes over -- or procedures under the supervision of an attending physician?

A So that's -- it's interesting because programs, I guess, differ on how long that training process lasts. Some of them have a hard cutoff where after 1 year of -- you automatically graduate to doing things solo. Some of them do it based on competency. So if they have seen you do it one or two times and they know that you're competent, they just let you do it by yourself.

I mean, even within the same program, certain senior physicians have different levels of comfort on how much they let -- that resident would do.

Q Right. So for you, how long did you do it under the supervision of someone before you did it by yourself?

A So for one -- my main -- the mentor I was assigned to, after one time he was allowing me to do it solo. Other people, even at the end of residency when I was about to graduate, I still had to have them present.

Q So for 3 years maybe?

A Yeah.

Q Okay. I'm really interested to go back to 2020 and your internal -- I think it

was your internal medicine residency in New York.

A Yes.

Q You said it was like during COVID, right?

A Yeah, peak -- the peak of the pandemic was March 2020, yeah.

Q That was probably an incredibly hard year, I'm assuming. Is that right?

A It was, yes.

Q Can you tell us about why it was so hard for that year?

A It was -- it was challenging because it was the first year of practicing after -- after graduation. So with a internal medicine team, it's a little bit different than for dermatology. So there's usually a hierarchy where the top level is the attending physician; next is a senior resident; next is a junior resident, which is what I was; and then below that there might be some medical students or nursing students.

So during the first part of the year before COVID hit, we were all -- my colleagues and I were all junior residents. Once COVID hit, there were just not enough residents to have like full teams for every ward. So you had some wards that had basically myself as a junior resident functioning as if I was a senior resident, and I would have a medical student that got promoted into being a junior resident. And then our attending physician might be from a nonmedicine specialty, so like radiology or rheumatology.

Q And I believe you testified earlier to the majority that it was just like system felt like it was stretched to its max capacity.

A That's correct.

Q Is that fair to say?

A Yes.

Q And I know I'm characterizing what you said, but that's kind of what I took from it.

A That's correct, yes.

Q I guess, why do you think -- or can you just tell us what was happening? Just describe the environment, what was happening with the day-to-day care.

A We had a -- previously before COVID, we had a rough guideline where one resident would be in charge of about eight patients. That includes their entire inpatient admission, so placing admission orders, their meals, their IV fluids, all medications that they need.

And once COVID hit, we were basically expanding that to 10 patients per resident. And the problem is that the 10 patients that we had were all pretty much all having COVID at that point. And since it was a new disease, there was really no validated treatments available.

A lot of times, we were essentially bringing in research to the clinic every day and saying, this is the latest data from China, latest data from France or whatever country. And we were making treatment decisions kind of on the fly, instead of having like guidelines that we could follow that would be the case for like most other conditions.

Q Right. What are the guidelines for most other conditions? Where do those come from?

A They usually come from specialty societies. So, for example, for heart failure, there's like a heart failure society that decides what medicines should be tried in what order, or there's like very well-known trial data that some medicines are more effective than others, and you use an algorithm to decide which a patients needs.

Q So for those guidelines, typically, does everyone in that specialty kind of follow the guidelines?

A So they're guidelines. So most people tend to follow kind of some version of them. However, there's exceptions made for specific patients or specific concerns.

And people try to work within them whenever possible. However, there is opportunity to go outside the guidelines.

Q Why is it important to have guidelines, in your opinion? Or actually, do you think it's important to have guidelines?

A Yes.

Q Okay. Why is it important to have guidelines?

A Because for people that don't have much experience, they can benefit from the experience of previous generations. I'll say that, as a dermatologist, a lot of our conditions, they're very rare, so there's actually not like very clear clinical trial data. There's not enough patients to run a clinical trial. So, essentially, guidelines allow you to base expert opinion, which is essentially someone just giving their opinion, but having it vetted through a panel where most senior physicians generally agree on that course of action. So you're able to use that experience until you gain the experience to make your own decisions.

Q And who develops these guidelines, for example, for dermatology?

A We have the American Board of Dermatology that makes a lot of the decisions, as well as we have a -- for specific diseases, we have a, like, subject task force that write the guidelines.

Q So if you were -- let's go back to your residency. You're a dermatology resident. You have these guidelines. Is this typically what your attending physician would teach you as you're going through the process --

A Yes.

Q -- of learning various treatments?

A Yes.

Q Okay. And I guess what made COVID hard is that there weren't a lot of

these guidelines because COVID was a new and novel virus. Is that right?

A Correct. Yes.

Q Is it fair to say that COVID is a unique circumstance that stretched our healthcare system differently than what a normal resident might go through?

A It was unique for this time period. However, a lot of physicians that I worked with during that said it was very similar to how they felt during the HIV pandemic. So, again, a new condition that there was very little guidance available.

So even though it was new for this time period, it is something that happens, unfortunately, not infrequently in the system.

Q Yeah, I wish we could stop these types of HIV or COVID pandemics. I definitely hear you there.

A Yes.

Q And I guess I'm just trying to put a pin on what made it so stressful. Was it the lack of knowing what to do in the moment, right? Is that what made it so difficult?

A So part of it is the lack of -- lack of guidance, as well as it seemed that we were -- the hospital was stretched beyond capacity, as I mentioned. We had to make COVID wards kind of makeshift out of auditoriums and cafeterias.

And there was essentially not enough traditional internal medicine residents to fill those spots, so we were forced to draft physicians who were not familiar with internal medicine. And some of them would say that they haven't practiced kind of general medicine in almost 30 years but were forced to kind of work on a COVID ward.

Q So that kind of supports my theory of having people who specialize in the area actually doing the teaching in that area. Is that right?

A Yes.

Q Is that kind of -- is it schools, hospitals? Like, how do you -- what is the

institution that does residency? What do you call it?

A Usually teaching hospital is what we use.

Q Okay. Isn't it important -- does that highlight the importance of teaching hospitals to have people that are qualified in the area that has attending physicians?

A Yes.

BY [redacted]

Q I just wanted to clarify. So you were talking about the teams approach, which seemed pretty important. And you sort of --

A Yes.

Q -- said it seemed to have a certain regimentation to it. Now, the regimentation seemed to go out the window during COVID, but you said that you usually have a team and the team has sort of a structure, and so you have like one resident with eight patients and that type of thing?

A Yes.

Q And so why is that team approach sort of -- why do you think they organize them that way?

A It helps delegate responsibility, because each level of training requires, like, different approaches. So, for example, as a junior resident, they're not familiar with basic medications or how orders are placed in the hospital. So they're required to kind of be the hands-on, like the first person that patient will call if they have any question.

And then the more senior positions are more for leadership, so being able to handle -- when things deviate from guidelines, how do we handle this unique situation, or potentially more advanced topics, such as discussing like three or four different options with a family member and then having them pick the one that they would like. So it helps kind of create a separation of responsibility.

However, I will say, in practice, it ends up being that the kind of lower ranked residents end up doing a lot of scut work, things that the senior residents don't really want to do. So things that may be outside of the purview of medicine, such as like organizing social work, organizing discharge papers.

And because the senior residents are -- essentially, they're like the boss of the junior resident, they will kind of delegate a lot of those kind of scut work to the junior residents.

Q Right. And so you also -- it felt a little bit like the wisdom of crowds, so the crowd being sort of the senior people in a field. That's where you sort of turn to to better understand how to proceed during challenging times like COVID and that type of thing. So they turn to -- what did you call them, like councils or boards?

A For COVID or -- I'm clarifying, is it for general kind of medicine or specifically for the COVID?

Q It could be for both.

A So for -- it depends on the situation. So if it's -- if it's a hospital setting, you'll have that team approach where the attending physician will kind of make the final decisions. If there's any kind of discussion over what course of action, you will have specialties that will comment on their specific field.

So, for example, a patient is admitted for like a pancreatic problem but end up having a heart problem later on, you will have a consult discussion with the cardiology team, and both teams will make a decision that fits what the patient needs.

BY [redacted]

Q Sorry. I just want to pick up on one point you just said, kind of like the senior folks delegating probably -- I'll just use grunt work, I'm a military guy -- so the grunt work. Is that fair to say?

A Correct, yes.

Q Do you think that's unique to the residency in medical field?

A No. I think that's true of any career.

Q Okay. Thank you. Because I was going to say I got some stories for you if you thought it was.

I know you talked a lot about the Match today and ACGME and things of that nature. Have you ever worked for the National Resident Matching Program?

A I have not.

Q Have you ever worked for ACGME?

A I have not.

Q Have you ever worked for the Association of American Medical Colleges?

A No.

Q So you're testifying here today from your experiences --

A Yes.

Q -- going through those programs? Okay.

Let's go back to medical school for a little bit. I'm curious just to go back through your residency application -- your Match application. Let me use the right terms.

A Okay.

Q Can you describe the timeline for your application for internal medicine -- right? Is that internal medicine?

A Yes.

Q -- and for dermatology? So like when you applied, what did that look like? I know you touched on it a little bit, but can you just walk us through the entire timeline?

A So I'll kind of frame it as like the medical school year. So I -- medical school's typically 4 years long. That's a whole separate discussion of whether that

should even be the case. But I had a slightly different tactic because I took a gap year between my third and fourth year of medical school to do my public policy degree. So I started my process for residency during the end of my public policy degree as I was reentering my fourth year of medical school.

Q Let me stop you there. So you started your residency application heading into your final year of med school?

A Yes.

Q Would that be the same if you wouldn't have taken a gap year? You would have started it heading into your final year no matter what, right?

A Yes.

Q Okay.

A So I started it during my public policy year, but technically I was entering my fourth year of medical school. At that point, there's a kind of -- this is a voluntary program. It's called away rotations, where if you really want to go to a specific residency, you do a 1-month audition in that program, and then you can get a recommendation from that program when you go through the Match later on.

So I did two of those voluntary rotations. And after that point I started my application for the Match program. I wrote one application for the internal medicine and a separate one for the dermatology programs. I submitted them both on the same day, around mid -- I think September 15th, roughly, middle of September.

And then around October is when internal medicine programs start releasing interviews. I did those interviews from around November to December or January of that year. And dermatology released interviews slightly later, so around December to February of that year.

And after completing interviews, I submitted my Match ranking algorithm in

around mid-February, and actually I remember because it was February 14th. They told us it was like matching like Valentine's Day. So we had to submit our application on the 14th, and then we received the results about a month later.

Q So you received the results probably like in March, it sounds like, about March?

A Yeah. I remember because it was March 15th. It was the Ides of March. So we got the results on that day.

Q A lot of memorable dates for your application period. Okay. So what are the interviews? Like, what does that -- what does it look like? I feel like I know what an interview is but I feel like I don't know what it is for a residency.

A It's pretty different, honestly, than it is for a traditional job. So for -- and even within specialties, it's quite different.

So for internal medicine, it's very much a standard interview. You meet with probably a senior attending physician, a residency director, and potentially even a senior resident for like 20 to 30 minutes per interview. And they'll just ask you about your job application and like your career, your goals, and things that you're interested in.

They know that you're going for a 1-year position, so they will ask you kind of how do you expect us to transition you into dermatology. So the internal medicine ones are definitely lower stress, because they know that we're only there for like 1 year as a temporary thing.

The dermatology ones are highly stressful. They tend to focus as -- almost like speed dating. That's how they -- they self-describe it that way. There's usually 15 or 18 applicants and like 15 or 18 physicians. And you spend about 10 minutes with each person, and then you rotate through like -- to like another room to like another 10 minutes.

So the whole process takes maybe 2 hours, but you're spending about 10 minutes with each person in like short-term interviews.

Q Are you in like hotels?

A It's usually a hotel or sometimes it's in the hospital if they have a bunch of rooms set up.

Q Lawyers and doctors, we're not creative. That's how we do it in the legal world too, so it's clearly not that much different.

I want to go back, though. I actually missed something. So you go to the interviews. How do you even know where to apply?

A So that's the challenge. There's a lot of guidance out there from the AAMC and from like wisdom from previous applicants. There are kind of rough guidelines on how many programs you should apply to, based on your board scores. However, in practice, most students don't follow that. They will basically apply to certain regions that they want to be in. They'll maybe apply to every single program in those States.

For example, if they're from New York, they'll apply to every program in New York. And then for dermatology or competitive specialties, they will essentially apply to every single program.

Q But, I guess, how do you even know what hospitals or teaching hospitals have the program?

A Oh, sorry. So there's a website called the ERAS. It's Electronic Residency Application Service. And this curates the list of active residency positions available. And students can search by state and then by what specific type of program and use that to apply.

Q Is ERAS part of the Match itself?

A I believe it is separate from the Match.

Q Okay.

A But I have to clarify that.

Q So when you're doing this whole submitting your applications and doing interviews, it's not in the Match algorithm at all?

A The Match algorithm is really just for the final aspect where you're submitting the rank -- the Rank Order List. The interview process is done through like individual programs; however, they have to conform to guidelines set by the matching system.

Q And what kind of guidelines are set by the matching system?

A The residents have to submit certain, like, scores of their exams, certain qualifications from their medical school, certifying that they finished the medical school, they're like in good standing, they finished certain requirements.

Pretty much all the schools that participate in the Match have to follow that same guidance.

Q Do you see any utility in teaching hospitals having to collect that type of information?

A It is helpful in the sense that you're ensuring that students are qualified to finish residency -- or finish medical school and start residency and that they're qualified to be a physician. However, some of the guidances, it changes so rapidly that it's difficult to keep up with.

So I'll give you an example, that our Step 1 score I was discussing previously became pass/fail. So some students were having a scored exam. Some students were having a pass/fail exam. In the same application cycle, you have students that have both scores available. Having that information is not very helpful, because you can't really compare a pass/fail to like a scored exam.

Q Gotcha. Going back to this ERA -- it's ERAS or ERAS?

A ERAS.

Q ERAS. I'm going to say the E-R-A-S. Is that right?

A Actually, when they released it that year, they said it was like Taylor Swift, like the Eras Tour.

Q Oh. I'm not a Taylor Swift fan, but I will -- and that's on the record now, unfortunately.

So it's -- that list, do you find utility in that list? I mean, I feel like it's pretty helpful to be able to know every type of position, every region that's out there.

A It is helpful; however, it has some limitations. Like, it doesn't allow applicants to sort by like region of the country. So you have to search by like State-specific instead of like the Northeast or like the South. So it has some limitations to it, but it does provide some value.

Q So let's say there wasn't that database. How would you have been able to identify every dermatology program in the country?

A We would have to go through a third party. So like the AMA has that FREIDA database, which is similar, or you would have to, like, physically call up or email every single program to find out.

Q Do you think that would be tough to do?

A It would be very challenging to do, definitely. However, there might be some utility in that students would be more judicious in where they apply, because currently they're -- like I said, they're basically hitting select all when they apply to certain residencies, and the reason is that it's very easy to do so.

BY [redacted]

Q Eighteen people interview you?

A In some programs. Sometimes it's less. I'd say between 10 and 15 is kind of the average.

Q Wow. So that's -- and 10 minutes each?

A Usually 10 to 15 minutes.

Q So that's a lot -- and that's for a single program?

A Yes.

Q So it's a lot of conversation.

A It is.

Q So you can talk about sort of more or less anything you want --

A Yes.

Q -- and they can -- yeah. Okay. So you could bring up salary concerns if you have them?

A Theoretically you could, although you would probably -- like, the way applicants are kind of counseled is that you have 10 minutes to make an impression on the interviewer. So they're -- you essentially want to put your best foot forward, and some of those concerns would probably harm your application.

BY [redacted]

Q So let's take a step back. Let's remove the Match. Let's remove that. Would you have brought up, you know, salary concerns in your first interview if it was a free market?

A I would not.

Q So walk me through the Match part now. So we're finally at the Match algorithm, right?

A Yes.

Q We're finally there. How does that work?

A So you have a list of -- you have a list of every single program in the country. In reality, you're only going to rank programs that -- where you got an interview, because that's where theoretically you would get a position at. And you rank them from whatever, one to however many you got.

It becomes more challenging if you're applying for two residencies, like I did. So you have to rank one list for your preliminary position, for internal medicine, and then a second list for your dermatology positions.

And you can do some kind of programming. Like if then -- like if I match at this program for the first year, I want to stay at this program for my second year. You have ways of kind of making more nuances. It's quite challenging, but essentially that's -- you would make two separate lists, one for one residency, one for the second.

You submit that list by a certain deadline. And then programs also submit a list of their applicants from like their most favorite applicant to like their least favorite applicant. And if they don't want even to take a applicant, they'll basically leave them off the list completely.

And applicants can also do that. If there's a program where you would rather not have a position than go to that program, you're allowed to leave it off the list.

Q And then there's like this algorithm that matches, like, your highest -- the applicant's highest rank with the institution's highest rank, and there's some matching that goes on. Is that kind of how it does at a high level?

A Yes.

Q If you don't mind me asking, and please feel free to say, [redacted] I'm not answering this, but did you get your number one program when you --

A I'm not going to comment.

Q Okay. Did you get one of your top programs that you applied for?

A Yes.

Q Okay. Do you have any complaints about your personal residency application process?

A Sorry. Say that again.

Q Do you have any complaints about your personal recollection of your experience?

A Yeah. I had an issue with the fact that there seemed no rhyme or reason to where I got interviews. And I told future students this when they applied, that I -- they used to say that you should, you know, apply to places where you think you're likely to get an interview. That depends on where you're from in the country. And if you write like a specific essay for those regions, you're more likely to get an interview.

So, for example, I'm from Connecticut. So I wrote a separate application for, like, Northeast programs, like New York, Boston, Connecticut. I wanted to be in D.C., so I wrote a separate application for D.C. programs. And I was also in medical school in Chicago, so I wrote like a separate one for those programs.

The majority of my interviews were in the South, so a place where I had no connection. And I'm not sure why I got interviewed in these places, but I didn't want to turn them down, so I still went to the interview. However, I ranked them relatively low on my list.

And the challenge was that there are programs in D.C. or in New York where I felt like I probably had a good chance of getting an interview, but I did not. So this is essentially what justified my logic to apply to every single program, because I had no rhyme or reason to like why I was getting certain interviews.

Q You think there would be a rhyme or reason to where you got interviewed if there wasn't a Match?

A I believe there would, because then students would only apply to places where they were serious about going to, instead of being worried that if I don't apply to programs, I may not get any position.

Q Okay. Did you put any of these Southern schools on the Match?

A I did rank all the programs --

Q Oh, you did --

A -- because I was worried that I wasn't going to get a position, but I just ranked them lower.

Q Gotcha. And you ended up going to one of the D.C. markets --

A Yes. I was very happy. The one interview I got in D.C., I'll say that, I ended up getting.

Q Okay. You now advise medical students on how best to position themselves --

A Yes.

Q -- right, to apply? What type of advice do you typically give students?

A I'll review their personal statements. I will review their letters of recommendation. I'll sometimes write letters of recommendation. I'll sometimes reach out directly to programs where I have a connection to, like, flag an applicant for them. And then I will usually tell them to, like, kind of tailor their application for specific programs.

Q Going back to the Southern schools, what could they have done -- let's just use -- I'm a Southern guy, so I feel I can say this -- or a rural place. What could they have done to get you to go to the residency there?

A So they could have given like a significant salary change, if that was allowed.

Q Why is it not allowed? Why can't they give a significant higher salary right

now?

A Right now, they're basically limited by the other programs in their area.

Q How are they limited by the other programs in the area? Couldn't they still do it?

A They theoretically could, that's true.

Q So are they limited by other things in their area?

A They have a database of the similar hospitals in the area.

Q Are they limited from a higher -- paying people more money in their area?

A They are not officially limited; however, they do limit the salaries.

Q Okay. And you think that would help motivate people like you, like I would say highly qualified candidates, maybe go to the South?

A Yes.

Q When you were applying for your residency, did you -- and you used this term -- did you receive any exploding offers?

A I did not. I will say for the residency itself I did not, but for interviews, yes.

Q And how did that work? Like, tell me what happened with those, with the interview, the exploding offer.

A They would essentially say that -- and, actually, I will say that since -- it's been almost like 6 years since I applied, but the AAMC has kind of cracked down on this practice. But they used to say that here you are guaranteed -- you are given an interview at this program. You have 24 hours to respond that you're going to attend and then pick a date that you're going to attend.

And sometimes you would respond and they'd be like, oh, this date's already full, you have to pick another date. And then you would just keep going back and forth. And now the guidance is that residencies should not give more interviews than they have

space for, because some students would -- if you didn't check your phone, you would not get that interview.

And, actually, I had friends in my medical school that they made a separate email account for that and they had their, like, wife or their parents check their email, because in case they're in the bathroom they could, like, respond immediately.

Q Right, right. There are so many similarities what you're discussing and big law hiring, it's blowing my mind right now.

So let's say hypothetically, right, that your fourth highest ranked program would have offered you an exploding offer. Let's say one of these schools in the South. Let's say Richmond, Virginia, because I love Richmond, Virginia, would have given you an exploding offer with a tight deadline. How would that have impacted your residency decision?

A I'm asking clarification because I would have to be sure that I would actually get the position, because as of now, they're not allowed to like --

Q So let's say they were -- let's go back to 1952.

A Okay.

Q And let's say a hospital in Richmond, Virginia, says we're going to give you an offer to come down to a dermatology residency in Richmond. It is 12 p.m. Your offer ends at 8 p.m.

How would that have impacted your residency decision?

A It would have made it less stressful, because, I mean, number four is like pretty high on the list. During this process, if I had a guarantee like that, I would have probably asked my top three programs if they could match that. And then if they said no, I would have taken the offer.

Q So let's -- I thought four would be low, so I must have messed up on this

hypothetical.

Let's say number 50, because you applied to a hundred schools, right?

A Yes.

Q Let's say number 75 would have given you an exploding offer that said you had 8 hours to accept this offer. How would that have impacted your decision-making?

A It still -- it would have provided some like mental, like, improvement, because initially I was worried that I would not get any positions.

Q Got it.

A So I'm at least getting one offer. And then the fact that it's like so time-limited means that they would perceive me as like a strong applicant.

Q So the stress you're talking about with the Match is just getting any offer. Is that the stress that you're --

A Yes.

Q How would that change, though, if it was an open market?

A In an open market, you would be able to have more clarity on your competitiveness as an applicant, because programs would be able to certify, like, we have certain guide -- certain requirements that are unique to our program. No other program has this. So if you meet those requirements, you have a decent chance of getting into that program.

Q So you believe that in an open market if you hit the job requirements, you would know you were going to get a job in that area?

A You would have a reasonable expectation that you would be competitive for that program.

Q Really? You really believe that?

A I do for residency.

Q Okay.

A Because there's a limited number of students that are qualified and -- I'll give you an example. So if there's a program that has a history of students failing their board exams, for example. Then they can say, like, well, we want everyone who applied -- or who gets into our program to be 95th percentile in their board certification.

So if you have a 97 percentile, you know there's only, like, very limited people that can match that.

[redacted] Who prohibits medical teaching hospitals from sort of signaling their requirements? I'm still -- I apologize, I'm still back on the fact that you had to go through 18 interviews. I mean, I went to big law too and, like, I thought having like, I don't know, five people talk to me was enough.

[redacted] We'll talk after this, [redacted]

[redacted] I don't want to know. I don't want to know.

BY [redacted]

Q But you had 18 people. They could have signaled any -- you would have had public knowledge in terms of people would get into programs with certain characteristics.

You yourself said that, I think, if you knew, you know, that a program really liked Master's of Public Health rather than MBAs, you'd apply to them.

A Yes.

Q Who prohibits them from saying that?

A There's no prohibition against it.

Q Okay. Because you said that you don't understand what the requirements are for the programs.

A So -- yeah, I should clarify that requirements are very kind of -- it's basically

the minimum that someone needs. So usually that's like they pass medical school, they pass their board exam. It should be more clear on what specific attributes they're looking for that would make someone more competitive for that program compared to another program. Because as of currently, if you look at most admissions programs for residency, they will say very generic things that we want, you know, caring doctors that care about their patients or that are interested in service. That, you know, addresses pretty much 100 percent of people that apply to those places.

Q Yeah, but there's nothing that stops them from being more specific. What they're doing is casting a wide net and saying, you know, we want lots of comers.

A That's true, yes.

[redacted] Okay, okay. Got it.

[Discussion off the record.]

BY [redacted]

Q Real quick before I move on to another topic. I guess I'm just curious. Do you think every student who hopes to join a particular residency program should be matched into that specific program? Do you think they should have the opportunity to do it?

A Not every single student.

Q Okay. We touched about the guidelines earlier. Are those kind of similar to medical standards, in your opinion?

A They're similar, yes.

Q Okay. How do you think standards or guidelines contribute to patient trust in the medical industry?

A They improve in trust in that they know that their doctor at least has some reason behind prescribing certain things, that they're following, like, kind of evidence or

wisdom from more experienced physicians.

Q And who -- you touched on this a little bit, but like who is responsible generally for developing these standards or guidelines?

A So each specialty has a board or a group that drafts like broad guidelines. And then for specific diseases, you'll also have like a disease task force on that specific condition.

Q Do you believe there'd be dangers posed by not having safety standards or guidelines within the medical profession?

A Yes.

Q Why would there be dangers posed by it?

A You would have physicians that are prescribing things that are potentially dangerous or they may have a conflict of interest with why they're prescribing certain medications or others. So having guidelines at least limits that ability where, even if there is potential conflicts, at least they're still following like a general standard of goodness.

Q And is it fair to say that the medical standards, they try to make like a baseline of care, right? Is that fair to say?

A Yes.

Q So that even if you're practicing or receiving treatment in a rural or underserved community, right, you can know that you're getting a certain level of care with that treatment?

A Yes.

Q And why is that important?

A Basic equality, and we're all human beings. We all deserve some modicum of healthcare. And it should not matter where you live or what your background is, but

we're all entitled to like some basic level of healthcare.

BY [redacted]

Q I want to go back to something for a second. Under the idea of it takes just one, you said that you were sort of surprised or puzzled by who chose to interview you and who didn't?

A Yes.

Q And it's sort of a black box. Did you ever get clarity on that after the fact, try to figure it out?

A I did not.

Q I would have been petty and tried to figure it out. I don't know.

[redacted] She definitely would have been.

Dr. Hussain. Actually, well, the problem is with dermatology, it's a very small specialty. So it's actually an issue with applicants where like if they get, like, known to be kind of difficult or like they can get blacklisted, it can actually harm your career prospects.

[redacted] Got it.

BY [redacted]

Q Okay, okay. So you got one interview in the D.C. region?

A Yes.

Q And that's one you obviously took?

A Yes.

Q And now you're happy about that?

A I am happy about it.

Q So going back to the hypothetical that [redacted] posed, if you had gotten your fourth choice, which was in the South in his hypothetical, you said you would have

selected it, right?

A I may have. I would have talked to the other three programs to see if they would match the offer.

Q Right. But if they couldn't have matched it or if they couldn't have matched it in this exploding timeframe --

A Right.

Q -- you probably -- what do you think would have happened?

A Yeah, I potentially -- if it was number four, I mean, I consider that like high enough that I potentially would have taken it.

Q Okay. So you would have ended up in the South rather than --

A Yeah, I --

Q We'll call D.C. the South if you want.

A Yeah, I may not have ended up in the same place.

Q Okay, okay. Got it. What do you believe is causing the physician shortage?

A So there's several factors. I think number one is that there is a cap on the number of residency positions available. So even though there are unfilled spots overall, there's still --

Q A cap imposed by whom?

A This was a -- I believe it was a balanced budget amendment from 1997 that set the cap on how much -- there are -- basically, Medicare contributes funding for certain residency positions, and that number has not -- it's changed slightly but not significantly since that time period.

The population has continued to grow, and during that time period there has been more demand for physicians. So the number of patients per physician has essentially

increased. And that shortage is more pronounced acutely in certain specialties and certain geographic regions.

Q Are you familiar or are you aware that the Medicare GME program has the goal of trying to supply a sufficient number of well-trained physicians in the U.S.?

A I believe it has that goal, yes. I don't know if it achieves that.

Q Right, right. And so this 1997 law that you talked about, it has that cap built in?

A Yes.

Q And that's -- do you know why the cap's there?

A I believe it was for -- there was a group of physicians that were concerned about an excess of physicians. So there was a discussion of whether to essentially stop creating new residency positions. And then also there was issue with essentially a balanced budget, so Medicare, to avoid overfunding the program.

Q Yes. So it was to make sure that the money -- cap the money?

A Correct.

Q It capped the number but it capped the money. Is that right?

A I believe it did both. I have to check.

Q Okay, okay. Do you agree that if we added a goodly number, say 14,000 additional Medicare-funded residency slots, would that be a good thing?

A I believe it would be -- it would help, depending on how those positions were allocated.

[redacted] But starting with the slots, that's the first step, though, right?

Dr. Hussain. Correct.

[redacted] Right. So how important is it that the slots be increased in terms of number?

Dr. Hussain. The number is definitely important. It's necessary but not sufficient.

[redacted] So you're saying there should be more slots added to it?

Dr. Hussain. The number is honestly one aspect, but it's really the specialty allocation and the geographic allocation that's more important. Because there are currently unfilled spots even now, but the issue is that the unfilled spots are not being filled for whatever reason, whether it's salary reasons or they can't find enough qualified applicants.

And then there are certain programs -- or certain areas of the country where there -- there's like no single dermatology residency in all of Wyoming, for example, but there's definitely people in Wyoming that need dermatology care. So adding a position in Wyoming might be more beneficial than adding one in D.C.

[redacted] Gotcha. Gotcha. Are there other -- give me just one second, please.

[redacted] So we'll introduce -- we'll use the -- we'll get the -- we'll introduce an exhibit. It's an article from the National Library of Medicine. Its title, Addressing the Physician Shortages in the United States with Novel Legislation to Bypass Traditional Training Pathways: The Fine Print.

We'll pass that -- we'll give a second for you to read it. We'll pass it out to everybody. And this will be exhibit 4.

[Hussain Exhibit No. 4
was marked for identification.]

BY [redacted]

Q We're going to ask you just to, when you have a moment, look at the highlighted section.

No, it's just the yellow part up front.

A Okay. Yes.

Q Do you agree with the fact that we're an aging Nation?

A Yes.

Q And how does that impact the physician shortage?

A So, generally speaking, elderly patients require more care in terms of more specialties as well as more specific procedures that are needed to care for them, so that essentially needs more physicians to perform those duties.

Q So that, going back to our prior conversation, what does that mean in terms of the number of what I'll call colloquially slots? You know, do we need more slots for residents as a consequence of that?

A Yes.

Q Okay. Then would you like to see them in specific fields that might benefit an aging population?

A Yes.

Q Okay. And where would you look to see that happening? How would you get them to be allocated in that way to get you to see the improvement you'd like to see?

A We would have to look at the percentages of students that are matching or not matching, and then looking at places in the country where there seems to be like an acute demand for care, whether there's high wait times or just a lack of hospitals in the area. And then being able to track whether patients in those areas are getting more or faster care as a result of those residency positions.

Q No, but you've already said that there are slots that are open and, you know, no -- people don't want to go there.

A Yes.

Q And so how are you going to get them to go there? It's not -- you didn't identify it as a matching issue. It's sort of students don't -- residents don't want to go to certain regions perhaps. They do not want to fill certain fields.

A Right. And the challenge is that there are certain areas of the country that are like more desirable to live in. And really, right now there is not any major incentive for students to choose those kind of more rural or like less desirable positions.

[redacted] Okay. Great. Thank you.

BY [redacted]

Q And we talked about it earlier. Couldn't those rural or underserved hospitals, couldn't they offer their own incentives to try to attract students?

A Theoretically, yes.

Q Nothing's stopping them from doing that, right?

A I mean, theoretically, there's no legislation stopping them, but the practicality, they're now going to face even more cuts in the next couple years probably, and the funding is really the main problem.

Q Why are they going to face more cuts in the future?

A Potentially like cuts to programs like Medicaid or other entitlement programs.

Q And when did those cuts come through?

A I'm sorry?

Q How did those cuts originate?

A This was the legislation passed this year.

Q The One Big Beautiful Bill?

A Yes.

BY [redacted]

Q So we're going to revisit a little bit of some of the things you've talked about in terms of the resident matching program.

How did students apply to the residency programs prior to the NRMP?

A Prior? So, basically, the students would apply as to any other job. So they would submit their application to a hospital. Hospital would review it and then contact them in whatever timeline they felt was reasonable and then offer them a position when they finish medical school.

Q Right, right. What were some of the challenges associated with that?

A So as I was saying before, the main issue is that you had a small group of like highly qualified medical students that would be getting the lion's share of the offers. And they would -- programs would be like competing to offer them better and better contracts, whereas some of the less qualified students may not receive any offers or be forced to take like less desirable positions.

Q How do you know that the students that were the best were getting better and better contracts?

A Because the hospitals would know that they're basically recruiting specific types of students from specific schools. And all the hospitals would essentially be competing for the same group of applicants, and they would have a rough idea of what these other places where offering.

Q So you're sort of speculating that you think it would -- the competition would have a certain impact?

A Yeah, I'm speculating, although there's some -- there's some like anecdotal experience. At least with residency, like, interviews that tends to happen, where there's -- for example, with dermatology, there's maybe 700 people that apply every year. And if you go to one of the top medical schools, you know there's maybe two or three

people in your class applying.

So the programs all know there's maybe like 30 to 40, like, top applicants that are applying every year. They all interview at the same programs, and the programs all are competing for that same group of students.

They might -- I know like one student might get 20 interviews, and then someone in my class might get zero because I know that they're not as qualified.

Q Not as qualified. Got it.

Why do you think the Match was created?

A The goal was to essentially allow that there'd be a one-to-one ratio where applicants are matched to one program and there is basically not an inefficiency where you have the situation where you have like some students getting a lot of offers, some of them getting zero. Instead, you have like a one-to-one match of those.

Q So one student can only fill one slot, ultimately?

A Correct. Yes.

Q Okay. And at the end of the day, after you get done with the Match and SOAP, what is the percentage of slots that get filled? Do you know?

A It depends on the specialty.

Q Overall?

A Overall, based on this article from this year, it says about 80 percent.

[redacted] Okay. We have another document I'd like you to pull up.

[4:34 p.m.]

[Hussain Exhibit No. 5

was marked for identification.]

[redacted] So this will be exhibit 5. I believe the title of it, I have it with me right here, is -- it's from The Match. It's a publication from The Match. It's called Results and Data, 2025 Main Residency Match. So we'll make this exhibit 5 and we'll pass it out for everyone to look at. Did he get a copy, [redacted]?

[redacted] Sorry about that.

[redacted] We'll go to the introduction part. That will be the most important part for you to read here. Take the time to read whatever you want, but that's what we'll focus on.

[redacted] Can you look at the physician fill rate on page 9, but page 9 is roman numeral IX. Thank you.

Dr. Hussain. Yes, I see it.

BY [redacted]

Q Can you tell me, this discussion of the fill rate for the 2025 residency program, ultimately, at the end of the day, what is the overall fill rate?

A So based on this, I'm reading this. It says, Based on this criteria on the physician fill rate for the 2025 Main Residency Match was 94.3 percent upon running the algorithm.

Q Okay. And then when they did, the supplemental, it was increased to what?

A So as the overall filled rate matching and SOAP process combined was 99.4 percent.

Q I'm sorry, I didn't hear you.

A The overall fill rate, matching, and SOAP process combined was 99.4 percent.

Q That's pretty close to one-to-one.

A Correct.

Q Great. Thank you. When -- one second. Does the number of residents accepted through the match program correspond to what the programs are equipped to handle?

A It's a subjective question, because programs will kind of have their own limits on what residents can and can't do, and each residency also has a certain -- like, each specialty has certain guidelines on how many procedures or how many things a resident should be responsible for doing.

BY [redacted]

Q Can I break it down a little bit? So earlier we talked about how educational residencies and educational -- it is, in part, educational. Is that right?

A Correct.

Q So you talked about earlier with your dermatology example, how you had the banana that you had to do the practice procedure on, right?

A Yes.

Q And then you had, like the fake skin that you did on it as well.

A Yes.

Q And you had the attending physician to teach it to you, right?

A Yes.

Q Do you think it's fair to say that every teaching hospital is able to afford that for every specialty?

A Well, every specialty is going to require different training materials. Some

of them may not require procedural training. They may require -- like, for psychiatry, it might just be, like, practice, like for therapy or other things.

Q So each teaching hospital is making their own independent business judgment on what they can afford to teach residents, correct?

A They're making their judgment. However, they have certain guidance from the ACGME for a certain kind of minimums that they have to meet.

Q So you're saying because of the -- don't you think that these educational standards are good typically?

A I mean, that's a separate question. What I'm saying is that the programs have to meet certain minimum requirements in order to be certified as a residency, so they have some flexibility on how they address those trainings, but they still have to meet certain, like, minimum baseline for how they continue.

Q So is it your proposition here today we should not have minimum educational standards?

A That's not what I'm saying.

Q I wouldn't say what you're saying. I'm asking you is that your proposition?

A That is not.

Q Okay. So then what is your proposition then?

A The proposition is that programs should have more flexibility in these minimum requirements. I'll give you an example that there is -- for in order to graduate a dermatology residency, you have to perform three-nail procedures, to perform or witness three nail procedures. Why is it three? Why isn't it ten? Why isn't it one? There's really no reason why it has to be three procedures, so if the resident, for example, if residents haven't seen a nail procedure even if they have completed every other aspect of residency training, they can't become a dermatologist doesn't really seem logical to

me, so it seems that some programs could have more flexibility in some of these requirements.

Q So then under what you just said, there could be an example where -- because you said one or none, right? Someone could go and be a dermatologist without doing a nail procedure. Would you be comfortable with that?

A That's comfortable, because there's certain dermatologists, in fact, that don't perform nail procedures.

Q Okay.

BY [redacted]

Q Would you agree that one of the things that's necessary is that you have to have sort of a certain throughput of patients in order to be a resident who gets adequate training in a program?

A On a certain level, yes. However, it's more about the diversity of patient experiences, because if you saw, you know, 100 patients where they all have the same condition, you're not really getting the, you know, broad exposure to other things.

Q So it's a -- so the calculus is what? That you need to have what? Some minimum -- in your words, like, what is it that we need to provide the residents with so that when they finish, they've gotten what they need? How do you make sure that happens?

A Yeah. They need a broad exposure to different types of patients, different types of concerns, and then if they're in a procedural specialty, ability to perform procedures with supervision and also independently. And they need someone to verify that they're able to do those things in a safe manner.

Q Got it. Got it.

[redacted] We're checking with the majority. We have 7 minutes, right?

Is that what you're calculated as?

[redacted] That's right.

[redacted] Perfect. I didn't write down the time, so thank you.

I think we're good there. We'll go off the record now. We're good.

[Discussion off the record.]

BY [redacted]

Q Back on the record. Thank you, Dr. Hussain. We want to start with a few questions relating to some of the topics you discussed in the last hour, and to begin, there were some questions about the difference between the resident as a student or an employee. You said in the first hour that you would characterize a resident as an employee. Why do you think it's important that we understand residents as employees?

A It is not my decision. That's a Supreme Court decision. It's important because residents are workers employed by a hospital and they receive a salary, they receive benefits from that, and their educational activities are important, but their primary function is to take care of patients and to be a physician.

Q So the primary responsibility is to perform tasks for the hospital as any other employee?

A Yes.

Q And, you know, when a hospital brings on a resident, they receive -- they receive subsidization, as you discussed in the last hour, from the government through CMS funding. Is that right?

A Yes.

Q And that's to the tune nationally of tens of billions of dollars, right?

A Yes.

Q And you discussed caps to that in the 1990s, and to be clear, that's not caps on the total number of residency positions that are out of the United States, right? That's, rather, caps on the funding to specific positions based on criteria laid out in the 1990s law?

A There's funding to specific positions. That's the kind of intent of the law. However, in practice, that results in a cap in the number of positions that are available.

Q It is not -- in other words, it's not a restriction on whether or not a program can add another resident if they would like to, correct?

A Correct.

Q It's just -- it restricts how much money goes to that position from CMS.

A Yes.

Q And would you say that separate from the CMS funding, residency positions provide value to teaching hospitals?

A Yes, they do provide value. There's examples of this where in the University of New Mexico had a neurosurgery residency program. They had eight neurosurgery residents. When the program shut down, they essentially had to hire about more than 20 PAs, physician assistants, to basically meet the demand of those eight residents, so they are essentially paying those physician assistants a similar even higher wage than the neurosurgery residents, but they were seeing fewer patients because they needed three times the number to accommodate the number of patients that the neurosurgery residents were seeing.

So that's just one example, but that's a good example of how hospitals do actually receive a lot of value from the care that residents provide.

Q So in other words, they -- the fewer number of residents were performing more tasks, more work than a larger number of nurse practitioners or physician

assistants?

A Yes.

Q And also residents, as you said in the last hour, performed the types of work that other doctors wouldn't want to do, right?

A Occasionally, yes.

Q And that provides value to the teaching hospitals as well.

A Yes.

Q And a lot of for-profit hospitals have residency programs, correct?

A Yes.

Q Would a for-profit hospital have a residency program if it was an economic loser?

A Logically speaking, probably not.

Q I'd like to talk a little bit about the salary distinctions between a residency -- a resident and a licensed, board-certified position, attending physician. Would you say that the type of work that you did your last year of residency was substantially different from what you do now as an attending physician?

A It's different in the sense the practice setting is different, but the actual day-to-day work would be roughly the same.

Q Roughly the same.

A Yes.

Q However, would you say your salary is different from the last year of your residency to now you're a new physician?

A Yes.

Q And what kind of order of magnitude?

A I'd say it's roughly, like, five times higher.

Q Five times higher, even though you're doing roughly the same sort of thing?

A Yes.

Q You also discussed in the last hour the idea of a team-approached residency, how folks move kind of year to year in the same sort of group.

A That's more for in-patient hospital residencies, like internal medicine or pediatrics. Other residencies have different hierarchies.

Q That sort of team approach could occur with or without the match, correct?

A Yes.

Q The match doesn't really have an effect on whether or not folks can move as a team year to year?

A Yes. In other careers, you have people that join the team at whatever stage in their career, and they kind of fit into wherever their publications are.

Q And the same sort of thing applies to other settings, like a law school, right --

A Yes.

Q -- where folks can move back and forth and move from year to year?

A I am not familiar as much with law having not studied it, but I assume it's similar.

Q Now, you also discussed the interview process in the last hour and you said that you probably wouldn't bring up salary in an interview, even in a free market setting. Is that right?

A Yes.

Q If you had an offer from one group and then a free market hypothetical from one residency position and you wanted to go to a different residency position, would you then, in that case, bring up salary with that more preferred residency program to try to get a better offer?

A I would likely do it in the setting once I had the offer secured. It wouldn't make sense to do it during an interview setting because you don't have any leverage at that point.

Q But when did you have the leverage, then you'd agree to that.

A Yes.

Q And, again, because of the matches requirements, you cannot do that.

A Correct.

Q Now, moving on to the FREIDA database that you discussed briefly in the last hour, and you said that that limited the ability for programs to adjust their salaries.

A It doesn't create a direct limit. However, programs have a very clear understanding of what the competitive salaries are for residents, and they will not deviate significantly from that.

Q The minority counsel drew a distinction between a limit in kind of in practice, and a limit in the letter, and what you're saying here is there's a limit in practice. Is that right?

A Yes.

Q And can you explain why that is the case, why in practice it's difficult?

A Since there's essentially one uniform way where students can secure a residency position, there's really no incentive for programs to provide a higher salary, even to attract certain students, because they know that if students don't take the lower salary that they're offering, they essentially will not become a physician and be unable to practice, so that's such a huge barrier to students that they'll essentially take that lower offer.

BY [redacted]

Q And part of that reason is because they cannot offer and have a resident

accept an offer before the NRMP. They know it's going to go into an algorithm and there's going to be assignments given to them. Is that correct?

A Yes, that's correct.

Q In a -- as he indicated, in a free market setting, you know, I've interviewed for a lot of jobs. I'll say I've never brought up salary requirements in an interview setting. What I have often done is leveraged one offer against another offer. That's impossible in this setting, because residents are not able to receive offers before the match. Is that correct?

A Correct.

Q And after the match, they have to accept the position they're given with no ability to change possessions or leverage that offer to get a different position. Is that correct?

A Correct.

Q So while a residency program could theoretically offer a slightly higher position, it wouldn't be able to attract specific applicants that it viewed as uniquely competitive by providing them that higher salary offer and ensuring that they would come to fill that position. Is that correct?

A Correct.

BY [redacted]

Q You also discussed the exploding offer issue that, you know, existed in some form prior to the match. Could a solution to the exploding offers, or rather, could there just be a ban on exploding offers without the other requirements of the match? And in your view, would that address hypothetically that issue?

A That would be part of the solution. Exploding offers are, like, one egregious example of hospitals having, like, an insane amount of leverage over students.

However, there is other aspects to the match that could be streamlined. For example, there's really no logic for why there's a 3-week wait between, like, submitting preferences and receiving the match letter, because that algorithm takes maybe, like, a few hours to fully compute.

Q So in other words, you could address the exploding offer issue through a less restrictive alternative to the match?

A Yes.

Q And the exploding offer issue occurred in a market as we discussed in the first hour where there were far fewer residency positions than there were applicants, right?

A Yes.

Q And so in that case, you know, residency programs could have potentially, you know, go a year without an applicant if they don't act quickly to hire someone, right?

A Yes. I believe the exhibit stated that there is at that point when the match started, there was maybe 10,000 roughly residency positions of, like, 6,000 applicants. That ratio is almost flipped at this point, so it doesn't really make sense in this context.

Q So if the ratio is flipped, how do you think that would affect how frequently exploding offers would occur?

A So the programs have much more leverage against applicants because there's just simply fewer positions available.

Q And so, in that situation, the kind of incentive structure has reversed to -- and it may disincentivize the frequency of exploding offers?

A Yeah. It may disincentivize it or they may kind of add other caveats to the offer that would kind of make them attract certain types of applicants.

Q You also discussed confusion with the kind of baseline requirements for a

program to accept an applicant. Is that right?

A Yes.

Q And one of the reasons that there's confusion is because under the NRMP's guidelines, it is against their formal rules for an applicant to ask what do I need to do in order to get a commitment from this program, correct?

A So essentially, applicants are -- I mean, it's not even what can I do to get a commitment. They're legally not allowed to get a commitment from the program.

Q And not just get a commitment, but even ask about an implied commitment.

A Correct. I mean, that would -- if they tried to do that, that would constitute a violation, and according to that exhibit, they could just be unilaterally withdrawn from the process.

Q Right. And so as a result of that, that creates a kind of a wall from finding answers that would resolve the confusion about what the requirements would be to get exempted from the program?

A Correct.

[redacted] Go ahead.

BY [redacted]

Q Along these same lines, we discussed casting a wide net and setting kind of the baseline standards relatively low, and you were asked why a program couldn't set standards necessarily above that, and as you testified, while there is no hard limitation on input in practice they tend not to, that's because they need to ensure that they have a high enough pool of residents ranking them with all their systems to get matches to fill their positions. Is that correct?

A Can you clarify that one more time?

Q Absolutely. So part of the reason programs often set their baseline

standards a little bit lower is to get more applicants and more applicants ranking them on their rank-ordered list. Is that correct?

A Yes.

Q And that's because they couldn't put out, say, a 95th percentile on the test, interview one round of applicants if they did not fill out the positions, then lower those standards.

A Correct.

Q And so because of that, you have a much larger pool of applicants sending out applications to programs that are very unlikely to accept them, and it is very difficult for programs to identify which applicants are likely to rank them and fill their positions. Is that correct?

A Yeah, that's absolutely correct. I'll give you an example. I'll give your type of example. We had roughly four positions available for each cycle. We received about 400 applicants, and we interviewed about 40 of them, so at each level there was, like, a 90 percent cut for the number of students that were accepted, and for even interview, and then eventually that were ranked to match, and at each level it was a very kind of difficult process where you would have to sift through, like, many, many applications and it was unclear, like, which students were committing to attend the program or which ones had just, like, simply selected all and applied to every single program.

Q In your opinion, is it likely the programs often maybe cut more highly qualified applicants out of fear that they may not rank them on their rank-ordered list?

A Yes.

Q And so, as a result, you get one bite at the apple, and a program needs to put out as wide of a net as possible to make sure they get the largest pool of applicants in

that initial round knowing they can't go down the list?

A Correct. They have one opportunity to interview applicants, and if they -- for example, programs fail to recruit the right number of students, they suffer by having fewer residents, or actually this has happened in our program where they had to take a student through the SOAP program, and they knew that this person was essentially less qualified than someone they would have got through, like, the regular match.

Q So in that way, the NRMP structure directly incentivized programs to provide less information about what they'd like in an applicant. Is that correct?

A Correct.

BY M[redacted]

Q I want to talk a bit about the physician shortage, and in the last hour you talked about how one of the causes of the physician shortage is an aging population, right?

A Yes.

Q And one of the specialties that focuses on folks who are older is geriatrics, right?

A Yes.

Q Geriatrics is one of the specialties that is not as competitive as others, right?

A Yeah. Geriatrics is interesting, because there technically is a fellowship in geriatrics. However, most physicians who are practicing are going to have experience with geriatrics, unless, obviously, it's, like, pediatrics or some pediatric specialty. Most, like, subspecialties are going to have a part of their residency that's focused on the aging population.

Q But it's not as competitive as something like dermatology.

A Correct.

Q And for that reason, you know, sometimes folks choose other specialties with higher pay as -- instead of geriatrics. Am I correct?

A Yes.

Q If the residency programs have the ability to adjust their salaries so that there wasn't this uniformity, and -- could a geriatrics program incentivize a resident to -- or a resident applicant, to come to their program through a higher salary in a free market, and in that way address some of the issues associated with the doctor shortage?

A Theoretically, yes, they could, yeah.

Q But right now, as you discussed, the uniformity kind of makes that impossible?

A Correct.

Q I'd like to turn now to a -- go ahead.

BY [redacted]

Q I have a couple more. So using this last document we looked at in the previous session provided to you by minority staff, you read that the overall fill rate matching and SOAP processes combined was 99.4 percent. Is that correct?

A Yes.

Q I'd like to jump to the very bottom of the page under applicant placement rate in the last line beneath the paragraph where it says, In 2025 the active applicant placement rate was 84.2 percent and the all applicant placement rate was 79.3 percent. Is that correct?

A Yes.

Q So as you understand that, programs are filling 99.4 percent of their positions based on the NRMP's data, yet applicants -- active applicants are only placing at 84.2 and overall, the applicant placement rate is 79.3 percent. Is that correct?

A Yes.

Q So there are more applicants than there are positions. Is that correct?

A Correct.

Q In a free market, when there is a larger supply of employees than there is demand for their positions, what effect does that have on wages?

A Say that again. Sorry.

Q In a free market when there is a larger supply of employees than there is a demand for employees, what effect does that have on wages?

A It would generally decrease the wages.

Q Okay. I want to go very quickly back, and then we'll jump to the discussion you had. You said in some cases, resident physicians are able to meet three times the amount of service needs as nurse practitioners or medical professionals. Is that correct?

A That was just one example, but in general, they can see, like, equivalent number to midlevel practitioners, but they have fewer -- let me phrase it this way: When they hire -- when a hospital hires a midlevel practitioner, they have certain requirements, like they have to limit the number of hours they can work, they get certain PTO. They negotiate like a regular contract, like a regular person, versus residents are bound by that really specific contract, so they have to work more hours, they're not guaranteed certain benefits as equivalent to a nurse practitioner or another midlevel provider. So in practice, a resident will be working more hours and probably seeing more patients because they have less restrictions on how much they can work.

Q Would you say that on average, a resident contributes at least as much as a midlevel practitioner in this area?

A Yes.

Q Do you happen to know what the average, again, roughly resident salary is?

A Roughly $65,000 per year.

Q Do you happen to know what the average salary of a nurse practitioner midlevel person in this area is?

A I do not, but I can estimate if you'd like me to.

Q If you have a rough estimate.

A I'd say roughly 95, 90 to $95,000 per year.

Q Okay. So at minimum, they are as valuable, yet are getting paid sometimes two-thirds to a half as much money. Is that correct?

A I would say that's accurate.

Q Okay.

[Hussain Exhibit No. 6
was marked for identification.]

[redacted] I'm going to turn to another document. This is the ACGME's common program requirements for residency programs. It will be marked, I believe, as exhibit 6. Is that right? Effective July 1st, 2025. Feel free to review the document. You can familiarize yourself. Let me know when you're --

Dr. Hussain. Yeah. Is there a specific page to go to?

[redacted] We'll start at page 5.

BY [redacted]

Q I'm sorry, I do just have a couple more questions that have come to mind. We discussed the training that residents undergo when they're in this program. Is that correct?

A Yes.

Q All right. I understand you've spent most of your life in the medical field, but is it your understanding that most employees undergo some training when they enter

a job for the first time?

A Yes.

Q Is it your understanding that those employees get paid for that training normally on the level that they'll receive a couple months down the road when they are doing things on their own?

A Yes.

[redacted] Wonderful.

BY [redacted]

Q All right. So are we at page 5 of the common program requirements?

A Yeah.

Q And to be clear, residency and any fellowship programs must comply with all ACGME requirements to receive accreditation. Is that correct?

A Generally, yes. There's some exceptions, but most of them, yes.

Q On page 5 under the header 1.7, workforce recruitment and retention, it reads, "The program in
partnership with its sponsor institution must engage in practices that focus on mission driven ongoing systematic recruitment and retention of a diverse and inclusive workforce of residents, fellows, if present, faculty members, senior administrative GME staff members, and other relevant members of its academic community," in parentheses, (core.) It says, "Background and intent, it is expected that the sponsoring institution has and programs implement policies and procedures related to recruitment and retention of individuals underrepresented in medicine and medical leadership in accordance with the sponsoring institutions mission and aims." Do you see those words?

A Yes.

Q Based on your experience as both a resident and admissions committee,

how is this requirement implemented in practice?

A It's a very vague requirement, so different hospitals will interpret that language essentially in however they see fit, so there's not a uniform way that it's used.

Q In your experience, how has -- sitting on an admissions committee, what's -- how did you interpret it and what steps were taken to kind of comply with it?

A So we were -- when students applied to the position, they were asked to write an essay about why they'd like to be in the program, and then during the interview they were asked about how they would contribute to, like, a diverse workforce, and that answer they gave would inform how we would rank them. It was -- partially it would be about their specific experiences that would -- that they would talk about, but also how they would contribute it to, like, a diverse experience in the class overall.

Q Would your program take steps to hire specific applicants because they contributed to a diverse and inclusive workforce over other applicants?

A So this was considered to be off the record when we discussed it in the committee. Our program director said they weren't legally allowed to say this. However, dermatology is pretty heavily female dominated. It's about 70 to 80 percent female compared to about 20 percent male, so we were told that we should give more preference to male applicants even if, like, legally we weren't supposed to do that.

Q And were there other underrepresented groups that you preferred above others because of this ACGME requirement?

A Maybe not underrepresented, but we were also told to give preference to people that had ties to the D.C. area, so, like, people who were from the region, we were, again, more like -- they're more likely to rank us as a higher rank, so for that reason, we were supposed to give them more preference.

Q Do you have concerns with the ACGME terminating a residency program's

accreditation because it does not sufficiently recruit, retain a diverse and inclusive workforce?

A I have concerns because, again, the language is so vague that I would -- they would need, like, specific guidance on what they were not fulfilling and why that was a reason for it to lose their accreditation.

Q Across the board, if a program, just generally speaking, a program, you know, given how vague this terminology is, loses their accreditation because in the ACGME's estimation they're not fulfilling this requirement. Do you view that as a good reason for an accreditor to terminate a residency program?

A That in itself should not be the reason to lose accreditation unless there were other issues that the ACGME also addressed.

Q And to be clear, the ACGME can terminate a program for failing even one of its requirements.

A I see. Okay. I was not aware of that.

Q I am asking you.

A I'm not aware of the specific grounds for termination of a program. I would have concerns if this was the only reason they cited for terminating a program.

Q Sure. Should residency programs in rural areas, for example, lose accreditation because they're unable to hire a sufficient number of individuals underrepresented in medicine?

A I don't believe so.

Q And in your experience, is it more difficult in some instances for programs to hire people from different backgrounds if they're a patient population? For example, in an area of the country is not reflective of those applicants?

A Yes.

Q And can you explain what that would look like.

A So, for example, there's a few residencies that see a high proportion of Native American patients, like on Tribal reservations or they work with a local Tribal community. There's very, very few applicants that are, like, medical school applicants that are Native American by heritage. I can maybe think of, like, one or two people I know personally. That's it. So it would be very difficult for a program to hire a residency pool that reflects the demographic of their program. That's just one example. There's other examples of that happening as well.

Q And you'd say there's a lot of value when a resident or a physician has similar background as the patient that they're caring for, right?

A Yes.

Q And so, if there is a requirement that a residency program has to hire someone from a background that doesn't reflect the patients they're caring for, that could interfere with the quality of the care that they provide.

A Yeah. I believe it should be an applicant's specific decision. It should not be a broad estimation. The program can make their own decision of which -- if the resident is best to care for their population.

Q And would you say it's fair to say that this requirement, rather than being an applicant-specific requirement, is a group-based requirement?

A I would say that, yes.

Q If a residency program is terminated because it is not diverse enough, how could that affect the availability of residency positions to aspiring doctors?

A It would decrease the number of potential residencies.

Q And so doing, how would that contribute to the doctor shortage?

A It would definitely worsen the doctor shortage as well, and depending on

where this occurred, if it, for example, occurred in a rural setting, that would also compound the geographic distribution problem.

Q From your understanding of rural programs in the United States, the patients that they care for, would you say that those tend to be a diverse populations or not? And if you don't know, that's okay.

A It's hard to say, because again, this language is so vague. So there's diversity of different aspects of someone's identity, whether it's their language, their ethnic background, their religion. There's various different ways you can define that. So the main issue I have with this is just how vague the language is.

Q Let's take an example. Wyoming you referred to in the prior hour as an area where there isn't a dermatology program.

A Yes.

Q And Wyoming, in terms of racial, just diversity, is not a very diverse State, correct?

A I'm actually not familiar with the demographics of Wyoming. I could assume that it's majority Caucasian with some Native American as well being the major ethnic groups.

Q And so a program in Wyoming hypothetically may have a lot of difficulty bringing in, by some definitions, more diverse applicants to that program. Is that correct?

A They may have challenges with that, although it's hard to specify, because currently it's speculation there's no actual residents programs there.

Q Let's turn to page 18 of the document towards the bottom of the page under the header 3.4, resident complement, it reads, "The program director must not appoint more residents than approved by the review committee." Do you see that?

A Yes.

Q In other words, the ACGME, through its review committees, controls the specific number of residents that a program can have, correct?

A Yes.

Q Okay. Do you have experience with this requirement as part of an admissions committee, and how does that factor in to whether or not you'll add residents or subtract residents from your program?

A Correct. So every cycle, there's a -- we're told explicitly this is how many positions are available, so we are essentially choosing -- when I was a senior resident, we had four positions available, so we have basically our top four applicants, and when we were in the committee discussion we would all have our top four, and that's how we would plan on how we would recruit the students. And this was made clear essentially at the beginning of the cycle, so it also informed how many interviews we conducted and how many applicants we invited for that process.

Q Do you have more resources as a program or do you have enough resources to add additional residency spots in your view?

A This is the other challenge that the -- in order to comply with the ACGME requirements, as I testified previously, you have to meet certain procedural requirements, so certain programs are much more able to meet some procedures rather than others, so, for example, one of the requirements is, as I was saying, it was three nail biopsies. I probably did more than three during the residency, so for example, if I had done nine, then two other residents could have also done three and all three of us could have met the procedural requirement. I can't point to the exact numbers, but that's just one example.

There's other procedures where it's much more difficult to receive, like, multiple X

the number. For example, doing 50 surgeries is one example as well. Some residents might do 51 and barely meet the limit. Others be do 100. So the problem is that the guidance is so varied that depending on the specific procedure, you may not meet the requirements in some cases but then be very much above it in others.

Q In the prior hour, you talked about how kind of the touchstone for accreditation requirements, or for the educational requirements for a program should be the kind of makeup of the experiences and the type of work that a physician does so that they have exposure to a lot of different types of procedures, and things like that. Is that right?

A Correct.

Q Is that a fair articulation? Given that kind of understanding of what a program needs in order to be successful, do you think that your program, for instance, does that so that it could hire, you know, five or more residents compared to the four that it is currently authorized by the ACGME?

A I believe they could fit more residents, yes.

Q Okay. And given America's growing doctor shortage, do you believe that an accreditor should limit the number of residency positions that a program can have?

A I believe there should be some limits, because there is an issue of overstaffing. You may have not enough procedures for all the residents, but the exact number as it stands is quite arbitrary, and I believe there should be some ability to negotiate above the current limit that exists.

Q Can you think of any other market in the United States where there is a body that tells employers in the market how many employees they can have?

A Off the top of my head, I can't think of one.

Q How do you think the ACGME's accreditation requirements, kind of generally

speaking, affect the medical residency employment market?

A They definitely limit the number of opportunities available. I think the goal is to provide confidence that a doctor who graduate have a certain modicum of experience and ability to practice medicine. However, in practice, it essentially limits the number of students that can become doctors, and this is as a side note, there is more medical schools being built every year, there's more positions being added to medical schools.

However, there is still the bottleneck where you can add, you know, 300 extra medical students, but without extra medical residencies, you're not going to be able to address that doctor shortage.

[redacted] Would you agree that there is a distinction between needing minimum requirements for education and specific minimum requirements for education?

Dr. Hussain. Yes.

[redacted] Would you agree that there can be specific minimum requirements for education that exceed those necessary to turn competent doctors?

Dr. Hussain. Yes.

BY [redacted]

Q Do the ACGME's accreditation requirements make it harder for smaller or rural residency programs to operate?

A Yes.

Q How so?

A So going back to, like, the minimum procedure requirements, they may not see certain rare conditions because they're practicing in a rural community where patients may only be coming in for certain different types of conditions. So if they're not seeing those specific cases, they're not going to be able to meet those procedural

requirements and then they're not going to have enough to graduate.

Q Which requirements do you think are the most burdensome on programs?

A I would have to review the individual requirements for each of the residencies, so I'm not sure at this time.

Q Can you think of just a few examples that you've encountered? And it's okay if you can't.

A I'm not sure at this time.

[redacted] Go ahead.

[redacted] Would you agree that an accreditor's decision to remove requirements is likely indicative that those requirements were not necessary in the first place?

Dr. Hussain. It could be a sign that they're not necessary or that they realize that the requirements were not really providing any benefit to the programs that did have them.

[redacted] But the cost of those requirements outweigh the benefits.

Dr. Hussain. Correct. I'll give you an example. There is a -- I'm part of the American Contact Dermatitis Society, so we specialize in allergy testing, and there was a discussion at our previous meeting whether to add an allergy testing requirement to residencies in order to graduate. That currently does not exist. About 20 percent of residencies don't have an allergy testing program.

However, I would not be in favor of such a position, because in practice, I'm one of very few people that practice allergy testing, and there was not a necessity that every single resident has to be, like, a certified allergy provider, so just giving one example of an -- of a requirement that was considered, but I would not be in favor of.

BY [redacted]

Q Can you describe how losing ACGME accreditation affects a residency program.

A If their accreditation is revoked, they're essentially not able to comply with licensing requirements in many States, so any student that goes to that program is going to have difficulty becoming board certified or becoming any kind of practicing physician after residency.

Q And if you lose the ACGMA accreditation as a program, you also lose access to CMS funding, correct?

A Correct.

Q And so, in effect, generally speaking, if you lose accreditation, you have to shut down the program?

A You may have to, although there is a few exceptions where they have private equity funded residency programs. They're basically for-profit hospitals that fund it. It's kind of unclear how good quality those programs are, so that's the challenge where if they don't have funding from the ACGME, they have to seek outside funding. And it's unclear the conflict of interest that may occur when that occurs.

BY [redacted]

Q Does the ACGME have other accreditors that it competes with?

A Theoretically, there used to be the American Osteopathic Association, which was for osteopathic residencies. However, as of 2020, those bodies have merged, so now there's really mainly the ACGME.

Q So the ACGME merged with its only competitor. Is that correct?

A Yeah, correct.

Q Is there another way to get GME funding except through ACGME accreditation?

A I am not familiar with any ways.

BY [redacted]

Q I want to circle back to something you just said that's fascinating. There are private equity firms that run residency programs, right?

A Yes.

Q And logically speaking, they see a financial benefit in having these residency programs, right?

A They must. I mean, that's the whole logic behind private equity.

Q And how -- exactly. And how often, or how many programs? Are you aware? What's the scale?

A I'd say very few. I'd say probably for each specialty maybe very few.

Q Okay. Okay. Can you describe, you know, when programs in rural and undeserved areas lose ACGME accreditation, how does that affect the distribution of doctors across the United States?

A It is challenging to recruit doctors to rural areas already, and one of the biggest predictors of practicing in a rural setting is doing some training, or being from that rural setting. So if a program in a rural setting has a residency, there is a higher probability that anyone who completes training is going to stay in that same area, whether it's for comfort reasons, they have a family, or the hospital gives them a nice contract and they like them. But if that hospital does not have a residency, then there's even less likelihood that someone from outside that program would end up wanting to move there.

Q I want to discuss the current statutory antitrust exemption that shields medical residency match from antitrust groups. And to do so, we want to talk about the next exhibit, which is an article that you wrote in The Hill a number of years ago, and this

will be marked as exhibit 7.

[Hussain Exhibit No. 7

was marked for identification.]

BY [redacted]

Q This is an article you wrote for The Hill on November 10, 2022, titled, "To Fix the Doctor Shortage You Must Create New Pathways For Residency." Do you recognize this document?

A Yes.

Q Let's turn to page 2 once you've had a second to look at it. Now, on page 2, you say the medical education system is in crisis. By 2034, the American Association of Medical Colleges, AAMC, predicts a shortage of between 37,800 and 124,000 physicians in both primary and specialty care. This shortage is especially pronounced in rural areas and communities serving marginalized populations. You see those words?

A Yes.

Q Could you explain how the growing doctor shortage has and will continue to affect the United States just generally?

A So generally what's going to happen is that there is going to be a tier system where people who live in areas where there's a high access to physicians, so D.C. area being a good example will have much more easy access where they'll be able to get kind of access to great healthcare. But you'll have a lower tier in these other areas where it will function similar to, like, basically other countries where there's long wait times or patients have to pay exorbitant amounts to get healthcare because their doctors are not going to be part of their insurance plans, and you're essentially going to create more issues with chronic diseases or diseases that are progressing rather than treat it early, which is actually going to burden the healthcare system further in terms of cost, and then

you will also have kind of decreased quality of life, decreased life expectancy as compounding effects on top of that.

Q What does the doctor shortage look like in your specialty now and kind of going forward?

A Dermatology right now there is a -- in most places you might have, like, a between three and six-month wait time to see a dermatologist. Again, that time period is not as bad in the D.C. area, but again, if you go to Wyoming, you may have to drive outside of the State to see a dermatologist.

My friend is actually a dermatologist in North Dakota and he's one of, I think, five in the whole State, and he routinely has people driving six, seven hours to see him, and right now he's considering closing up shop. At that point, if he shuts down his practice, that's a 20 percent reduction in the number of dermatologists in North Dakota. And as the shortage gets worse, you're going to have elderly doctors retiring, and not enough younger doctors to replace the retiring group, and you may have some of that care being replaced by midlevel providers, like nurse practitioners or physician assistants. However, those providers still need usually a supervision from a physician, and that will be less and less available.

Q Just out of curiosity, your friend in North Dakota, did he do residency in North Dakota?

A He actually did medical school in North Dakota and residency in Georgetown with me.

Q Okay. But he went back there. Was he from there?

A He was from there, yep.

Q Okay. Gotcha. How does the doctor shortage affect physicians trying to meet demand?

A It's challenging, because a lot of hospitals or clinics will have a pressure to see a high number of patients. Part of that is also compounded by there is reimbursement cuts every year as part of the -- there's, like, a doc fix that goes through Congress. Some years it doesn't happen, and then inflation goes up, Medicare reimbursements go down. So in order to meet demand, or to basically make ends meet, doctors are seeing more and more patients to accommodate that.

So on an average day, like, I'm a dermatologist. I might see 35 patients in a day. And as I was mentioning before, the average time for a visit is, like, 10 to 15 minutes. And part of that is because I often feel bad if patients have to wait more than a week to see me, because they have, like, urgent conditions that need treatment, so I'll feel pressure to add on more patients rather than have them wait, like, six, seven months to see me.

[redacted] Now, you know, I know you and almost every other physician tries to offer the highest quality of service possible, but does having to meet a larger number of patients within the same period of time decrease the quality of service you can provide to each patient?

Dr. Hussain. I would not say that it decreases the quality of care to the patient. However, I'll say it worsens my quality of life as a physician, because I'm more stressed that I want to take care of them as best I can and I'm worried that if they can't get an appointment, I'm, like, what's going to happen to them in the future, so it doesn't -- it doesn't affect the patient directly, but it more affects the providers that are responsible for them.

BY [redacted]

Q What are ways that the doctor shortage affects patients? You talked about access, but can you expound on that?

A Yeah. For example, there is a big shortage of endocrinology in this area. I would say that I had a patient literally this morning that had a thyroid problem and, like, a vitamin D problem, so they're, like, 12 years old so I told them that, you know, I can help you with some of this, but you really need to see a specialist and I referred them to an endocrinologist. The endocrinologist might see them after six months. So some other doctors may have to at least do some of the care to, like, hand off that, but the patient's not going to get the true, like, specialist evaluation for, like, several months down the line and their health problems are going to compound on top of that.

Q Turning back to the document here, in the next paragraph, you state, "Faced with the stresses of both a growing population and an increase in the number of retiring physicians, action must be taken to ensure the future of American healthcare. Then you call on Congress to repeal the antitrust exemption granted to the residency match process for medical school graduates and allow for alternative certification pathways." Do you see those words?

A Yes.

Q Could you explain why you believe that repealing the medical residency antitrust exemption would be a good step towards addressing America's doctor shortage.

A Yes. The main reason I support this is because it seems that this was just added to kind of appease the specific lobby. The problem is that increasing competition essentially means that you're allowing more pathways for people to become physicians. You're not changing the existing pathway.

The match will still exist if it wants to, and if there is a market for that, people will still go through that process, but the problem is that being the only pathway limits the number of opportunities for people that can go through the match or they need to fill positions like during the other cycle, so essentially that the -- this antitrust exemption was

passed at, like, the 11th hour, a rider to a previous bill without any discussion from Congress, so it was not really discussed properly, and it was added, and it's been stuck in this kind of limbo for the past almost 20 years.

And as this has happened, the doctor shortage has compounded. There's really no other way for people to become physicians, so I believe that repealing the specific proposition would allow more pathways and then the market could determine what's the best way to make certification happen.

BY [redacted]

Q As you said, repealing this antitrust exemption would not abolish the match, would it?

A Correct. I mean, as long as they were still complying with legislation, they could allow -- be allowed to continue and students to still go through it.

Q In fact, all it would do is open the match up to antitrust scrutiny. Is that correct?

A Correct.

Q Antitrust scrutiny is applied, in most days, I would say, the market with a few exceptions. Is that correct?

A Yes.

Q And I know you're not an antitrust expert by any means, but are you aware that during the antitrust process, parties are able to offer procompetitive justifications for their behavior?

A Yes.

Q Wonderful.

BY [redacted]

Q What do you mean by in the document here by allowing for alternative

certification pathways?

A So, for example, instead of this one-size-fits-all approach where medical students have to go through the match and then residency, and et cetera, there would be other ways for them to demonstrate competence and become a physician, so the most obvious example of this is foreign graduates, so right now, foreign graduates, as the law currently stands, they have to finish a ACGME requirement like, a required -- sorry, accredited residency in order to become a board certified dermatologist. So I have a colleague that --he's from France. He did a dermatology residency and a surgery fellowship in France. When he came to the United States, he had to repeat the dermatology residency and the surgery fellowship, so basically 5 years of kind of wasted education and where he was actually more experienced than the people training him, and then now is allowed to practice as a dermatologist. So it just seems like you're wasting a lot of talent, and this is just one example of how, like, if someone has demonstrated competence and an expert already in another country, for example, they have to just demonstrate competence. They don't want to have to go through that arbitrary training period in order to become a dermatologist.

Q Let's turn to the next page, page 3, and in the third paragraph you state, "In 2022 alone, thousands of graduating U.S. medical students went unmatched via the National Resident Matching Program, NRMP match system, effectively preventing them from practicing medicine unless they can find an unfilled position, switch to a different specialty, or reapply the following years." Do you see those words?

A Yes.

Q Can you explain how the problem of unmatched doctors, and we've talked about this before, but how that problem affects America's doctor shortage.

A So you have roughly 2,000, roughly 2,000 I would say, like, residents, or

students each year that fail to get a residency position, so for these students they have finished medical school, they've likely finished all the qualification requirements to become a physician, but they're not able to essentially become a physician.

So in most job markets, if you are not able to get a position, you can either negotiate for a different one or you can switch to a different specialty, but for medical students there's really no other pathway for them. They can't really become a physician unless they have to go through this one unified pathway, so they have to either switch to a different career, whether it's, like, research or consulting rather than actual practicing medicine, or they essentially have to waste a year of their time and, you know, expenses and then reapply for the following year.

And as I mentioned, they may have an even lower chance of matching the subsequent year because of that kind of stigma of not matching the previous cycle. So that essentially compounds, and those students are basically well qualified to be a physician as long as they had a position to be, but they're not able to get a position. Therefore, they can't practice.

Q And these folks, they, in many cases, have lots of debt from medical school.

A Correct.

Q And the application process, as we've discussed, is expensive as well?

A Yes.

Q And their chances of applying -- or of matching in subsequent years is not as high as the initial year, right?

A Right. And maybe the same or less than previous years.

Q Do you think that this just arduous process may deter folks from even going to medical school in the first place?

A Absolutely. That was the next thing I was going to say is that the problem

is that students basically have no guarantee of becoming a doctor, and that's really the problem. Like, I have family members from India and other countries, and the first thing that when medical students here apply, they're, like, Oh, I hope I can become a doctor. They're, like, you're a medical student, why can't you? They're, like, if I don't match, then I can't become a doctor. They're just, like, most people can't fathom that system, and it's just, like, when you finish medical school, don't you have an MD? It's, like, yeah, you do, but if you can't do residency, then you can't see patients or do anything.

So it's just such a weird kind of limbo where you can be qualified and finish medical school and everything, but without this kind of arbitrary training period or the specific way to do training, you're not able to actually see patients.

Q You state that unmatched doctors often have to reapply the following year through the match process. Would allowing applicants to secure residency positions outside the match improve this process and kind of allow them more access to positions?

A So what I'll say is that they are allowed to, but once the match is over, they are allowed to go through, like, unmatched or outside the match positions. I think the challenge is that they should be allowed to do this really at any time, and as we were discussing, the NRMP law, or NRMP contract that they sign prevents them from doing that during the match, so essentially they finish the match process, the match process is over, they haven't got a position, and now they have this really limited time to find another position whereas if they're allowed to do this kind of in a normal time period throughout the year, they would have more leverage or just more opportunities to find positions.

Q You mentioned the antitrust exemption. Are you familiar with the lawsuit that kind of led to that antitrust exemption?

A Are you referring to Jung versus AMC?

Q Yes.

A Yes.

Q What were the concerns of the residents in that 2002 lawsuit?

A I have to review the exact text of it, but I realize the gist was similar to this position where residencies essentially have a monopoly on the number of training positions and that residents were not allowed to negotiate for certain conditions in their employment.

Q More than 20 years later from that suit, do you believe that the medical residency labor market has become more or less competitive?

A I would say less competitive.

Q In what ways?

A So as your colleague mentioned, the American Osteopathic Association, which was the only main competitor in today's ACGME, has now merged, so the main kind of alternative certifying body no longer exists as an independent body. They have essentially become part of the same practice, and the number of positions for residency has essentially stagnated while the demand for physicians and the number of medical school graduates has also increased. So those factors all come, in a combination of ways, have worsened the shortage.

Q Let me see here. Now, currently the ACGME accreditation is the only way for residency programs to receive Federal GME funding through Medicare and Medicaid as we discussed prior -- earlier. If residency programs could receive Federal funding through an alternative means of accreditation, how would this affect the total number of residency programs and positions in the United States?

A It would likely increase the number. Depending on what those new requirements were, you may have different types of programs that were able to receive

the Federal funding, and then that would, in turn, allow more doctors to be trained in those programs.

Q And until recently, as we discussed, the American Osteopathic Association accredited osteopathic residency programs separately from the ACGME, what does this tell us about the feasibility of an alternative means of accreditation?

A It seems like it would be a reasonable proposition.

Q Okay. Now -- go ahead.

[5:40 p.m.]

[redacted] Do you want to --

[redacted] I'm trying to --

BY [redacted]

Q Are you aware that there has been an increasing rise in unionization amongst medical residents in recent years?

A Yes.

Q Unions typically come into existence, at least theoretically, to address low wages, poor working conditions, things of the like. Is that correct?

A Yes.

Q As we've established, in your opinion, the Match process leads to lower wages, worse working conditions, less negotiating power. Is that correct?

A I'd say it's -- the Match is part of the issue, but it's also the ACGME's, like, overall structure.

Q Certainly. So the overall structure of this market in some ways could be contributing to this increasing unionization. Is that correct?

A Yes.

Q And is it your understanding that unions typically form amongst students or employees?

A Employees.

BY [redacted]

Q I want to turn to the prepared statement you read -- you read the introduction to at the beginning of your time here. And I'd like to turn to page 2 if you have that there. It's exhibit 1.

At the very bottom of page 2, the sentence that goes into page 3, you say, "During

my residency at," and then going to page 3, "MedStar/Georgetown combined program, I experienced firsthand how ACGME requirements imposed excessive burdens that hindered effective training and workforce solutions. For example, a single dermatology resident was sometimes responsible for managing inpatient consultation services at three separate hospitals -- Children's National, MedStar Washington, and Georgetown Hospital -- spending hours daily commuting in traffic between sites. This grueling workload compromised our ability to focus on patient care and education. When residents raised concerns about being overworked in ACGME surveys, the response was an ACGME site visit that, rather than allowing the program to recruit additional residents, imposed additional documentation requirements. These mandates increased administrative burdens without alleviating workload issues. Furthermore, the program was barred from expanding resident slots until it demonstrated that existing residents performed a minimum number of certain procedures, despite these thresholds being arbitrary and uncorrelated with technical proficiency. Such policies limit the ability to scale training programs to meet workforce needs, particularly in underserved areas."

Do you see those words?

A Yes.

Q First, could you just provide more context and details of what happened in this specific instance?

A So, as I stated, there was three major hospitals that we see inpatient consults, meaning that the patients admitted to the hospital. You take care of a lot of their needs there. You're -- as a consultation, meaning that you're a specialist, so they're addressing like a specific concern with you. In practice, that means that a lot of these patients have like severe skin problems, like severe burns, or other life-threatening conditions. So you're spending many hours for each patient.

And the challenge is that you're not physically onsite for a lot of these cases. Because there's one resident managing two and sometimes even three hospital systems, there might be life-threatening conditions at several places. And instead of being present at the bedside of the patient, you might be at another hospital or dealing with an urgent call somewhere else.

So it just created an additional stress where like -- you guys have all probably driven through D.C. traffic. It's -- like you want to focus on patient care, but then I'm worried am I going to get called while I'm traveling to another site. So it just added like an additional stress on top of the workload.

There was also just challenge where we were responsible for nonphysician tasks, as I mentioned. So keeping the supply rooms at three different hospitals stocked with supplies, ordering extra biopsy kits, if needed. So this added additional documentation requirements that essentially made the residents overworked.

So the problem was the residents tried to raise this issue, saying that they potentially worked more than the 80 hours, or other ways that they essentially went over the ACGME limits on how many hours they could work in a specific week or month. The program was hit with a sanction. And the way that works is the ACGME's only real penalizing tool is either to put the program on probation or to do a site visit, which they did the site visit.

We had to -- basically, someone from the ACGME came to the program. They interviewed us about our experiences. And the issue was that raising any kind of substantive concerns would end up just harming the program. Essentially, what happens is if I'm like -- I'm getting overworked, I feel like it's unsafe for patient care, the worst thing the ACGME can do is actually shut down the program. So if that happens, then you're out of a job. You have to go find a program somewhere else and you're

back to square one with the whole residency process.

So it's really -- there's no incentive for students to raise any concerns or even -- sorry, for residents to raise concerns, because essentially the only thing that's going to happen is that the ACGME will force the program to meet certain requirements, saying that residents are actually not overworked, looked like the survey responses have improved this year.

And obviously, when they say that, the program will say that, you know what's going to happen if you write the truth on these surveys. The program is going to get in trouble. So you're essentially incentivized to write more like rosy-colored opinions of the program to ensure that the program keeps functioning.

And dermatology, I will not say that is the most demanding specialty by any means. We had a relatively decent work-life balance as a resident, and I can't imagine what this is like for like neurosurgery or surgery residents.

Q So you would say it would be better if there was perhaps more stages where a program, instead of just going on probation or the accreditation being withdrawn, there could be kind of more due process in a sense so that issues can be addressed without residents fearing that they're going to lose their job in the program entirely?

A Correct, yeah. I think right now there's -- it's like a one-size-fits-all approach. Basically, is the program compliant? Yes. Then continue as status quo. Is the program not compliant? Then you get all these sanctions.

There needs to be some kind of, like, middle ground where we can address specific issues. Like, if there's not enough residents, we can add a resident, or we can like adjust the workplace conditions without having these kind of binary decisions.

Q And the -- your program tried to get additional residents to kind of fill this -- to kind of fill the gap, correct, in this instance?

A Yes.

Q And they were denied by the ACGME?

A Yes.

Q And, you know, why were they denied specifically?

A They -- they mentioned that -- I have to -- you would have to confirm with the program director. We're actually not allowed to read some of the guidance, because they often have, like, kind of private employee data about how certain residents are performing.

There were some concerns that some residents weren't performing up to standard. So, essentially, the program was -- they were told that if you can't even train like this number of residents competently, how can you possibly train more residents?

And then the issue was the residents were not being trained well because they're overworked. So there's really -- it's kind of like a catch-22 where you try to fix one problem, it creates another problem.

Q Do you feel like -- what changes could be done to the way that ACGME handles this that would kind of allow for more due process and more flexibility?

A I think the main issue is that there's just one body right now that goes through everything. So having an alternative body, even a third party that basically assigns accreditation separate from the ACGME or has a way to address specific workplace concerns would add another layer to this.

Because right now, the ACGME has just so much power over the process that there's really no incentive for programs or residents to really raise any concerns about the issues. Otherwise, they themselves are going to be harmed by raising those issues.

Q Okay. Turning to page 4, in the middle of the first paragraph --

A I should have numbered these pages.

Q It's the next page. In the middle of kind of the first big paragraph, in the sentence that says, "While these systems appear to offer alternatives to the NRMP."

Do you see that?

A Yes.

Q It says, "While these systems appear to offer alternatives to the NRMP, they are not entirely independent. Both the SF Match and the AUA Match must align with ACGME accreditation standards, as their programs are ACGME-accredited, and they often coordinate with the NRMP to ensure compliance with broader residency placement policies, such as those governing applicant eligibility and program participation agreements."

Can you describe the nature of this kind of coordination between these various matches in the market and what that looks like?

A So this -- I use these examples as ways that they don't go through the standard NRMP match, but they still follow the ACGME requirements. And the problem is that there's really no way around the ACGME requirements in the current system.

So the SF Match is for ophthalmology. The AUA Match is for urology. They have a different timeline on how they select students. They apply usually at an earlier timeline. They get the results usually in like January of the calendar year, and they're committing to that one specialty.

Historically, there was some requirement where they had to submit a Match application even if they knew they were already going to go through the other system. Now, I think that application has been -- that process has been streamlined a little bit. But, essentially, that even though they offer a different placement algorithm in terms of matching, they still have to align with ACGME accreditation for the actual residency positions.

Q So, in other words, even though there's separation, there's still coordination between this kind of medical establishment web that means that the requirements are basically the same for the market?

A Correct.

Q All right. Let's turn to the next page, page 5. In the last section, under the heading "The NRMP and Resident Compensation," starting with the sentence that says "The NRMP's 'all-in' policy".

A Yes.

Q "The NRMP's 'all-in' policy, which requires programs to offer all available residency slots exclusively through the Match, eliminates alternative pathways for filling positions, such as a direct negotiations or independent recruitment. This policy harms residents by locking them into a system where programs face no competitive pressure to improve salaries or working conditions, as they are guaranteed a pool of applicants through the Match. It also disadvantages hospitals and communities seeking to address local shortages, as they cannot bypass the NRMP to recruit talent directly."

In other words -- so, first of all, do you see those words? Is that correct?

A Yes.

Q Okay. In other words, the all-in policy basically means that a residency program, if they are going to enter the Match, have to fill all of their positions that they're intending to fill through the Match, right?

A Correct, yes.

Q And can you describe what the market looked like before this all-in policy?

A Before this policy, they're -- as I testified previously, they were essentially -- hospitals could negotiate directly with medical schools, with students in medical schools. So if a student was graduating in a certain year, they would know that

they're going to be available to work at this time. So the hospital could give them a contract for that year starting whenever they want. And they could basically have a residency where they could essentially, again, negotiate directly with students or with medical schools.

[redacted] This all-in policy operates as the type of exclusivity agreement. Is that correct?

Dr. Hussain. Correct.

BY [redacted]

Q And in the kind of pre-all-in policy market, if a program wanted to hire an applicant before the match or outside of the Match, they had the freedom to do so even if they had some of their applicants through the Match, correct?

A Correct, yes. So, for example, if we're looking at Georgetown with four positions, they would be not allowed to hire like three through the Match and one outside of the Match. They would have to offer all four through the Match or none at all.

Q And do you think that there -- were there a lot of programs that wanted to do this that it was helpful for them?

A Are you talking about the current time or the --

Q Pre-all-in policy. Did programs hire some applicants outside of the match?

A It's hard for me to comment because it was the 1950s, so I'm not as familiar with the training back then.

Q Okay.

[redacted] So, just to confirm, if a program put a position through the Match, it didn't get filled, put a position through the SOAP and it didn't get filled, they could not on the back end then hire a resident through their own private practices because of this

all-in policy. Is that correct?

Dr. Hussain. So if it's after the Match occurs, I think the ACGME has an exemption where if you tried through the Match, then it's after the end of the process, then you are allowed to go outside the Match.

BY [redacted]

Q But during the Match and prior to the Match --

A Correct, during the process you're not allowed to.

Q And you talked about how this policy harms residents by locking them into a system where programs face no competitive pressure to improve salaries.

Could you describe kind of what that looks like?

A Sure. So, for example, if a residency says that we need to fill, you know, five spots and, you know, these -- the -- three of the spots we want to offer through the Match we're going to give this contract. But the two spots that we want to hire, they're going to be slightly different. We want to make them work at this like underserved hospital. We want them to work in this other clinic that's more difficult, but as a benefit we'll maybe give the resident like a better salary or like more PTO or something like that.

As the current law stands, that would be illegal. They would have to offer the exact same contract to all five residents. So they are not able to make adjustments for, like, specific things. Essentially, all residents have to do the same training, even if there may be some differences in what the program would like them to do.

Q And finally on this issue, do you describe -- so the all-in policy basically says that -- has the effect of including more positions ultimately under the NRMP?

A Yes.

Q And so can you describe the effects that that gives to the NRMP's market power over the medical residency market?

A It gives them essentially a monopoly over the market, because they are the one and only place where majority of -- vast majority of residencies go through.

So as programs are committing to that all-in, they are not allowed to use any other recruitment tools unless it's like outside of the exemption that they're granted. So the NRMP essentially controls the supply of physicians that are available.

Q If the all-in policy didn't exist, do you think that your program would potentially look outside the Match to fill some of its spots?

A Potentially, because then we would have -- if there was like one hospital that was in like high demand, you could recruit someone specifically for that position.

Q The last thing that I'll ask about here real quickly is, in the same paragraph at the tail end here, starting at, "When the University of New Mexico Neurosurgery Residency". It says, "When the University of New Mexico Neurosurgery Residency Program closed and eight residents left the institution, the university hired nearly three times the number of physician assistants to match their workload, indicating that neurosurgery residents were profoundly overworked."

Could you just expound on that particular instance a little bit more?

A So neurosurgery is -- I chose this example because they're one of the only specialties that has an exemption to the 80-hour limit on residencies. So neurosurgery residents are allowed to work more than 80 hours per week.

And to be, like, candid about it, it's like no sane person would do that in a normal job. So, essentially, when they had to close the program and neurosurgery residents left, they said, okay, now we have to have someone fulfill these positions, let's hire some physician assistants.

And the physician assistants are not going to work 80 hours a week, like 28-hour shifts nonstop. That's -- again, no sane person would do that unless they were forced

to. So they would work kind of normal hours, and because of that, they had to hire like a much larger number of people to fill those positions.

Q Okay. So we covered a lot so far. Is there anything else that you'd like to share or discuss or comment on about all these issues?

A I would just like to say that, you know, this is -- this is a medical crisis in terms of the care. And all of us are going to experience it at some point. All of us are relatively young. So we're not feeling it now, but 20, 30 years down the line we're going to feel the effects of a doctor shortage.

And my goal here is really just to kind of give you advice on my experience in this process and ways that we can improve it for everyone. So that's -- I'd basically just like to state that that's really my goal with this is not to be partisan or pick a side on this but just to kind of address the issue that's facing all of us.

[redacted] All right. We can go off the record.

[Discussion off the record.]

[redacted] Can we go back on the record? All right. It is 5:54.

BY [redacted]

Q I have just a few questions, no exhibits. We'll be okay. I know you probably got to get out of here.

So can you go back to that example of the hypothetical doctor coming from France?

A Sure.

Q So what would preclude them from coming and practicing medicine right now?

A They would be -- in order to become licensed, they would have to complete an ACGME-accredited residency.

Q And the license, is that through ACGME or through the States?

A So majority of States have tied their licensing requirements to the ACGME accreditation.

Q Did the ACGME force the States to tie it to it?

A They did not.

Q So, I guess, why would a State use ACGME accreditation standards?

A It's essentially the only major accreditation board that exists, so they use it as an easy way to determine if the physician is competent.

Q An easy way or they're relying on what they consider experts?

A I would say it's a combination of both.

Q Okay. And so, again, so you have this example of someone from France coming over. Why did you use an example of an international doctor coming to the United States to practice medicine?

A Because I believe there's a very high number of qualified physicians that come from abroad. I mean, my [redacted] one of them. He actually did a residency in the United States and then became a practicing physician here.

But since this is like an acute shortage and you have people that have completed essentially equivalent training abroad, it seems illogical to force them to go through the same training. And I use that example because he was literally more senior than the people training him, which is just completely illogical.

Q Understood. And so do you think, is it your general impression that the best and brightest from around the world would want to come over here and practice medicine in the United States?

A I believe so, yes.

Q And do you think that we should have immigration laws that encourage

people to come over here from across the world to practice medicine in the United States?

A I believe we should be recruiting the best talent to practice who want to serve their fellow Americans, yes.

Q Do you think that could help, you know, close the gap in our physician shortage?

A I believe it could.

[redacted] Thank you. No other questions. We'll go off the record.

[Whereupon, at 5:56 p.m., the interview was adjourned.]

Certificate of Deponent/Interviewee

I have read the foregoing ____ pages, which contain the correct transcript of the answers made by me to the questions therein recorded.

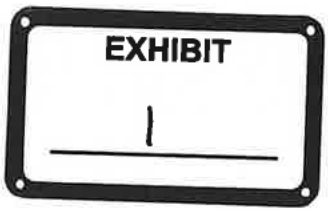
_____

Witness Name

_____

Date

Exhibit 2:
Dr. Aamir Hussain Prepared Statement
(Transcribed Interview Exhibit 1)



Prepared Statement on the U.S. Medical Residency System

Aamir Hussain MD, MAPP

List of Acronyms and Abbreviations

- **AAMC – Association of American Medical Colleges**
- **ABMS – American Board of Medical Specialties**
- **ABPS – American Board of Physician Specialties**
- **ACGME – Accreditation Council for Graduate Medical Education**
- **CMS – Centers for Medicare & Medicaid Services**
- **ERAS – Electronic Residency Application Service**
- **GME – Graduate Medical Education**
- **NBPAS – National Board of Physicians and Surgeons**
- **NRMP – National Resident Matching Program**
- **PGY – Post-Graduate Year (e.g., PGY1 = first year of residency)**
- **USMLE – United States Medical Licensing Examination**

OPENING STATEMENT

Dear Committee Members,

My name is Aamir Hussain and I am a board-certified dermatologist. It is my honor and privilege to assist our esteemed representatives in addressing the national physician shortage.

This crisis affecting America's healthcare system is deeply personal to me, as I witnessed death and devastation on an unimaginable scale during the first wave of the COVID-19 pandemic in New York City in March 2020. As a newly graduated doctor at Northwell Health in Long Island—one of the nation's top five hardest-hit hospitals—I saw our healthcare system stretched beyond its limits. To meet overwhelming patient demand, we transformed auditoriums and cafeterias into makeshift COVID wards; we promoted medical students into practicing physicians, and doctors from specialties like rheumatology and radiology, untrained in critical care, were recruited to manage these new hospital units. This experience exposed the stark reality of our physician shortage, projected to reach up to 124,000 by 2034. In Maryland, represented by Subcommittee Ranking Member Jamie Raskin, the patient-to-physician ratio is worsening, with some areas reporting over 2,000 patients per primary care doctor. Similarly, in Ohio, represented

by House Judiciary Chair Jim Jordan, rural counties face ratios as high as 3,000 to 1, leaving families vulnerable when emergencies strike. This ratio is even worse for specialties such as dermatology. In the next pandemic, would you want yourself or a loved one to face a situation where no doctor is available? Even outside a crisis, this shortage affects us all. As a new parent with a one-month-old baby, I can't imagine the terror of needing a doctor in the delivery room and finding none available.

I am a physician with a master's in public policy from the University of Chicago. I currently practice dermatology in Northern Virginia, focusing on high-quality patient care while advocating for health policy reforms. I have written extensively on these issues for major publications, including The New York Times, The Hill, and The Baltimore Sun, drawing on my expertise to highlight systemic flaws in medical education and healthcare delivery. My experience as a resident in the MedStar/Georgetown combined dermatology residency program, combined with my policy expertise, provides me with unique insight into the urgent need for reform. The solution is simple: eliminate the artificial cap on physicians and unleash the potential of thousands of medical students eager to serve their fellow Americans.

The ACGME's Shift from Competence to Subjectivity

The ACGME, which accredits residency programs funded by nearly $20 billion annually in taxpayer dollars through Medicare, has shifted its focus over the past two decades from objective measures of physician competence, such as board certification exam scores, to subjective "milestones" that lack evidence of improving patient outcomes. A recent study of Medicare patients showed these milestones have no impact on care quality, while board exam scores remain the only reliable predictor of better patient outcomes. Yet, the ACGME and ABMS are moving to make these exams pass/fail, obscuring objective competency data and undermining efforts to ensure skilled physicians.

While the transition to pass/fail for the certain exams was intended to reduce stress among medical students, evidence suggests it has inadvertently heightened their anxiety. Previously, Step 1 scores, typically earned in the second or third year of medical school, provided students with a clear gauge of their competitiveness for residency programs, much like SAT scores inform college admissions prospects. Since the exam shifted to pass/fail in 2021, medical students have reported increased anxiety and burnout, largely due to the absence of clear metrics to assess their standing. This uncertainty is compounded by many medical schools adopting pass/fail clinical grading systems. Residency programs, lacking objective data, struggle to evaluate applicants effectively, often resorting to less relevant metrics such as the volume of research publications or medical school rankings, which are heavily influenced by research funding rather than clinical aptitude.

ACGME's Role in Workforce Shortages

The ACGME bears significant responsibility for the nation's physician workforce shortages, which are primarily distributional rather than absolute. During my residency at the

MedStar/Georgetown combined program, I experienced firsthand how ACGME requirements imposed excessive burdens that hindered effective training and workforce solutions. For example, a single dermatology resident was sometimes responsible for managing inpatient consultation services at three separate hospitals—Children's National, MedStar Washington, and Georgetown Hospital—spending hours daily commuting in traffic between sites. This grueling workload compromised our ability to focus on patient care and education. When residents raised concerns about being overworked in ACGME surveys, the response was an ACGME site visit that, rather than allowing the program to recruit additional residents, imposed additional documentation requirements. These mandates increased administrative burdens without alleviating workload issues. Furthermore, the program was barred from expanding resident slots until it demonstrated that existing residents performed a minimum number of certain procedures, despite these thresholds being arbitrary and uncorrelated with technical proficiency. Such policies limit the ability to scale training programs to meet workforce needs, particularly in underserved areas.

AAMC and NRMP's Financial Conflict of Interest

The Electronic Residency Application Service (ERAS), administered by the Association of American Medical Colleges (AAMC), and the National Resident Matching Program (NRMP) derive substantial revenue from the escalating competitiveness of the residency application process. In specialties like dermatology, applicants commonly apply to 70–80 programs to secure a small number of interviews. The cumulative direct cost of applying—including ERAS fees, USMLE transcript fees, and NRMP registration—can exceed $800 per applicant. With over 52,000 applicants participating in the 2025 Match, ERAS fees are estimated to generate more than $30 million in annual revenue for the AAMC, comprising roughly 20–25% of its overall operating budget. NRMP Match fees contribute the majority of that organization's $6–8 million budget. These figures underscore how the financial burden of residency applications—often financed by student loans—is fueling a centralized system that provides no guarantee of a match or return on investment for applicants.

ACGME Regulations Limiting Free Market Solutions

ACGME regulations also stifle free market solutions that could address distributional workforce issues. For instance, ACGME mandates that all residents at the same institution and postgraduate year (PGY) level be paid the same salary, regardless of specialty or workload. A surgical resident working over 80 hours per week, including after-work responsibilities like charting and patient follow-up, earns the same median PGY1 salary of approximately $65,100 as an emergency medicine resident working half that time. For surgical residents, this translates to less than minimum wage when factoring in total hours. Allowing differential salaries would enable programs to offer premiums for high-demand specialties like primary care or pediatrics, or for practice in underserved regions, incentivizing medical students to pursue these careers and addressing workforce maldistribution.

Antitrust Concerns and Failure of NRMP Alternative Match Systems:

The near-universal state requirement for ACGME-accredited training for licensure—coupled with employer mandates for board certification—cements the ACGME and NRMP's monopolistic control over the physician workforce pipeline. The 2020 merger with AOA eliminated the last meaningful accreditation alternative. "Alternative" matching systems such as the SF Match (for ophthalmology) and AUA Match (for urology), while seeming promising on the surface, operate within this same restrictive framework. Unlike the NRMP, which oversees the majority of ACGME-accredited residency programs, these matches operate independently to pair applicants with programs in their respective specialties. The SF Match, for instance, uses a centralized application service (Central Application Service, or CAS) and a matching algorithm similar to the NRMP's to coordinate placements for ophthalmology and other subspecialties. Similarly, the AUA Match, managed by the American Urological Association in collaboration with the Society of Academic Urologists, places applicants into ACGME-accredited urology residency programs. While these systems appear to offer alternatives to the NRMP, they are not entirely independent. Both the SF Match and AUA Match must align with ACGME accreditation standards, as their programs are ACGME-accredited, and they often coordinate with the NRMP to ensure compliance with broader residency placement policies, such as those governing applicant eligibility and program participation agreements. While the SF Match and AUA Match provide specialized pathways, they do not challenge the NRMP's monopoly over the broader residency market. Unmatched applicants in these systems face the same barriers as in the NRMP: limited off-cycle positions, fragmented information, and administrative obstacles tied to ACGME compliance. In effect, all pathways into residency and, by extension, licensure and employment, remain locked into a monopolistic system where ACGME and board certification requirements dominate.

Nearly all U.S. states require at least one to three years of postgraduate training in an ACGME-accredited program. Exceptions to ACGME training requirements are rare and usually limited to waivers or permits that tie physicians to ACGME-affiliated institutions, further reinforcing the centralized structure. The widespread employer mandate for "board certification" or "board eligibility" intensifies the anti-competitive nature of this system. These designations typically require completion of a full ACGME-accredited residency and, for certification, passage of a specialty board exam. While not legally required for licensure, board certification has become a de facto requirement for employment, hospital privileges, and insurance participation. Employers—hospitals, medical groups, and managed care organizations—use certification as a proxy for physician quality, effectively excluding non-ACGME-trained physicians from most of the job market. This market-driven standard links employment directly to ACGME training, creating a closed loop in which physicians must go through an increasingly narrow and inflexible pathway to practice.

Although the standardization of physician training has theoretical benefits, the current system has become ossified and unresponsive to the evolving needs of the healthcare system. Residency pathways remain rigid and outdated, failing to account for workforce shortages in critical specialties. For instance, pediatric residency requires three years, followed by two to three more for subspecialty fellowships in areas like endocrinology or rheumatology—despite national shortages of pediatric subspecialists. Programs are prohibited from meaningfully shortening

training durations or offering differential compensation to attract residents to shortage specialties. The system prioritizes bureaucratic uniformity over adaptability, impeding innovation and workforce responsiveness.

ACGME's Reporting System Harms Residents

The ACGME's reporting system further harms residents by discouraging accountability. When residents at my program reported issues like excessive work hours, the ACGME's response—such as the site visit mentioned—penalized the program in ways that negatively impacted residents, such as increased documentation demands or threats to funding. This punitive approach disincentivizes reporting, protects non-compliant programs, and leaves residents vulnerable to exploitation.

Collusion Between ACGME and ABMS

There is clear evidence of anticompetitive collusion between the ACGME and ABMS. While the Centers for Medicare & Medicaid Services (CMS) recognizes three physician certifying bodies—ABMS, the National Board of Physicians and Surgeons, and the American Board of Physician Specialties—the ACGME only accepts ABMS certification for faculty at accredited programs. This excludes highly qualified physicians, such as those certified by the American Board of Physician Specialties, from training residents. The overlap of board members between ACGME and ABMS, including ABMS executive directors serving on ACGME residency review committees, underscores this collusion, which stifles competition and limits the pool of educators.

The NRMP and Resident Compensation

The NRMP exacerbates these issues by operating under an antitrust exemption granted by Congress in 2004 through the Pension Funding Equity Act, following the Jung v. AAMC lawsuit, which alleged that the NRMP and academic institutions violated antitrust laws by restraining market competition for resident services. This exemption was added as a last-minute amendment to a spending bill, passed without significant Congressional debate, shielding the NRMP from legal challenges. Despite its profound implications for resident compensation and market competition, the issue has not been revisited by Congress since 2004. The exemption allows the NRMP to standardize resident salaries far below their market value, preventing negotiation. The NRMP's "all-in" policy, which requires programs to offer all available residency slots exclusively through the Match, eliminates alternative pathways for filling positions, such as direct negotiations or independent recruitment. This policy harms residents by locking them into a system where programs face no competitive pressure to improve salaries or working conditions, as they are guaranteed a pool of applicants through the Match. It also disadvantages hospitals and communities seeking to address local shortages, as they cannot bypass the NRMP to recruit talent directly. Despite a median PGY1 salary of $65,100, residents are structurally underpaid compared to physician assistants and nurse practitioners, whose labor would cost hospitals significantly more. When the University of New Mexico Neurosurgery Residency Program closed and eight residents left the institution, the university hired nearly three times the

number of physician assistants to match their workload, indicating that neurosurgery residents were profoundly overworked.

The Crisis of Unmatched Medical Students

The NRMP's rigid structure contributes to a devastating crisis: the annual sidelining of unmatched medical students, whose wasted potential exacerbates the physician shortage. Each year, approximately 1,500–2,000 U.S. medical graduates—around 8–10% of applicants—fail to match into a residency program through the NRMP. These students, despite completing rigorous medical training at a cost of hundreds of thousands of dollars in debt, have no realistic path to becoming practicing physicians other than waiting a full year to reapply in the next Match cycle. This delay not only stalls their careers but also deprives communities of desperately needed healthcare providers, particularly in underserved areas. The lack of alternative pathways, coupled with the ACGME's restrictive accreditation policies, traps these graduates in limbo, squandering their potential and worsening the workforce crisis at a time when every qualified physician is needed.

The Residency Selection Arms Race

The residency selection process has become an "arms race," with applicants in competitive specialties like dermatology (averaging 27.7 research items in 2024) and neurosurgery (37.4) prioritizing quantity over quality in research output. This trend, coupled with the Match's stable matching algorithm, disadvantages applicants who cannot secure numerous interviews or who pursue additional graduate degrees, which data shows reduce match likelihood. Meanwhile, specialties like pediatrics face declining interest, with 8% of positions unfilled in 2023, highlighting mismatches in workforce distribution.

Proposed Solutions

To address these systemic failures, I propose the following solutions, building on legislative efforts to create new pathways for residency training:

1. **Fund a Competing GME Accreditation Entity**: Allocate less than $5 million—0.025% of the GME budget—to establish an alternative accreditation body, fostering competition and streamlining program approvals to address workforce shortages.
2. **End the NRMP's Antitrust Exemption**: Pass H.R. 8131, the Increasing Competition for Medical Residency Act, which aims to repeal the NRMP's antitrust exemption, allowing residents to negotiate salaries and enabling alternative certification pathways while ensuring new programs maintain rigorous training standards to avoid perceptions of inferiority.
3. **Increase Residency Slots with Targeted Funding**: Support the Resident Physician Shortage Reduction Act (H.R. 2389/S. 1302), which proposes to add 14,000 Medicare-funded residency positions over seven years, prioritizing underserved rural and urban areas to address distributional shortages.

These reforms will restore competition, transparency, and accountability to GME, curb the financial exploitation of medical students, and ensure a physician workforce that meets America's urgent needs. Thank you for your attention to this critical issue.

Exhibit 3:
Transcribed Interview of Dr. Jason Melehani

COMMITTEE ON THE JUDICIARY,

U.S. HOUSE OF REPRESENTATIVES,

WASHINGTON, D.C.

INTERVIEW OF: JASON MELEHANI

Friday, July 25, 2025

Washington, D.C.

The interview in the above matter was held in room 2237, Rayburn House Office Building, commencing at 9:58 a.m.

Appearances:

For the COMMITTEE ON THE JUDICIARY:

[redacted] PROFESSIONAL STAFF MEMBER

[redacted] DEPUTY DIGITAL DIRECTOR

[redacted], COUNSEL

[redacted], PROFESSIONAL STAFF MEMBER

[redacted], MINORITY SPECIAL COUNSEL FOR INVESTIGATIONS AND SENIOR ADVISOR

[redacted], MINORITY CHIEF COUNSEL AND SENIOR ADVISOR

[redacted], MINORITY SENIOR COUNSEL

[redacted], MINORITY LEGAL INTERN

[redacted] MINORITY INTERN

[redacted] This is a transcribed interview of Dr. Jason Melehani.

Chairman Jordan requested this interview as part of the committee's oversight of the adequacy and enforcement of U.S. antitrust laws as it relates to competition concerns in the medical residency market.

Would the witness please state your name for the record?

Dr. Melehani. Jason Melehani.

[redacted] On behalf of the committee, I want to thank you for appearing here today to answer our questions. The chairman also appreciates your willingness to appear voluntarily.

My name is [redacted], and I am with Chairman Jordan's staff. I will now have everyone from the committee who is here at the table introduce themselves as well.

M[redacted] professional staff member for Chairman Jordan.

[redacted], with Chairman Jordan.

[redacted], with Ranking Member Raskin and also with the Antitrust Subcommittee.

[redacted], with Ranking Member Raskin.

[redacted], Ranking Member Raskin's office.

[redacted], Ranking Member Raskin's staff.

[redacted], with Chairman Jordan's staff.

[redacted] I'd like to now go over the ground rules and guidelines that we will follow during today's interview.

Our questioning will proceed in rounds. The majority will ask questions first for 1 hour, and then the minority will have the opportunity to ask questions for an equal period of time if they choose. We will alternate back and forth until there are no more questions and the interview is over.

Typically, we take a short break at the end of each hour, but if you'd like to take a break apart from that, please just let me know.

As you can see, there is an official court reporter taking down everything we say to make a written record, so we ask that you give verbal responses to all of our questions instead of nods or "uh-huh"s, things of the like -- "yes" and "no"s or more along form responses.

Do you understand?

Dr. Melehani. Yes.

[redacted]. So the court reporter can take down a clear record, we will do our best to limit the number of people directing questions at you in any given hour to just those people on the staff whose turn it is.

Please try to speak clearly so that the court reporter can understand and so that folks down at the end of the table can hear you. It is important that we don't talk over one another or interrupt each other if we can help it, and that goes for everybody present at today's interview.

We encourage witnesses who appear before the committee to freely consult with counsel if they so choose. It is my understanding that you are appearing here today without counsel. Is that correct?

Dr. Melehani. That's correct.

[redacted] Thank you.

I want you to answer our questions in the most complete and truthful manner as possible, so we will take our time. If you have any questions or if you do not understand one of our questions, please just let us know. Our questions will cover a wide range of topics, so if you need clarification at any point, please just say so.

If you honestly don't know the answer to a question or do not remember, it is best

not to guess. Please give us your best recollection. And it is okay to tell us if you have learned information from someone else; just indicate how you came to know the information.

If there are things that you don't know or can't remember, just say so, and please inform us who, to the best of your knowledge, might be able to provide more complete answers to that question.

You should also understand that this interview is not under oath but that, by law, you are required to answer questions from Congress truthfully. Do you understand that?

Dr. Melehani. Yes.

[redacted] This also applies to questions posed by congressional staff in an interview. Do you understand that?

Dr. Melehani. Yes.

[redacted] Witnesses that knowingly provide false testimony could be subject to criminal prosecution for perjury or for making false statements under 18 U.S.C. 1001. Do you understand this?

Dr. Melehani. Yes.

[redacted] Is there any reason that you are unable to provide truthful answers to today's questions?

Dr. Melehani. No.

[redacted] Finally, I'd like to make note that the content of what we discuss here today is confidential. We ask that you not speak about what we discuss in this interview to any outside individuals to preserve the integrity of our investigation.

For the same reason, the marked exhibits that we will use today will remain with the court reporter so that they can go in the official transcript, and any copies of those

exhibits will be returned to us when we wrap up.

That is the end of my preamble. As I understand, you have an opening statement.

Dr. Melehani. Yes, I do. Thank you.

[redacted] At this time will you make the opening statement?

Dr. Melehani. Yes.

Members and staff of the committee, it is my distinct honor and privilege to speak to you today about medical residency training in the United States.

My name is Jason Melehani, and I'm a licensed physician in the State of California.

Like many physicians in this country, my desire to become a doctor started early, in middle school, with that journey spanning more than two decades of education and training. I earned my Bachelor of Science from the University of California, Los Angeles, and my M.D. and Ph.D. at the University of North Carolina, Chapel Hill.

Starting in 2018, I completed internal medicine residency and obtained board certification. I pursued further training in fellowship while at Stanford in rheumatology and pulmonary medicine. During my time at Stanford, I received over 100 exemplary evaluations from my peers and faculty.

In 2020 and 2021, I served on the front lines of the COVID pandemic. I was among the first team of residents working overnight to stabilize and care for patients being admitted to the hospital for respiratory distress before we had any understanding of methods for diagnosis, treatment, or the risk to our own safety.

I served in surging ICUs at the Santa Clara Valley Medical Center; the county hospital in San Jose, California; and at the Veterans Hospital in Palo Alto, and at Stanford's University Hospital, even volunteering to step away from my rheumatology training to help with overwhelmed ICUs.

Despite my track record of professionalism and excellence, my training at Stanford was derailed by a contract dispute in the fifth of my 8 years of medical training. Asserting my right to the terms of my contract led to me being placed on unpaid administrative leave for 8 months, which Stanford said was to, quote, "give me time to decide," unquote, if I would accept their substantially detrimental modifications to my contract to protect their wage-fixing scheme.

Although I'm happy to share my individual story today and evidence from my case, I'm not here to litigate my case against Stanford. I have been defending my rights under the law in the arbitration proceeding and look forward to my day before the arbiter to make my case.

Instead, I'm here to shine a light on how the ACGME and corporate health systems have created a labor monopsony, reinforced by Federal law, to the detriment of physician wellbeing, patient safety, innovation in healthcare delivery, and ultimately have damaged the American healthcare system.

If you look at the ACGME annual survey of residents, everything appears fine. However, there are widespread beliefs that reporting negatively about your program in the ACGME survey has the potential to negatively impact accreditation of your program, thus ultimately negatively impacting the reporter.

The truth is, medical residency training is in crisis. Multiple peer-reviewed publications reporting on surveys of medical residents have found physical, sexual, and emotional abuse are common and gender and racial discrimination are rampant. These abuses are often perpetrated by those who are responsible for the training.

Programs implicitly or explicitly pressure residents to report compliance with 80-hour-workweek rules established by ACGME, hiding the dangerous work environment these violations foster.

Wages are stagnant, with almost no change in inflation-adjusted terms since the 1970s despite the massive growth in education debt, resulting in distortions to specialty choice and aggravating physician shortages in primary-care specialties.

Workplace protections are minimal, fear of retaliation is common, and frustration with the lack of improvement is widespread.

Even when a program has violated the law, the system victimizes the residents a second time by providing them with almost no path out from their abusive workplace and few protections through due process given the patchwork of regulations and court decisions related to classifications of residents as students versus employees.

To challenge the status quo, especially through formal complaints or litigation, risks retaliation with the potential to impact future career opportunities. This all leads to residents keeping their head down to get through while their wellbeing and patient safety suffer.

Imagine for a minute if we were here talking instead about airline pilots, truck drivers, or people working in heavy industry and manufacturing. Industries where safety of employees and the public is paramount leave little room for error. If the circumstances and outcomes of our medical training program were applied to the airline industry, the outcry would be enormous.

The current medical residency system in the United States was born out of an effort in the late 1800s and early 1900s to standardize medical training and practice. Since that time, nearly every aspect of American life has been transformed. In the past 100 years, America has led the way in thousands of innovations producing massive improvements in quality of life, scientific advancements unraveling the mysteries of human disease, and technological developments that have made nearly all knowledge in the world available within seconds on a small device each of us carries in our pockets.

During that same time, the structure of medical residency has remained largely unchanged.

My understanding is this committee has focused on the creation of the National Resident Matching Program, which is known as "the Match," in 1952 and the 2004 Pension Funding Equity Act, which prohibited citing the Match as evidence in a case asserting antitrust violations. I believe the AAMC, ACGME, and NRMP lobbied for this rider because they knew that a thorough accounting of the economic distortions resulting from the Match program would result in it being found a violation of antitrust laws.

Over the years, the AAMC, ACGME, and corporate health systems have asserted that the Match provides an optimal outcome for health systems and residents and protects medical students from exploding offers earlier in their training.

Instead, the Match severely constrains competition, resulting in feeble wage growth, and inflates expenses for medical residents, especially those interviewing for competitive specialties, and distorts specialty training preference away from the much-needed primary-care specialties towards higher-paying specialties.

At times, they have also asserted that the physician shortages are the result of the high cost of training medical residents and the subsidies from CMS frozen in time, pointing the finger at Congress for failing to invest in medical education.

At the same time, though, they hire newly minted physician assistants and nurse practitioners with half the education of a medical resident, paying them twice as much to work for half as many hours doing the same work as a medical resident.

The health systems show their economic preference through their actions and make clear that the problem isn't a lack of subsidy. Through this monopsony, health systems create the physician shortage, and they rob medical residents collectively of billions of dollars in salary each year.

The monopsony has several key factors which result in these detrimental outcomes.

First, the ACGME accreditation is a de facto requirement for medical residency programs. This is because eligibility for board certification under the American Board of Medical Specialties, a near-universal requirement for physician employment in the United States, requires completion of an ACGME-accredited training program; and, as well, CMS created an enormous financial incentive for institutions to pursue and achieve ACGME accreditation by tying direct GME payments to ACGME accreditation with little oversight of how the funds are spent.

Second, ACGME controls the size of all accredited residency programs through an opaque process not subject to public disclosure or oversight. Programs make requests to expand and are routinely denied, having to opt instead to hire physician assistants and nurse practitioners at a substantially greater cost to cover the gap in patient care.

Third, the NRMP's "all-in" policy requires that all ACGME-accredited programs participating in the Match offer all of their positions through the Match, preventing any competition for candidates outside the confines of the Match program and limiting medical students to a single offer for employment.

Fourth, the NRMP Match program is exempt from antitrust laws, preventing any challenge to these economic distortions in U.S. courts.

Fifth, the ACGME constrains job mobility for residents, limiting transfers between institutions by requiring the sponsorship of those transfers by the current employer. A program with available positions can't poach residents from other employers without the explicit endorsement of the employer, effectively serving as a nationwide non-poach agreement.

Even worse, a resident in an abusive program will have to carefully navigate the

risks of retaliation from that abusive program when seeking better opportunity elsewhere. Without the support of their employer, transfer is not possible, making it nearly impossible to defend one's legal rights while continuing training.

Sixth, CMS further constrains job mobility of residents through the initial residency period rule. Under this rule, Medicare determines the individual residency period in number of years for which a hospital can count the resident as a full-time employee for the purpose of direct GME payments at the time a resident first enters the residency training program and does not permit adjustments if the resident switches specialty to a longer training program. This disincentivizes programs from accepting transfers for specialty changes.

And lastly but importantly, although there are no specific policies from ACGME or NRMP dictating wage levels, there exists widespread sharing of salary information between institutions through public publishing of the exact and complete wage and benefit information and direct sharing through the FREIDA database and the COTH survey, the C-O-T-H survey.

There exists an apparent unspoken agreement to prohibit individualizing offers to recruit exceptional candidates or create incentives to fill unmatched slots, as 96 percent of programs report paying identical salaries to every resident of the same PGY level regardless of specialty, performance, or institutional needs.

In the 2025 Match, 2,473 slots, representing nearly 6 percent of slots overall, were unfilled, almost half of which were in primary-care specialties, those facing acute physician shortages, raising questions as to why programs would prefer to face an employment shortage rather than individualize an offer.

As demand for healthcare services continue to rise, these factors exacerbate the physician shortage, leading to overworked and burnt-out healthcare providers, long wait

times for patients, and a growing sense of dissatisfaction with the American healthcare system.

Residents provide the bulk of bedside care in America's teaching hospitals -- residents enjoying few labor protections and having suffered under policies from the ACGME in Federal law that actively diminish their freedom, their right to work in a safe place, and economic opportunity.

Residents need the same opportunities as any other worker in this country -- the opportunity to negotiate the conditions of their employment, to decide to leave an unsatisfactory employer, and to defend their rights through administrative procedures or litigation without suffering career-altering consequences as I have.

Today, I look forward to answering your questions, and I hope to provide a helpful perspective on how these economic distortions are harmful to medical residents in the American healthcare system.

I hope to encourage you to continue your work to examine the rules and regulations around medical residency training programs, to repeal the 2004 antitrust exemption, and to disrupt the de facto monopsony by which ACGME controls medical residency programs with no real oversight or accountability.

On behalf of the more than 160,000 medical residents in this country, I thank you for your attention to these important issues, and I welcome your questions.

[redacted] Thank you very much.

Is there anything that my colleagues from the minority would like to add?

[redacted] I'd just like to note, this is being recorded --

Dr. Melehani. Yes.

[redacted] -- just so you know that.

[redacted] The clock now reads 10:15. We will start the first round of

questioning.

EXAMINATION

BY [redacted]

Q Thank you, Dr. Melehani.

I want to begin by discussing a bit about your educational background in medical school and residency.

You mentioned that you attended medical school at UNC. Is that correct?

A That's correct.

Q Could you describe some of your academic achievements during your undergraduate medical education?

A So the program that I was enrolled in at UNC is an NIH-sponsored program called the Medical Scientist Training Program, which is an 8-year commitment combining a medical degree and a Ph.D. together.

The program is highly prestigious. It effectively is a full ride to medical school in terms of payments. It entails the first 2 years of medical school training, followed by a switch to Ph.D. training for 4 or however many years it takes, and then completing the final 2 years of medical school after that.

During that time, I -- as I did at Stanford -- I received high evaluations in all of my coursework, high evaluations in all of my clinical performance. I completed, of course, the requirements of both of those degrees and obviously was regarded as a competitive candidate, as I then was placed into residency at Stanford.

Q So -- that's right. So, following medical school, you sought employment at a resident physician, correct?

A That's correct.

Q And can you briefly define "medical residency" for us?

A Medical residency is a period in training which is performed at these -- largely these ACGME-accredited periods which represents effectively an apprenticeship of physician practice.

So, out of medical school, those who decide to pursue residency training will conduct that training usually at a teaching hospital within a medical specialty of their choosing. And that hospital usually will rotate them through various practices, either different hospitals, different clinics, or different sites depending on the service region that the hospital addresses.

And that can include, for example, in my case, where I pursued internal medicine training, the opportunity to experience a wide range of specialties and subspecialties related to internal medicine, all with the goal to develop the skills, the mindset, and intuition of a physician to ultimately achieve board eligibility and ultimately certification after that.

Q Should residents primarily be considered students or employees? And why, exactly?

A So, in my opinion, I would -- I look at my experience as an experience as an employee with an employer.

The vast majority of my time as a resident is spent in advancing the core mission of the hospital, the economic needs of the hospital, providing care for patients, and pretty much all my time and instruction was revolving around that.

A very minuscule fraction of my time was spent in educational exposure, half of which, I would say, was actually conducted by my peers -- so peers giving lectures, peers sharing their experiences on the hospital wards or in the clinics. But that amounted to no more than about an hour a day in a usual 14-hour workday.

I think the distinction of an individual resident as a student is quite confusing and,

I think, is one, of course, that the institutions, the employers themselves, are highly favorable of, because it gives them the leeway and leverage that comes with academic deference in lawsuits.

But if 90 percent of my time was spent advancing the mission of the hospital through its usual economic activities, to me that would be an employee-employer relationship. As well, unlike any other experience I had, I would say, I was provided with a salary, a benefits package, and a clear employment contract every year.

Q Instead of going directly to the physician workforce proper, why did you feel the need to go through residency after you completed medical school?

A So, after completing medical school, I believe in all 50 States you cannot go to the physician workforce. You have to first complete at least 1 year in order to be eligible to be licensed. And that's at least true in California, and I believe it is true in every State.

The medical industry has shifted over the past 70 or so years from an industry in which physicians would commonly hang their own shingle and open their open clinic to one in which physicians now are largely employed by corporate health systems.

Even hospitals and clinics -- so we've seen a concentration of practices, large groups like Stanford, UC San Francisco, University of North Carolina, begin to recognize the advantage they achieve by creating these sprawling enterprises. It improves, I think, the referral for services from the clinics to the hospitals if they own those clinics.

And so, in reality today, many physicians have to achieve board eligibility and ultimately board certification to find gainful employment in their specialty of choice within this kind of evolving, corporate-focused system.

Q So, in other words, an aspiring physician needs to participate in medical residency in order to become a State-licensed physician and also receive board

certification.

A That's correct, uh-huh.

BY [redacted]

Q And not just a medical residency but an accredited medical residency through the ACGME. Is that right?

A As far as I understand, that's correct, uh-huh.

Q Can you briefly describe the process of applying for a medical resident position?

A Yes.

So, in the final year of medical school, typically in the fall, you begin to prepare your application, which -- there's a standardized application for pretty much all programs. That includes the typical kind of biographical information and other types of accomplishments that you would list on a CV or resume.

And, if I recall correctly, at that point, there's also typically an essay as to what's your interest in this specialty and why you are applying for the specialty that you chose to apply for.

That application is submitted through a common application portal, I believe, with -- I think it's hosted by the AAMC. And that application then can be sent out to as many hospitals as you want, and you have to pay a fee for the hospitals that you select to send it to.

That's effectively the first round of this process.

The second round of the process often entails, in some cases, requests for additional information, sometimes additional essays, and then ultimately progression to an interview round, which, you know, of course, with the COVID pandemic and things, has I think evolved a little bit but I think has returned to the point of now being back to

primarily in-person interviews.

So, for the institutions that offer you an interview, typically in the wintertime, December to February or so, you would go around, often on your own dime, paying for your own flights and hotels, to interview at each of these institutions.

It is quite common for residents to interview, I believe, in around 14 to 15 programs. Depending on the competitiveness of the specialty -- for example, dermatology, plastic surgery, orthopedic surgery, and many others -- I had colleagues and peers who interviewed at up to 30 programs, which of course is an enormous expense. And a reflection of that is that financial services companies have begun to offer loans specifically for this purpose because of how cumbersome this expense is.

After completing all the interviews, around the same time, the end of February, early March, everyone has to compile what they call their match list or their rank list, where they will list in sequential order their preference of the hospitals that they would find acceptable to attend for their residency.

They're under no obligation to put hospitals on there that they would not attend, but of course there's a widespread view, and it's probably quite true, that the bigger your list, the more likely you're going to hit some match rather than having no match at all.

That all goes into the Match system. At the same time, the hospitals themselves are ranking all the candidates that they interviewed. And then the match occurs usually mid-March.

Q When you were putting together your applications and your match list, what factors did you consider when deciding which residency programs to select?

A So, at the time I was undergoing this process, there were a number of factors that were quite important to me.

First and foremost is, I was married at the time, and so I wanted to ensure that it

was a location that my spouse would be happy with, would be able to start her career in law at that point in that location, and would provide us with the kind of opportunities and comforts that we would want to have as we kind of began what we anticipated to be the next almost decade of our lives together.

I was very focused on building a research career. As I mentioned, I completed this M.D. and Ph.D. program, which is a program intended to develop physician scientists to become kind of the next leaders of academic medicine and other practices of medicine. So I was looking for an institution that had tremendous expertise in research and opportunity for me to continue my research -- or, rather, continue to develop my research interests at the very least.

And then I would say third but probably substantially lower on the list of considerations was the cost of living and quality of life. You can tell by where I landed that that one obviously wasn't terribly important compared to the other two. But, of course, in thinking about starting a family in the next 10 years of that phase of my life, I investigated issues as to how, you know, rentals and housing costs would be, what daycare would look like in places like that, and how the institutions themselves would provide support for residents and fellows.

Q What role did salary play in those decisions?

A I would say it was effectively not important in any way. The salary between institutions is very narrowly differentiated.

There are some cost-of-living differences from the high-cost-of-living places compared to the lower-cost-of-living places. It typically does not make up for the substantial difference in cost of living between a place like Durham, North Carolina, and Palo Alto, California.

But, in effect, I viewed the range of programs that I was applying to to provide me

with nearly equal salaries in that respect.

BY [redacted]

Q Would salary have played a more important role had there been more diversity in the salaries offered by different programs and institutions?

A Yeah. I think if there was a broader range of salaries offered through these programs, then that certainly would have been an important factor, especially as I thought about the future of my personal life and building a family, uh-huh.

Q Following your residency, you were also admitted to a fellowship program. Is that correct?

A Yes. So the program I applied to at Stanford was somewhat similar to how I did the M.D. and Ph.D. It was effectively, at the time of the Match application, I was accepted into this kind of prestigious subgroup of internal medicine residents who were guaranteed the opportunity to continue fellowship at Stanford. So that was already in, kind of, the plans at that point, uh-huh.

Q Could you briefly describe the difference between a residency and a fellowship?

A Yeah. So residency is focused on -- in some specialty areas, it can be somewhat of a nuanced distinction, but -- kind of the general medical specialties or the general practice of a medical specialty. So the, kind of, largest ones are internal medicine, pediatrics, family medicine, and general surgery.

But underneath those are subspecialty practices, which -- one has to pursue fellowship training in order to achieve board eligibility in those subspecialties. So, if you wanted to be a pediatric cardiologist, for example, you'd have to do pediatrics training and then cardiology.

The reason I hesitated at the beginning is, there are some what would kind of, I

think, appear to the public to be specialty practices but are themselves residency programs, such as dermatology or plastic surgery, where I think probably primarily for historical reasons they have their own residency programs and then, in some cases, their own subset of specialty programs. So you might do a plastic surgery residency even though that seems like a subspecialty, but they have subspecialties like facial reconstruction surgery and others like that.

So it's somewhat nuanced, but those are the general aspects, uh-huh.

Q So is it fair to say that, at a high level, fellowships tend to be a bit more specialized than residency programs?

A Yes, that is absolutely true. The fellowships are more specialized. And they have to follow the residency. You can't go directly into a fellowship.

Q And for these more specialized fellowships, do salaries tend to remain fairly consistent as they do with residency programs as well?

A Yes. So, as I mentioned in my opening statement, 96 percent of institutions report to the AAMC that they pay every resident and every fellow the same salary based on what's called the PGY, or the postgraduate year, scale.

So, at Stanford, on their website, on their GME website, you can see the full scale from year 1 to year 8. And so you will know, as will everybody else know, exactly the dollar amount and the benefits that you make, depending on that.

So, in my case, I was an internal medicine resident for 2 years, and then I was to be a fellow for the 5-1/2 or so years following that. And so I could tell exactly what my salary would be and that that would be the same had I chosen any other specialty or any other fellowship.

BY [redacted]

Q And the uniformity of salaries is consistent across specialties, as you said.

So, in other words, a resident in their first year in family medicine is paid the same as a resident in their first year in surgery. Is that right?

A That's correct, uh-huh.

Q Would you say that there is a significant difference in the terms of, like, the content of work between family medicine and surgery?

A Yes. Yes, absolutely.

[redacted] Could you describe that a little bit?

Dr. Melehani. Yeah.

So I by no means want to diminish the intensity of residency for any specialty, but there certainly is a reputation, especially among the surgical programs, of an extremely high degree of intensity. While everybody, technically, under the ACGME, is supposed to abide by an 80-hour workweek, I would say surgeons probably are most often the ones to violate those rules and often have the fewest protections in violating those rules.

Surgeons, as well, will spend most of their training in the hospital, in ORs, operating rooms, and caring for patients in that setting, whereas family medicine will spend a lot of their time in clinics, where of course clinics operate during normal business hours, as anyone has been to probably a clinical practice and seen their physician. Though the family medicine doctors, as well, will service patients in the hospitals in many cases.

So there can be kind of a work-hour difference, an intensity difference, a cultural difference, certainly, in these practices.

BY [redacted]

Q So, in other words, it's fair to say that the value of the work for a family resident is not necessarily consistent across the board with the value of the work of a surgeon. They're working more hours as a surgeon. In some cases, they're performing

more complex operations. Is that all -- is that fair?

A So I guess it depends on what you mean by "value." I would say, certainly, a neurosurgery resident performing a spine surgery is going to generate more revenue for the hospital than probably the family medicine would in the entire day in clinic. But I think the family medicine resident, as well as the other primary-care specialties, play a very important role in providing care and service to the community and for the hospital that they work for.

And I think that's really exemplified by the hospitals reaching out and acquiring hundreds and hundreds of family medicine and primary-care practices. They recognize the value that these individuals generate maybe not through direct revenue generation but through referral generation or through other impacts.

So I think the system, in some ways, kind of distorts the landscape and the economic opportunity for really everyone, not just those in the most competitive and highest revenue-generating specialties.

BY [redacted]

Q You spoke both in your opening statement and just now about the tendency of residents and fellows to exceed the maximum number of working hours allowed by the ACGME. Is this something that residency programs know about?

A I'm certain they must know about it. There are many instances of, kind of, independent surveys that are published in the scientific literature where residents will anonymously volunteer that they are breaking these hours, and so it would seem to me that the programs would have to be aware.

Q Have you heard of situations where residency programs might be encouraging residents to either break these hours or to say that they are in compliance with ACGME requirements on things like surveys?

A Yes. Yeah. Absolutely. Even at my own program, in some of the discussions I had with colleagues who were in the surgical specialties like urology and others, they effectively were told that if they reported honestly that they had worked over 80 hours, they would be criticized, maybe even as far as punished, and the program would view it as they were not efficient enough, that they should have worked harder and more efficiently to get their hours below 80, rather than recognizing what is obviously the truth, that the hospital was understaffing the services, leading to the residents then having to work over 80 hours.

BY [redacted]

Q Just kind of a two-part question. The first part is, what policies on the part of the ACGME make it difficult for programs to add residents when there are those, kind of, workload issues?

A So, from what I understand -- and this is in part from my own experience at Stanford as well as having read about this on the ACGME's website -- if a program wishes to increase the pool of the number of residents in their residency program, they have to work as a program with their department of graduate medical education to make a request to the ACGME to increase the positions.

The ACGME does list a few criteria by which they evaluate these requests, which include things like having adequate volume and adequate support for education and training, but these requests are entirely opaque. There's no public reporting of how many requests are made, how many requests are accepted or denied.

In my time at Stanford, when I was in both rheumatology and pulmonary fellowship, I heard from the program directors that they had year after year requested to increase the size of their programs and had been denied year after year, despite what we were experiencing at Stanford to be very rapidly rising patient volumes. And even, I

believe, to this day, the waits to get into a rheumatology at the clinic at Stanford can be up to 9 months because of the understaffing of the overall programs.

So that, as far as I understand, is the process by which a program would seek to increase their capacities for residents.

Q The second question: If a resident is being overworked or otherwise mistreated in their residency program, what ACGME policies make it difficult for them to transfer to another program?

A So --

Q Or other policies in the medical residency market.

A Yeah.

So, to leave a program and to transfer between institutions, you need to find an institution, of course, that has a need, and the overall stasis of transfers I think in part is driven by the fact that people often don't, so there's not a space that's created. And the limit on the increasing size of a program prevents new spots from becoming available on an ad hoc basis.

The second is, if you want to leave your program, that program has to provide the information on your training, your performance evaluations, and other details related to your progression through the training program to the accepting program. If your program is not willing to effectively endorse you leaving them -- which, of course, leaves them understaffed further, as they may have already been understaffed -- then you cannot transfer. ACGME will not permit you to move without the support of your sponsoring institution.

Q To secure a residency position, you enter the National Residency Matching Program, or NRMP, often referred to as "the Match," correct?

A That's correct, uh-huh.

Q Could you generally describe the Match process?

A So I had earlier described the application process up to the point where the rank list was submitted and the hospitals submitted their rank list.

My understanding is, this then goes into a computer system that the NRMP describes as aiming to create the optimal match for residents as well as for programs but effectively -- I think, in their words, they say that it gives preference to the residents' preference.

So I think, effectively, they would look at all the residents' first rank and see, for a program that has, let's say, 30 positions, if I put Stanford as number one and I'm in Stanford's top 30, then that match is made. And that plays out sequentially in order to ensure that people who have matches possible receive those matches.

At the same time, the same day, all across the country, every medical student receives a letter. And medical schools often, of course, will make a big deal out of this and have a big ceremony, almost like a graduation ceremony, where you receive your letter and everybody opens them and sees, you know, "Congratulations, Jason Melehani. You've been matched to internal medicine residency at Stanford."

The NRMP requires that if you participate in this process and you receive a match that you accept that offer. After having submitted your list, if you are to back out, you have to request an exemption from the NRMP to back out, which can only be granted on the basis of what they call "hardship," which is not really well described on their website as to what that means. But they have published some information on these requests, I believe, over I think it was a roughly 10-year period from the mid-2000s to mid-2010s, where they described the number of hardship requests and stated that only about half of those were granted.

In order to fulfill the contractual obligation to the NRMP on account of having

participated in the Match, you have to, I believe, enroll and participate in the residency program you were assigned to for at least 30 days, after which point you are kind of released from your obligation of the NRMP's contract, though, of course, at that point, you would have signed a contract with the institution you're working at, and you have to find a path out of that if that wasn't a suitable path forward for you.

Q Did you attempt to secure a residency position outside of the Match?

A So I ended up in a very unique circumstance because, as I described earlier, the program I applied to, which was a residency program but effectively guaranteed my fellowship, while that traditionally requires one to still apply through the Match, Stanford effectively would say, we would just rank you number one and give you that guarantee. But I went a bit further and wanted to create my own fellowship program at Stanford.

I had initially enrolled with the intention of doing pulmonary and critical care medicine and, over time, recognized critical care medicine wasn't something I was very interested in. So I worked with Stanford to create a combined fellowship in rheumatology and pulmonary medicine without the critical care aspect.

My program director, working with GME, made a request to the -- as far as I understand -- made a request through the ACGME for a temporary expansion of the rheumatology and pulmonary programs, which was granted, which then permitted me to enter into that position without having to participate in the Match.

I don't quite know how that worked out, to be honest, because of the "all-in" rule in the Match. So, effectively, I was offered a position that was in violation of these "all-in" rules. But I think since I didn't challenge it -- it worked in my favor, of course -- I didn't ever learn as to how they were able to navigate that.

BY [redacted]

Q Two quick questions.

One: So, as you understand it, Stanford's, essentially, offer to you outside of the Match and ability to secure your position, to your understanding, violated the technical rules of the NRMP and the Match. Is that correct?

A That's correct, uh-huh.

Q Second, you used the term "GME" as separate from "ACGME." Can you briefly define that?

A Yeah. So this probably will be how I speak throughout the rest of the day as well.

But "GME," I am often referring to Stanford's GME, or the graduate medical education, office. It's a bit of a weird name for what it effectively amounts to a human resources organization that oversees the employment of residents and fellows. They're responsible for the administrative aspects of the employment of residents and fellows. So they, along with the program directors, issue and sign the contracts for employment, they establish the institution-wide policies and procedures that govern the residency programs, and they enforce the salary and benefits that everybody else has.

"ACGME" is the accreditation council of GME programs. So this is an organization which is -- I believe its board of directors are primarily physicians and staff from GME programs at institutions across the country. And they set the policies -- or they set the accreditation standards, rather, by which the GME programs at the institutions then have to comply with in order to achieve and maintain accreditation.

BY [redacted]

Q I want to jump now and discuss your work at the rheumatology and pulmonary fellowship at Stanford.

As part of your fellowship training, you received approval from your program directors and the American Board of Internal Medicine to conduct research as an

employee of a pharmaceutical company, Gilead Sciences, to satisfy the requirements of your training. Is that correct?

A That's correct.

Q Could you please describe the process of receiving that approval and how your work at a pharmaceutical company relates to your work as a fellow at Stanford?

A Yes.

So, as a fellow, I believe, in nearly any medical specialty, there's the expectation that some period of time will be committed to the clinical training and specialization. So, for me, in those two specialties, it was seeing patients in the hospital as a consulting physician; seeing patients in clinic, particularly on the pulmonary side; developing expertise in the procedures of pulmonary medicine, including bronchoscopy; working with patients with lung transplants and other complex medical conditions.

The second portion of the training is intended to focus on research training. And that can range -- for me, it was going to be 2 years clinical training, 3 years research training. And this was set out at the time I worked with my program directors and with the American Board of Internal Medicine to establish this rheumatology-pulmonary combination.

I think one thing that's quite important to recognize is, this fixed period in training is a requirement to be board-eligible. That would be true regardless of what my M.D. and Ph.D. program looked like. Had I just done a medical degree, I still would have to do 3 years of research training. The fact that I did a 4-year Ph.D. when 90 percent of my colleagues had not done that degree of research training did not exempt me from any amount of research training.

So, during the time in clinical training in fellowship, I was approached by a company, which was not the one I ultimately ended up working for, but they had an

interest in developing medicines for patients with autoimmune diseases and lung diseases, so it perfectly matched to my training.

I had a longstanding interest in drug development and in the complexity of the scientific process as well as the business processes that it takes to make an effective medicine and distribute it to the world, and so this was quite appealing to me. And I had never really given consideration to the possibility of working in a company to do my research training until that point when I was approached.

It was quite attractive, because the type of work that's performed in a pharmaceutical company does not at all overlap with the type of work that is performed at a university. You simply cannot get training at a university as a fellow doing the work designing and conducting and analyzing large Phase 2 and Phase 3 global clinical trials. There's just an enormous difference in resource availability. Oftentimes, as I'm sure you've heard in the media, those trials can cost anywhere from 200 million to a billion dollars. A university simply just doesn't have the money to do them. So this represented a unique opportunity for me to advance my training and education.

So I took that initial interest from the company and went to my program directors in November of 2021 and said, "Hey, I've been approached by this company. I haven't thought about this, but this seems quite compelling. Would you be willing to support this?" And they were quite supportive. They had known about my interest in drug development and thought that this represented a great opportunity for me.

Of course, it's rather out of the ordinary to do research with a company, and so we set out together to try to ensure we got, kind of, all of our ducks in a row from a compliance standpoint.

The first part of that was that I drafted a petition to the American Board of Internal Medicine describing my intent to perform research as an employee with the

pharmaceutical company while still completing my obligations to Stanford, which included half a day a week of clinic and a few hours a month of, kind of, educational sessions.

And my program director signed that petition; I submitted it to the American Board of Internal Medicine. And they replied in email that that petition and the details of the proposal satisfied the requirements that I would need to be board-eligible after the 3-year -- the further 3 years of research training.

So that was November '21. Unfortunately, the initial company ultimately couldn't deal with the complexity of the situation and found a candidate that they preferred other than me. But, having this lead, I started to apply for other jobs which kind of reflected the nature and spirit of the agreement I had with Stanford and had submitted to the American Board of Internal Medicine.

By around February or March of 2022, I had gotten some traction. And in April, Gilead Sciences had made clear to me that I was going to receive an offer for employment as a -- what at the time I thought was the title "associate medical director of clinical development." And so I went back to my program directors and said, "Hey, I'm anticipating I'm going to receive this offer."

At the same time, Stanford had offered me a kind of standard contract, you know, the form contracts that they have for every annual renewal of employment. And I wanted to make sure that if I received and signed a contract from Gilead that I wasn't going to have any conflicts with my Stanford contract, and, in particular, needed to have some degree of flexibility to scheduling my clinics around my schedule with the company as well.

And so that email chain in April really focused on those aspects. And they encouraged me to inform GME at Stanford that I will be signing the form contract but,

ultimately, once the Gilead contract came in, I would likely need it to be amended.

So, on May 2nd of 2022, I contacted the director of Stanford GME. I notified them I had this intent, in agreement with my program directors, to work for the company and that I would not need salary from Stanford because the company would be paying my salary.

The director replied, asking me to clarify whether the company would be paying me directly or would be paying Stanford so that Stanford could pay me. I stated clearly in writing in an email to her that the company would be paying me for work I would be doing for the company, at the company, under the direction of the company, and all I would need from Stanford was permission to continue to see patients and malpractice coverage.

Stanford, like many large corporate practices, is self-insured. So they have a pool of money that covers their malpractice liability. They don't have a third party that provides it for them. So this seemed like it would be a non-issue.

The director at that point raised no concerns about the payments from the company directly to me and just stated that, in order to see patients and have malpractice, I needed to still an appointment, a title, at Stanford which would allow me to have that coverage.

My program directors responded on my behalf, stating that they were in the process of completing my contract for the next-year fellowship, and so I would have the title I needed and would have the opportunity to complete that aspect of my training.

That was May 2nd, as I said.

On May 18th, I received the offer from Gilead Sciences, the employment contract, the notification of the title and the remuneration associated with it. And I contacted, again, my program directors to say, "Here is" -- you know, "I've received this offer to join

Gilead Sciences as a senior associate clinical development director." I described what the responsibilities of the job would entail and how that would further my research training and career development.

At the very end, I asked if they had any concerns or questions. I was acutely aware of how unusual this whole situation was and wanted to be sure I didn't run afoul of anything.

They replied and even expanded the email chain to other leaders at Stanford, saying, "Congratulations. You have our full support. We're so proud of you." One of them even, in talking to me, said, "We never thought you could pull this off. This is so fantastic. Great job."

So, as far as I could tell, everything was in order at that point. I signed and accepted the contract with Gilead. And, as I notified on May 2nd that I would need an adjustment to my contract with Stanford, I contacted GME, this HR organization, to make that adjustment. I made the request to drop my salary to cover what amounted to a 10-percent time commitment to Stanford.

And that's when they, for the first time ever in 6, 7 months, objected, saying that the company could not pay me directly, despite them having raised no objections before.

Q What was the date of that statement?

A That was May 26, so after I had signed my contract with the company.

[redacted] And just to clarify, up until that point they had made no objections to the direct payment from Gilead to you. Is that correct?

Dr. Melehani. That's correct. They had full knowledge of that as of May 2nd and made no objection to that.

BY [redacted]

Q And also no objections to any of the other factors related to your

employment there.

A Yeah. No objections at all. The individuals involved felt that the arrangement was appropriate for my clinical training, for my research training, and offered their full support all the way through.

Q So, when Stanford first expressed concern over your employment offer from Gilead, do you know who specifically expressed this concern?

A Yeah. So there are two people who lead the GME organization at Stanford. One, I believe, is the title "director," and she's effectively the administrative manager of the HR organization. Her name is [redacted] The second, who she looped in at that point in time, was the associate dean of graduate medical education, so it's a physician who serves in this HR capacity, whose name was [redacted]

So, on May 26, in writing, [redacted] raised the initial objection at that point to having the company pay me directly, said, "You have to talk to [redacted] about this." And then [redacted] scheduled a call with me and my program director, I believe it was that day or perhaps the next day, to discuss further.

Q So, in other words, Stanford told you that you could not receive compensation from an outside company.

A That's correct.

Q Is that fair?

A Uh-huh.

Q And had Stanford previously communicated this to you at all?

A No, they had not.

[redacted] Did they give you any indication that this might be an issue?

Dr. Melehani. No, they did not.

BY [redacted]

Q Based on your conversations with Stanford, why did they not allow you to be paid by an outside company?

A So, in the first conversation with [redacted], they recognized and acknowledged that the salary from the company was substantially greater than the salary they were paying me based on the PGY scale, which -- at the time, I was set to be I think it was a PGY-5.

And we had an open discussion. I remember telling my program director, this is such a big difference -- we were talking about, over a 3-year training period, a difference of nearly a million dollars in salary. And that was the kind of money that would allow me and my wife to start a family in the Bay Area, of course, which is very expensive. To even imagine paying for childcare is -- is quite the same as paying for rent. So I told them this was very important. "We had an agreement that this was okay, and now that you're raising an objection, we need to find a way to satisfy your objections."

[redacted] expressed that this was in the interest of fairness for everybody else at Stanford who wasn't working at a company, that I could only be paid the PGY scale, even though my work was being performed at Gilead for Gilead.

I tried to understand what motivated this, if there were any policies, and he did not describe anything specifically. He just said, "This is how we do things here."

He even voluntarily brought up an example where the Department of Orthopaedic Surgery at one point wanted to recruit a resident who they thought was a stellar candidate -- a medical student at the time who they thought was a stellar candidate to join their program, and the Department of Orthopaedic Surgery made a request from GME to make a better offer than what the PGY scale offered. And [redacted], in volunteering this information, then said that they denied that ability, so they could not deviate from the set scale that everybody had to be paid.

[10:57 a.m.]

[redacted] During your conversations -- actually, let's back up a little bit. So do you recall what your PGY-5 salary was from Stanford?

Dr. Melehani. I can give you a ballpark of that. It was probably around $84,000, I think.

[redacted] Eighty-four thousand.

[redacted] This series of conversations where they initially expressed some hesitancy about moving forward with this occurred because you prompted them to reduce your salary to fit the time you would spend working directly at Stanford. Is that correct?

Dr. Melehani. Yes, that's correct. I asked to match the time, which was about 10 percent of, kind of, a 40-hour workweek. And when they rejected that, I asked them to just simply not pay me at all, that I would do the work for free, and all I needed was the permission to see patients and have malpractice coverage. And they rejected that as well, insisting that they then pay me a full-time salary.

[redacted] Why would they reject a decrease in your salary?

Dr. Melehani. I don't know.

[redacted] And just to confirm, absent the malpractice insurance, you offered to forego the entirety of your salary and essentially work for free in order to make this easier on Stanford. Is that correct?

Dr. Melehani. Yes. Yeah. So I was really driven by the desire to not receive effectively double payment for work. If Stanford was paying me a full-time salary and I was spending 90 percent of my time working at Gilead, they were in effect paying me for something I wasn't doing for them, which felt wrong to me.

And so this just felt horrible, that I was trying to do the right thing and suddenly

had this corporate institution coming down on me to smash the agreements and plans we had already made and affirmed in contracts.

[redacted] Did anyone from Stanford ever ask you if there was a way Stanford could bill Gilead for your salary and benefits?

Dr. Melehani. Yeah. So that was what [redacted] wanted. This was the plan he came up with, was, instead of Gilead paying me my salary -- which, I believe my starting salary was somewhere around $250,000, plus expected annual bonuses in stock and cash -- he said what he wanted was for Gilead to pay Stanford the PGY-scale salary, so roughly $84,000, and then that would allow Stanford, in his words, to funnel that money to me, effectively allowing them to maintain the appearance of paying me but using Gilead's money.

He was clear at that point that there was not an option for me to receive the full salary from Gilead under this plan. It was strictly to enforce his view of an equitable situation for the other residents and fellows and, as I said, to maintain that appearance.

[redacted] Did he use the word "funnel"?

Dr. Melehani. Yeah, he used it both in talking to me as well as in writing in an email sent to me, I believe, on May 27th, 2022.

[redacted] Were you told that the issue with your employment with Gilead was related to where money comes from and how much you would be paid?

Dr. Melehani. Yes. In that email, [redacted] said the issue was essentially the source of funds, salary, pay scales, and how the money is funneled.

He reiterated this again in writing in another email in June, about a month later, where my program director had emailed him, saying, you know, "Jason's about to start the next year," which happens on July 1st. "We want to ensure everything's in order for him to see patients, and he has this plan, of course, to work at Gilead." And my

program director -- in writing this email, [redacted] responded, saying, "Our problem is not Jason working at Gilead." This is in writing, an email. "It is the source of funds and pay scales."

So it was quite clear that was driving the interest here.

BY [redacted]

Q So I just want to confirm this. Did anyone ever tell you that there were any other issues with the distribution of your work, this arrangement, anything outside of salary and how the money would be dealt with?

A So not during any of the first, I'd say, 6 months of discussion was anything really brought up except that by Stanford.

I brought up on several occasions what I believed to be issues that they might have, just to ensure that we dealt with everything up front all at once. And so I asked them if there were intellectual-property concerns or if there were conflicts-of-interest concerns.

And in handwritten notes I took contemporaneously with the phone call I had with [redacted] on May 26th, my notes reflect that, in relation to the intellectual-property concerns, [redacted] was primarily concerned with the ability of me to essentially advance my career using the work I performed at Gilead. So he wanted to make sure I wasn't bound by such strict degrees of confidentiality that I wouldn't be able to get my next job because I couldn't talk about the work that I did.

I assured him that I would have the opportunity to contribute to conference abstracts and publications, the typical kind of currency of academic medicine in medical careers, and that I had been assured by Gilead that I would have the opportunity to discuss that research within the appropriate confines of, you know, the company's trade secrets and other limits like that. [redacted] told me that that satisfied him with

respect to intellectual property.

On the conflicts-of-interest side, after I brought up this potential for concern related to conflicts of interest, we had a discussion about how, as a fellow, I continued to be overseen by attending physicians, how my notes and the decisions I make are supervised by those attending physicians, and so there was minimal conflicts-of-interest concerns, as effectively my work was 100-percent checked.

The other aspect of the conflicts of interest I think helped diminish concerns was, my work at Gilead was focused on liver disease and not on pulmonary medicine, not on autoimmune disease, so there was no overlap between my Gilead work and the patients I was seeing. As well, Gilead at the time was not manufacturing and had not produced any medicines which were prescribed by a rheumatologist or a pulmonologist in the course of my usual practice, I would say, with one exception of a super-specialty practice of pulmonary hypertension, which wasn't something I was involved in.

So, after I had brought up the conflict-of-interest concerns, [redacted] described to me that there would be a committee that would review this but, in his mind, everything seemed okay from that respect.

Q So the only, at that point, concern that he had expressed was related to your salary and how you would be paid. Is that correct?

A Yes. It was the source of funds and the amount that I would be paid.

BY [redacted]

Q And you were told that Stanford would need to funnel the money to you because everyone has to be paid the same. Is that right?

A Yes.

Q Who told you this?

A [redacted]

Q And what did you understand him to mean by his statement?

A He made very clear that the fact that Gilead was going to pay me nearly three times as much as what Stanford was willing to pay me, that he viewed that as unfair to everybody else and thought, even though I was doing work for the company, that my salary should reflect the salary they were paying me.

Q Are there any other reasons why everyone would need to be paid the same, that you're aware of, that could've provoked this?

A So, as far as [redacted] had mentioned, he approached this out of a sense of fairness. It seemed to me that this was actually in the interest of kind of maintaining control of the residents.

I, I think 4 days after, on May 30th, had a phone call with a mentor of mine who was a former program director of internal medicine and was heavily involved in faculty education and faculty career development and advancement. He expressed to me -- so I brought him this story and told him, you know, Stanford doesn't want me to get paid this money.

He said, "Well, that is probably because they are worried that, if you do this, you set a precedent where other residents are going to want to do this as well. And the residents represent a very low-expense, high-quality workforce for the hospital and for the research labs. And if this starts happening in a big way, it can really lead to a lot of economic pressure on Stanford to begin to match the salaries with the outside competition."

He told me at that time that I probably was going to be running into trouble and I would likely either have to quit Stanford, quit the company, or take a leave of absence and perhaps one day come back to finish my training, and thought they would be unwavering in this request.

Q Why did he feel so strongly that Stanford would not want to set a precedent that one of its fellows received higher compensation than the others?

A Yeah, it was a bit striking to me, because everything up to that point that I had heard from my program directors, from the division chiefs, and others was that this was something they wanted to advertise. They wanted to use my experience and how interesting and unique it was to help recruit people to Stanford, to say, "Stanford's a place where you can do interesting and incredible things and you can genuinely customize your experience." The chair of medicine even said, "I want Stanford to be the kind of place where these things happen, and support this."

But GME was unwavering, and this mentor of mine, the former program director of internal medicine, seemed to understand that their unwavering approach to this requirement was because of the enormous difference between the salary that Stanford was paying me and the salary that I was being paid by the company.

You could imagine, at that time in fellowships -- so I had already completed a Ph.D. I had already completed residency training. I had completed the clinical subspecialty training of rheumatology and pulmonary. At that point in time, I was probably one of the most qualified doctors, as fellows often are, in the world, having trained at a premier institution for my specialties. And they were to receive the benefit of my work over the next 3 years in either the clinical setting or research labs at effectively $15 an hour. Quite a benefit for them.

Q Are you aware of any specific policies at Stanford, including union agreements or things like that, that could have influenced this drive towards uniformity of wages?

A Yeah. This was a bit of an interesting time at Stanford. As my situation was coming together with my program directors, with GME, in that early-2022 period,

there was a drive to form and recognize a union at Stanford. So there was not one yet, but a vote occurred I think in that spring, and the vote was overwhelmingly successful. And then the NLRB recognized that the vote was successful and acknowledged the formation of a union at Stanford.

So, during the time of the formation of the agreements, there was no union. As I began to try to navigate this apparent conflict with Stanford related to the salary and pay scales, the union had been formed and recognized but no contract was in place with the union. I think it took almost 18 months for the union to reach a contract with Stanford, which, of course, they have now.

Q So, in your view, do you believe that the formation of that union contract influenced the salary conversations in one way or the other?

A Well, the union contract didn't happen until Stanford already raised their concerns about the salary. So it was clear, in kind of the temporal progression, that Stanford had this interest in suppressing my salary before the union was ever involved.

Q And, in fact, just to get the timeline correct, your example of the orthopedics resident, that occurred well before this union contract was even discussed, right? Is that timeline correct?

A Yeah, that's correct. I don't know the exact year, but [redacted] described that that was in the past, well in the past.

Q Over the following months, how did Stanford attempt to resolve its concerns with your concurrent employment at Gilead?

A So my program directors initially, I would say, were quite helpful in trying to find a path that would provide me the opportunity to work at the company and to receive the salary from the company. So they generally were supportive. And, together, we set out to find an alternative to an appointment within the GME structure that would

alleviate me of this burden of whatever policy they claimed governed the pay scales, that I needed to receive this salary.

So I initially went and tried to talk to the Office of Postdoctoral Affairs, which is kind of a separate group at the university that, of course, governs the hiring and policies and procedures of post-docs. I didn't find much traction there. And, in fact, they just initially were completely unresponsive. And it took several months to figure out that that was not a path to receiving the salary from the company directly at the level that the company wanted to pay me.

I spoke to the chair of medicine to see whether there was an appointment position, like an "instructor" title or something, outside of the, kind of, training structures, the GME or OPA structure, that I could get into. And GME quashed that, saying that I could not have what amounted to a junior faculty title while still pursuing ACGME training.

So that process took, kind of, several months to figure out exactly how to try to navigate the corporate structure of Stanford and the university.

During that same time, Stanford made clear to me that they wanted an agreement with Gilead for Gilead to pay that money to Stanford. And I asked them to provide an example contract, to provide details of what exactly it was they were looking for. And they said, "Go talk to Gilead; Gilead will know, and Gilead will give you the contract to bring to us," which I thought was bizarre.

But, nonetheless, I went to Gilead. And, you know, I signed my contracts with them in May and started my first day on July 11th, so it was hard for me to go talk to the senior corporate counsel at Gilead as a new hire. It took some time, working with my boss, the vice president, and then the senior vice president of my division, to set up meetings.

The attorneys at Gilead were enormously supportive and thrilled to have me on the team, as were my supervisors, but they said, "We can't pay your salary to Stanford for the work you do for us. That opens us to liability that you could claim we're paying you less or we're not paying you a salary at all, and that would be a liability for us." They were helpful. They said, you know, "We're happy to talk to Stanford and figure out whether something can be arranged so that all parties can be satisfied."

I went back to Stanford and relayed the information that this was a no-go, Gilead was not going to pay Stanford directly a reduced salary. So Stanford began to request meetings directly with the attorneys, and [redacted] asked me to just give him the attorneys' emails at Gilead so he could meet with them.

I insisted that if they were going to have conversations about my life and my career that I have the opportunity to be present, and I felt they were attempting to exclude me from those conversations. He apologized and was quite kind about it, and he said that wasn't his intention, and just kept pushing for this meeting.

So I attempted to arrange a meeting between the corporate counsel at Gilead, between the leaders of the HR organization, my program directors, and myself. Working with everybody's assistants, I got a meeting on the calendar.

And then the day before the meeting, I sent emails to Stanford, saying, "I want to make sure you guys are ready and prepared for this meeting. Is there any information or anything I could provide for you?" And they said, "Oh, we don't have it on our calendar; we don't have time for that tomorrow," so we had to cancel the meeting.

This was an enormous embarrassment for me, as a new employee, a junior member of the team, to go to the senior counsel at Gilead and be like, "Sorry. I wasted your time." They were very supportive and understanding, fortunately.

And I tried to set up another meeting, which -- you know, all these senior people,

trying to get something on their calendar takes weeks and weeks. And so, during that time, Stanford began to accuse me of stonewalling this meeting, even though they canceled the first one. And we ultimately were able to arrange a meeting, but during those months things got increasingly bizarre, and I could tell the situation was degrading.

Stanford began to ask me -- they would send me emails saying, "Who's paying us your salary? Who's paying us your salary?" And I'd reply, "I don't know what the hell you're talking about. You guys are paying my salary. I'm not responsible to tell you who's paying my salary." I didn't use those exact words. I didn't say "hell" to them, but -- and it just kept coming, over and over.

And I remember during this time becoming increasingly distressed and anxious. It was clear that this was not going well for me. And it felt like something was going to break, my career at Stanford or my career with the company, both of which would be substantially detrimental to me personally from a career advancement standpoint, as well as financially.

I remember, then, on November -- I think it was November 1st, my program director sent me an email and said, "Things aren't going well. Everybody is very frustrated and angry with you. You need to make a decision. You have one of three options: You can quit Stanford, you can quit Gilead, or we'll continue to pay your full-time salary to you but you have to donate the salary back to us. But, in doing that, you have to pay our FICA taxes, you have to pay your employment taxes, your income taxes for State and Federal, and your own FICA taxes. That way, you make us whole but we keep you on the books and keep this appearance of paying you."

This, of course, seems extremely illegal to me and very bizarre, for a corporation to effectively ask me to subsidize my own employment with them. But I went and talked to a tax attorney. I said, "Does this lead to me running a foul of any tax laws, or is

this their problem?" I don't want to -- you know, given the past 5 months, at that time, of what was increasingly distressing and clear trouble I had with Stanford, I didn't want anything on top of that to jeopardize my career.

The attorney advised me that this was probably okay for me. It was extremely bizarre, it might be illegal, for Stanford to do this, but I probably wouldn't run into any trouble.

And so I emailed Stanford that I accepted their offer to receive the salary, pay the tax penalty, and pay it back to them. Because that still was better than accepting just the salary Stanford was paying me.

After having accepted that offer, they replied that they could not work that out, and they rescinded the offer. So I was kind of back to square one.

At that point, I emailed the chair of medicine, and I said, "Things are not going well. They're being -- this is, like, really bizarre. They're asking me who's paying them. They're giving me these seemingly illegal kind of financial structuring offers. And I need your help to get through this."

He replied, I believe on November 15th of 2022, that he could not help me because no adverse action had been taken against me, that my contract allowed for an internal grievance procedure, which he would govern the first stage, but until they had taken a clear adverse action against me, I was on my own to deal with GME.

This was rather disappointing because this was someone I had known, worked with, and was extremely supportive up to that point.

Around this same time, I finally was able to have the meeting with GME, Gilead's attorneys, Stanford corporate counsel, and then myself. And I, at this point, had my own attorney present. This was by Zoom.

Everybody joined the call. We went through introductions. And after everyone

introducing themselves, the Stanford corporate counsel said, "We're not going to participate in this meeting. We aren't going to talk about Jason in front of Jason and his attorney." And I, of course, expressed dismay, that this is my life, my career; of course you're going to talk about me with me present. And they backed out of the meeting.

Gilead made an attempt to try to recover, say, "At least give us an idea of what you want, how we can help, where we can maybe have a discussion internally about what we can do to appease your interests in this situation." And Stanford's corporate counsel said, "We're not going to talk about anything," and the meeting ended after about 4 minutes.

At that point, nothing -- there was essentially no further communication until I received a letter on December 18th notifying me that I was in violation of Stanford policies that had nothing to do with salary and they were placing me on unpaid administrative leave to give me an opportunity to decide if I would come back into compliance with their policies.

[redacted] Let's go briefly off the record here.

[Discussion off the record.]

[Recess.]

[redacted] We'll go on the record at 11:33 a.m.

EXAMINATION

BY [redacted]:

Q Good morning again. Just to reintroduce myself, I'm [redacted] This is my colleague [redacted]. We've met before. Thank you again for meeting with us about a month ago now, it feels like.

A Uh-huh. Yep.

Q So I know in your opening and in the majority hour they talked a little bit

about your educational background. I guess I just wanted to learn more about -- I think you talked about the medical school piece; you talked about your residency. I don't think we got into your doctorate.

You have a doctorate in philosophy as well, don't you, as well?

A It's a Ph.D. in pharmacology.

Q Can you just give us just the overview of your Ph.D. in pharmacology and your Ph.D. work specifically?

A Yeah. So the Ph.D. program itself includes a small amount of coursework focused on, kind of, the enterprise of science and understanding the scientific methods and its application to, you know, the topic you're interested in, so in my case it was pharmacology.

But the majority of the Ph.D. is focused on performing direct research. So I was in a research lab, studying how the immune system recognizes and differentiates self from non-self. So, of course, the immune system needs to know "this is infection; I need to fight that," and "this is pancreas; I shouldn't fight that."

Q Right.

A So I studied in cell cultures and in small-animal models aspects of this which are called the NLRP3 inflammasome. It's what's called a pattern-recognition receptor that helps facilitate that differentiation and then, in the appropriate settings, in the appropriate case, leads to inflammation to help fight off infections.

Q Got it. Got it. Thank you for that explanation.

And so I believe, also, you were talking to the majority in your opening -- you said you completed 2 years of residency in internal medicine at Stanford? Or, that was your -- what were you doing at Stanford? That was your fellowship, correct?

A Stanford was my residency and fellowship.

Q And fellowship. Okay.

A Uh-huh.

Q So just help us understand what you completed with your residency at Stanford.

A Yeah. So, conventionally, an internal medicine residency is 3 years, but with this combined program where I was offered the fellowship guarantee up front, they effectively let you trade one of your residency years for a fellowship year.

Q Got it.

A So that's why I had 2 years of internal medicine residency; and then 2 years of clinical training in my subspecialties, rheumatology and pulmonary medicine; and then 3 years of research training as part of that fellowship.

So I had completed the entirety of those clinical training years and then was in the first research year when that first 6 months of the dispute with Stanford was playing out and was suspended and -- or was placed on unpaid administrative leave in December of that first research year.

Q So, if the dispute with Stanford would not have happened, how much time would you have left in your program?

A Two and a half years.

Q Two and a half years. And what would you be doing those last 2-1/2 years?

A So that would be the research training. If the dispute didn't happen, I would have been continuing my work at Gilead under the agreements we had structured and would have been seeing patients in rheumatology and pulmonary clinics at Stanford and participating in things like a board review session and grand rounds seminars.

Q Are you currently working somewhere other than Gilead right now?

A Yes, I am.

Q Where are you working right now?

A I'm working with Eli Lilly.

Q What are you doing with Eli Lilly?

A I oversee the design and conduct of clinical trials from a medical aspect.

Q Are you still seeking opportunities to complete the remaining years of the training you just described at Stanford?

A As far as I'm aware, no opportunities are available to me.

Q What do you mean by that?

A While I was at Stanford and had these agreements formed and had reached kind of an understanding that there was not an overwhelming conflict of interest, in part, as I described, because my work was in liver disease and my clinical work was in a separate disease area and I was being supervised, now my work has shifted. At Eli Lilly, I work in pulmonary medicine. There is a substantial conflict of interest. Eli Lilly makes several medicines that would be prescribed in the context of that work.

So I would have to go to an institution, tell them, "I have 2-1/2 years to complete to satisfy the requirements of my board eligibility, but I only will work for you half a day a week. I need you to agree to this unusually structured thing that I previously had with Stanford that they disrupted and accept all the potential conflicts of interest that I have now as a senior director at Eli Lilly."

I had previously talked to UC San Francisco about whether they would even allow me to do the rheumatology and pulmonary together, as I had set out to do and was doing at Stanford, and they said they had no interest in supporting that. And so it seemed clear to me that this was a -- quite an uphill battle to find an opportunity.

Q And the uphill battle is because of your current employment and what you're currently doing for your day job, right?

A It's partly the current employment, but it's also that the contribution I would make to the institution that would hire me would be minimal -- I would do half a day of clinic a week -- but they would have to incorporate me into, effectively, their HR organization. They'd have the same administrative burden of overseeing that half-day a week as they otherwise would if I was a full-time employee there. So it's just not a compelling offer to make to the university.

Q What goes into clinical work? Like, what does that mean?

A So I can describe it in the two settings I'm most familiar with from my training and then a little bit about a third from my medical school experiences.

The core of my residency and fellowship training was in the hospital. As an internal medicine resident, I would be responsible for what are called the general medical wards. So all the patients who are admitted to the hospital who were overseen by a general medical physician, I would participate in the care of, you know, some -- usually it was 8 to 12 of those on my team.

That would be checking in on them first thing in the morning to see how things went overnight; talking to the night residents to understand if there were any acute issues or any changes in the medical plan that occurred overnight; reviewing the data that was generated that day, which is often vital-signs data, laboratory data, notes from the nightshift doctors and nurses; going around and seeing all the patients to perform daily physical exams and ask them how they're doing and how they're progressing in the course of their care.

And then we would gather as a team. Usually it would be two junior residents, two interns, and one senior resident, a second- or third-year, and then an attending. Then we would spend several hours going around for the rest of the morning as a team seeing the patients. And, as the intern, you would present all the findings overnight, the

updates, the labs and things, as I mentioned, and then propose a plan as to what should be done today to advance the care of the patient -- changes in medications or physical therapy and other services like that.

Q If you don't mind, I'm going to cut you off right there.

A Yep.

Q When you're discussing these plans, are you talking to any, like, let's say, attending physicians? Teachers? Are they involved in this process at all?

A So, yeah, it's two interns, a senior resident, and an attending.

Q Okay.

A Yeah. The structure is often such that the senior resident is supposed to be the leader of the team --

Q Uh-huh.

A -- and then the attending is kind of the authority if there's uncertainty. They're the one who's supposed to provide, kind of, the final decision on matters.

Q So were you the senior resident in this case?

A So I have done the junior-resident, the intern role, as well as the senior-resident role.

Q And when you were at Stanford, were you mostly in the -- doing, like, these last clinical years, were you mostly in the senior role? Or --

A So I was a fellow in those final years.

In pulmonary medicine, you participate in that same team structure in the ICU, where you are the addition to the team, so two interns, a resident, a senior resident, a fellow, and then the attending. And then the fellow is supposed to be kind of the authority, and only in rare instances does the attending chime in.

The other capacity as a fellow is to serve as a consultant for the hospital. So, if a

patient is admitted to the general medical ward that has a pulmonary question, they might call the pulmonary doc and say, "Come see this and give us your thoughts on, you know, what this finding was on the CT" or whatever it may be.

Q Okay.

A So I served in all of those capacities at various times.

Q So, just to make sure I'm understanding just the current situation right now, I think you have said you pretty much find it impossible for you to continue your program elsewhere right now due to your current employment and job with Eli Lilly?

A Yes. Yeah.

Q Okay.

A It's also -- because of what I had previously described around the rules related to transfer between programs, my understanding is I would need Stanford to sponsor me to restart my residency -- I'm sorry -- restart my fellowship at another institution and to provide to that institution the details of my training progression and, very likely, also why I'm transferring.

Q But just to make sure I'm -- you said your "understanding." Did you ever try to transfer?

A I have not tried to transfer, because the circumstances are overwhelmingly not in my favor.

Q I think my question is very clear. Did you ever try to transfer?

A No, I did not.

Q Thanks.

Have you ever worked in the National Resident Matching Program?

A Have I ever worked in it?

Q Yeah. Have you ever done work for the National Resident Matching

Program?

A No, I have not, huh-uh.

Q Have you ever worked for the Accreditation Council for Graduate Medical Education, or ACGME?

A No, I have not.

Q Have you ever worked for the Association of American Medical Colleges?

A No, I have not.

Q So, earlier and throughout kind of the majority's hour, you -- I mean, correct me if I'm mischaracterizing -- you made a lot of statements about how ACGME works or how the Match works. What are you basing this off of?

A Their published policies on their websites.

Q Okay. But you've, like, never actually worked for ACGME to stop a medical school from adding residency slots, correct?

A No, I have never worked with ACGME to stop that.

Q Have you ever worked at a medical school and applied for additional residency slots?

A My program directors had and communicated to me the results of those.

Q Did you ever apply for additional residency slots on behalf of a hospital?

A No, I did not, huh-uh.

Q Okay.

So let's circle back to medical school for a little bit. When did you apply for your residency?

A I applied for residency -- that first round of applications started in, I think, the fall of 2017.

Q Okay. Can you describe, I guess, like, what you were considering when you

were applying for your residency?

A Yeah. I had mentioned before that the important aspects were the quality of the training programs that I was applying to, the opportunity to advance my research interests and career there, and then the location and the quality of life that I would attain, as I was also moving with my spouse at the time.

Q Okay. How did you go about identifying the schools you wanted to apply to?

A A lot of it was driven by just research on public websites, trying to investigate where different professors ran labs that aligned with my research interests.

Q So we talked about salary earlier between the different residency programs. How were you able to identify what the different salaries or benefit packages would be when you were applying?

A Most institutions, I believe, have their website -- usually it's the GME website -- where they post the entire PGY scale, so the dollar-and-cent amount of their salaries, as well as details about their benefits.

They're supposed to also make available the contracts that one would anticipate signing if they were to matriculate in that program.

And then, of course, during the process, you have the opportunity to ask questions about all of that.

Q Okay.

You made a few answers to the majority earlier about, you know -- I think you might've said, like, it's an effective agreement between the schools about salary. I guess, can you help us understand why you believe that or what's your basis for that?

A Well, it's a near- -- so I think what you might be referring to is this report that the institutions themselves volunteer to the AAMC in a survey that 96 percent of

them pay everybody the same based on the PGY scale. So it seems there is universal practice -- near-universal practice in that.

I'm not aware of any formalized agreements that they have or any policies which require that they do that, but it just is quite striking that they all ended up doing the exact same thing.

Q I think what I was referring to, actually, was the -- I think you said there was, like, no meaningful difference in the pay between different residency programs. Did I mishear you? Or were you talking about the specialties?

A No, no. So between institutions --

Q Uh-huh.

A -- the pay is effectively adjusted for cost-of-living differences, but accounting for those differences is nearly similar across the --

Q And so what is your view of that?

A I think that's strikingly abnormal.

Q Why do you believe it's strikingly abnormal?

A Well, I think if you work in any other industry and any other job, that is not the case. I think there are salary differences based on the needs of the corporation or institution, based on the quality and performance of the candidates, and based on performance in the job itself.

Q And it's your belief that this is not what residency programs are doing right now?

A I'm certain that's not what residency programs are doing right now, uh-huh.

Q You're "certain"? What does that mean? What's your certainty based upon?

A Based on the comments from [redacted], that they do not provide -- or

they do not allow programs to offer better salaries in order to recruit candidates to address institutional needs or to recruit candidates based on their qualifications or to improve the standing of employees based on their performance on the job.

Q Who was the "they" that [redacted] was referring to?

A [redacted] was referring to Stanford.

Q Stanford does not allow that.

A Yeah.

Q Okay.

Was Stanford your top choice for residency?

A Stanford was my top choice.

Q So, since you were matched into Stanford's program, would you say the Match worked for your professional goals?

A I'd say I'm not satisfied with my standing right now, but at the beginning I was quite satisfied.

Q So, when you were going through the program, Stanford being your top choice, you were matched there -- the program, I guess, or the Match worked for you, in your instance. Is that fair to say?

A Yes.

Q Okay.

A Uh-huh.

Q So do you have any complaints about your personal residency application process?

A Yeah, I do.

Q Okay.

A I do.

Q Can we hear them, please?

A Yeah. So when -- it's -- I kind of contrast the residency application process to my experience trying to get this research position and fellowship.

When I was in medical school applying for the Match, as I described, I had to apply for every university institution I was interested in at the time. And, on top of that, because of the uncertainty as to what offer I would receive, and had to ensure that my partner was satisfied, as well, with the location and career opportunities for herself, it took us several weeks to travel the country together, after I had already traveled on my own to go do all the interviews, for us to then revisit sites for her to visit and see, do I want to live in Nashville, or Palo Alto, or Seattle, or anywhere else? So I had to take out a loan of about, I think it was, $30,000 to help facilitate that as well as to help facilitate my ultimate move to Stanford once I received that offer.

In contrast, when I applied for the programs with the companies during fellowship, I submitted six applications. I received, I think, four offers to interview. Those interviews were conducted remotely. It was performed expeditiously. And then I received an offer, having incurred effectively no expense --

Q Uh-huh.

A -- to do that.

Q No, I hear you.

A Uh-huh.

Q So, just to summarize that, I guess what I'm hearing about your residency application experience was, right, you had to go there to the different schools to interview in person? Is that -- did I hear that right? The first time, you had to go interview by yourself. And then you had to go tour it with your partner at the time as well. So it was like two effective trips per place you wanted to apply to?

A Yes, uh-huh.

Q Yeah. No, I'm definitely empathetic to that point, especially -- but is that different than, like, regular undergrad, where people might have to go travel for the same reason and pay out of pocket?

A So, regular undergrad, usually you receive offers from all of the institutions that you'd like to apply to, and then at that point in time you're able to decide which of these -- you know, if you had one top choice -- in my case, Stanford was my top choice. Had I received competing offers, I could've said, "Well, this looks great. Let's just go look at Stanford" --

Q No, I'm not talking about with the actual application though. Let's say, when you're going through the exploratory phase of what you were talking about, if you're at different schools, you have to go visit it yourself, and then you have to take your family to visit it as well, I guess I'm trying to understand how that's different than any other kind of application process.

A Yeah, so I was trying to answer that. The application process in the university setting allows one to receive multiple offers at the same time. So you can apply -- and, most of the time, universities, you don't have to interview. The, I think, one case in the universities that I was applying to where I did interview, I think, was someone from Johns Hopkins, who they had me interview with someone in the town who was a former alumni.

Q Uh-huh.

A So I incurred no expense to apply -- to travel to apply for the universities.

Q Uh-huh.

A Once I received the offers for universities -- I think, if I recall, I applied to roughly 10 -- I was able to look at those offers and say, which of these are the ones I'm

most excited about? And then, among those, I went to UC Berkeley, I went to UCLA, and I went to the University of Chicago --

Q You visited all three of those?

A I visited all three of those.

Q Okay. Did you pay out of pocket for those?

A I think -- I went with my dad, and I think he paid.

Q So your dad paid out of pocket?

A Yeah, uh-huh.

Q Okay.

A For fellowship -- or for residency, rather -- I'm sorry -- you do not know what you're going to get until you get it.

Q Right.

A And so you have to make your decision in advance. Which, for me, I had, I think, 10 programs on my match list that my wife and I had to see and make decisions about how to order those.

Q So I just want to suggest maybe a potential solution. What if these residency programs could offer interviews in your town or virtual for you? Would that have changed the experience a little bit for you?

A That would've alleviated some of the burden of the cost, uh-huh.

Q Would it have alleviated the fact that you and your spouse or partner would've had to go travel to visit these places to make sure it would've worked for their career?

A Probably not.

Q Okay.

A Yeah.

Q When you were applying for residency, did you receive any exploding offers?

A No, huh-uh.

Q Would you say that the way the Match is right now, that's a benefit, because you don't receive any exploding offers?

A I can't say. I can't say.

Q What is an exploding offer, in your opinion?

A My understanding is this was something that was done in the 1940s, early 1950s, before the Match program came about, where the residency programs would aim to kind of fill the residency slots well in advance. So they would go to medical school students sometimes, from what I understand from the reading, either in their second, third, or fourth year medical school and make them an offer to say, "Come do residency here in this specialty. Here is, you know, the package or whatever, and you have 48 hours to decide if you want this or not."

Q So, with that definition and that historical, I guess, perspective you just provided, how do you think that would've impacted your applications for residency, if people were giving you 48-hour offers as a second-year student?

A It certainly would've made things challenging to do the visit with my partner, but, otherwise, I don't think I personally would have been terribly concerned about it, because I recognized I was quite a competitive candidate and would continue to receive offers under a circumstance like that.

Q What are the primary reasons medical students, in your opinion, do not find success in the Match?

A There's a number.

I'd say probably the most straightforward is someone who ends up ranking very few number of locations. This often happens when a person is with a partner or

someone else in their life and they have a specific geographic need or a specific location that they have to be at either for their partner's career, for family reasons, or otherwise.

Certainly, two individuals who themselves are medical school students together have to apply in kind of what they call a couples match. And so that requires that both people then qualify and get matched to the same location, which can be quite a challenge sometimes.

There certainly are people who apply who are not competitive candidates, who underperformed in medical school, and perhaps institutions are not interested in ranking those individuals highly.

Those are the ones that are first of mind, I would say.

Q With the partner one that you described, how is that any different than considering where you work in any other industry with a partner? Aren't people going to be geographically constrained by, potentially, their partner and, therefore, limiting the number of opportunities they might have? Is that different than any other profession?

A Yeah. So I believe there's around, I don't know, 160 institutions that sponsor residency programs in the United States. I can speak best about the Bay Area. There's probably four or five programs in the San Francisco Bay Area. Whereas, in comparison, when I started to look at biotech and pharma jobs, I believe there's over 80 companies in the Bay Area who, you know, provide employment for pharmaceutical jobs.

So the geographic constraint is more narrow in these academic training programs, because you just have to vie for a smaller number of positions.

Q Or is it just more narrow in the path you chose? Right? Because in the example you just gave, right, the biotech industry, let's say you were in Richmond, Virginia, right? You wouldn't have the opportunities there, right?

So it sounds like more so you're talking about what works for the Bay Area

because that was what worked for your family. Is that accurate to say?

A So, yeah, certainly there is unequal geographic distribution of companies, and there's obviously areas that have specialized sectors. The Bay Area has a specialized tech sector. Boston has a specialized pharmaceutical industry.

So there's always, when navigating life with another partner, some amount of collaboration and consideration as to how fitting a location is.

But the range of opportunities that's available, very greatly depending on the industry, the location, and the constraints of the specialty as well.

Q Do you think that all graduating medical students should pursue a residency or should have the opportunity to be a resident?

A Yeah. If they want to pursue that, I think they should have an opportunity to pursue that.

Q Why do you believe all graduating medical students should have the opportunity to be a resident?

A It's quite a commitment, to go to medical school. So of course everyone will have completed their undergraduate degrees, and then they, you know, set down on this path in the service of the American public. I think it's a very noble thing for them to do. And I think, you know, if they succeed on that path, they should be able to continue forward in order to see themselves through to that career that they've aimed for.

Q Thanks.

BY [redacted]

Q So that would have as a caveat to it underperforming students that you mentioned previously?

A Sure, if you get to the end of medical school and you have substantially underperformed and aren't competitive, aren't qualified, frankly, to continue on. The

residency is without a doubt the hardest thing that almost any physician will go through. And so someone underperforming in medical school likely will continue to underperform in --

Q What makes it so hard?

A I think it's, by and large, the time commitment that it takes. You know, we talked earlier about the 80-hour-workweek rules from the ACGME, which are loosely followed in many instances. To be clear, there's about 144 hours in a week, so 80 hours is more than half of the entirety of the week, even, you know, giving consideration for sleep.

In my experience when I was at Stanford, the longest period of time that I would work continuously was 30 hours straight. I would be, as the senior resident, responsible for the care of patients in the ICU at the county hospital, which could include up to 25 or 30 beds.

Q Right.

A And this --

Q Right.

A -- was of course --

Q Can I ask you a question?

A -- in the midst of the --

Q You keep referring to --

A -- COVID pandemic as well.

Q -- the 80-hour workweek for ACGME. Does the ACGME require an 80-hour workweek?

A My understanding is the ACGME has a rule that requires a no-greater-than-80-hour workweek.

Q So what you're saying is the ACGME does not require 80 hours. That is a cap.

A That's correct, uh-huh.

Q So the examples that you've given in terms of the excess hours above 80, those would be in violation of what the ACGME has as a cap to protect students, or residents?

A Yeah. There's a bit of a nuance to the rule. The cap is that the 80 hours applies over a 4-week period averaged.

Q Right.

A So, if you had 100 hours in 1 week, the next week, you know, on average, would have to be 60, and such and such. But that's a cap, yes.

Q So that's a restraint on what the teaching institutions could do.

A Yes.

Q Okay.

And you talked also about, before, the encouragement of the residency programs to tell the students not -- the residents not to report violations of the rules, such as going over 80 hours. Is that correct?

A I'm sorry. Can you rephrase the question?

Q Absolutely.

Before -- correct me if I'm wrong. Before, I think you were talking about how students are reluctant -- or, I used the word "student"; my apologies -- residents are reluctant to complain about their programs because that would then cause trouble for the program and that sometimes the programs actually discourage students from doing -- the residents from doing so.

A Yes.

Q That is true?

A Yes.

Q Okay. And so how is the ACGME supposed to learn about this?

A My understanding is, the ACGME has essentially a website where one can submit complaints about their program. As far as I understand, the website does not allow for anonymous complaints. But, there, they would detail that they were reporting -- or, you know, being told or being punished for working over 80 hours.

Many institutions -- I believe probably all of them, I think, on account of ACGME rules -- are supposed to have kind of an ombudsman and other unbiased third parties outside the program where one can go and talk to those individuals to help kind of mediate and resolve disputes or deal with complaints. The GME office is supposed to also deal with complaints.

And then the ACGME also conducts a survey of residents -- I think it's the ACGME -- annually, where they ask questions about training quality, compliance with work-hours, and things like that.

BY [redacted]

Q You said you worked, I think you said, 30 hours straight? Is that what you just said?

A Uh-huh.

Q Did you ever submit a complaint about that?

A I did not, huh-uh.

Q And when you said, like, the GMEs are supposed to have third parties and ombudsmen and -- is that true? In your experience, did Stanford have these?

A Yeah, Stanford had an ombudsman who was a member of the faculty, if I recall correctly, who was, from what was advertised, there to mediate disputes, uh-huh.

Q Right. So I guess I'm trying to understand what's the issue, then, if the school you went to had this third party to hear disputes about work-hours?

A I'm sorry?

Q What's the issue -- I mean, I think --

A What's the --

Q Yeah, what's the issue? If you have someone you can make a complaint to pursuant to the rules, what is the issue?

A So a lot of residents are both directly discouraged from --

Q By whom?

A -- reporting --

Q By whom?

A By their program directors, by the attendings who supervise them --

Q What is your evidence for that?

A The colleagues I worked with at Stanford telling me directly that that was happening to them.

Q So your testimony today is that you've had colleagues tell you not to submit complaints at Stanford?

A I had colleagues who themselves were told by their supervisors not to report overworking their hours.

Q So, just to make sure we understand this for the record, you have colleagues at Stanford who have colleagues who told them not to report any misconduct by Stanford?

A Walk with me here.

Q I am trying.

A I have colleagues at Stanford who themselves were told directly by their

programs --

Q Okay.

A -- not to report that they worked over the hour limit.

Q Did anyone ever tell you that directly?

A Yes.

Q Who told you that directly?

A My colleagues at Stanford. This was particularly as we were going through the union negotiation process and discussing the types of problems and grievances that the union, as it was forming, wanted to address. There was a WhatsApp chat group where all the residents were. And so I recall a colleague from the urology department who mentioned this in the group.

Q And I think -- look, I'm asking because I think you probably understand that, like, this is serious. This is a serious allegation --

A I very much --

Q -- that we'd want to --

A -- very much understand it's serious because I lived it.

Q And that's why we're trying to understand the evidence that supports your assertion of --

A Uh-huh.

Q -- a colleague telling you this.

A Yeah.

BY [redacted]

Q Okay. And so the concern that the institutions have, the project program directors telling your colleagues not to report violations, encouraging -- discouraging them from reporting violations, that is because the ACGME presumably will take action

and you sort of will cause trouble for the programs, correct?

A Yes.

Q Okay.

So ACGME has rules. When the rules are violated, there's a mechanism by which the residents can complain. And it's your understanding that, in fact, ACGME does actually come in and discipline or, you know, cause this trouble for the programs.

A Yeah. There's -- as I mentioned in my opening statement, if a resident submits complaints, if the ACGME has concerns about the accreditation -- the standards of the program meeting the accreditation standards, then the ACGME has procedures in which they place the programs on probation and, in some cases, will revoke the accreditation status, which, of course, ultimately negatively affects the residents, in that they no longer are working for an accredited program and have to then go find new employment --

Q Right.

A -- which often, as I mentioned about the transfers, can be quite a difficult situation.

Q Okay.

A As well, as I mentioned before, if residents or fellows raise concern about their work-hours to their programs, many times they will be met with, "How come you aren't efficient enough to do your work in the 80 hours?" --

Q Right.

A -- rather than --

Q Do you think that's sometimes a legitimate response?

A I think sometimes it probably is a legitimate response.

Q Okay. Thank you.

Moving on to another point that you just were discussing, you mentioned that residency programs were -- you were talking about residency programs, the consistency of the salaries across years -- so, like, the PGY-1 year.

A Uh-huh.

Q And you sort of talked about how you don't know of any other industry that sort of has that outcome.

A That's correct. Uh-huh.

Q Okay. Who pays for -- who funds residency programs?

A So my understanding is, the bulk of the funding for residency programs comes from the institutions that pay for the residents themselves.

Because of the -- there's a subsidy which is provided by CMS, which comes in two forms -- a direct payment based on the number of residents, which has been capped largely, I believe, since the mid-90s, with a small expansion that occurred in the COVID years, and then there is -- so that is intended to kind of pay directly for the residents themselves. It's a direct GME payment.

And then there's an indirect payment, which is an adjustment based on, I believe, the proportion of patients covered under Medicare who are cared for at the hospital. And that is intended to make up for what is perceived to be the greater use of resources by these hospitals who employ residents.

[12:07 p.m.]

BY [redacted]

Q Would you be surprised to know that the primary funder of graduate medical education is the Federal Government?

A Yeah, I would be surprised to learn that, because I believe the cap has severely been outstripped by the institutions' needs for residents and that they hired far more than the cap pays for directly.

Q Across the entire country, for all hospitals?

A I believe so.

Q That the different research and the teaching hospitals, you think the teaching hospitals are the primary payer?

A That would be my -- yeah, uh-huh.

Q Okay. And the teaching hospitals get that money how?

A The teaching hospitals are a revenue-generating entity and use that revenue to pay their employees.

Q Okay. And -- okay. Okay. So I wanted to also go back to your interesting discussion about drug development, which you obviously have clearly had a prolonged interest. And you talked about how the pharmacy -- the pharmaceutical companies offered unique training and educational opportunities.

Can you tell me just a little more about that? What was so unique about it?

A Yeah, as I mentioned, the type of research which is performed at a university may range anywhere from lab-based research to perhaps phase 1 clinical trials, to clinical research in kind of more of an observational setting and working with patients.

A pharmaceutical company, of course, is aiming to advance their interest of developing new medicines, which ultimately become marketed products for physicians

and patients to use, and use -- run studies, usually phase 2 and phase 3 studies, which are considerably more expensive --

Q So these are training opportunities and educational opportunities, in your opinion, you would not have in a normal teaching hospital?

A Yes.

Q And you need to be in these pharmaceutical companies in order to get that training and education?

A Yes.

Q Okay. Would you consider yourself to have been an employee of these pharmaceutical companies?

A Yes, uh-huh.

Q Okay. So is there any inconsistency between being an employee and having a robust teaching and educational opportunity?

A No.

Q Okay. And is there any inconsistency between contributing to the bottom line of an organization and still having a learning opportunity?

A No.

Q Okay. Thank you.

What you contributed to the drug development when you were working there, is that something that ends up directly benefiting the pharmaceutical company in the sense of you helped develop a drug and it gets sold, et cetera, like, your labor redounds to their economic benefit? Is that right?

A Yes.

Q Okay. And is it a straight line, what you do sort of ends up maybe increasing their profits a certain way?

A There's a considerable risk involved in the process and oftentimes things fail along the way, but in the successful instances, my contributions in the design and conduct of clinical trials is a straight line to the development of new products.

Q Are you aware of whether or not teaching hospitals are able to get full reimbursements for residents in terms of the procedures and things that they're engaged with?

A I believe it depends on the degree of supervision that the procedure was performed under as to whether they get the full reimbursement for the procedure.

Q Okay. So there will be certain instances in which they do not?

A I believe so.

Q Okay. Thank you.

In a general sense, what are medical standards? Medical standards in terms of, should we have standards associated with what it takes to become a practicing physician?

A So yes. I think generally across the United States in the training of physicians, as well as in the practice of medicine, there are standards as to what constitutes appropriate medical care based on, you know, the progression and development of new scientific technologies and procedures and also the availability of resources in the setting that's -- where the practice is being performed.

Q And so having that consistency, what it takes, you know, accreditation in order to become a doctor, in order to be a resident who completes it successfully, is that something that contributes to making sure that the relevant medical standards are met?

A I think it is tailored towards a specific interest and is not necessarily flexible for the vast ranging practice settings that exist in the United States.

For example, a rural hospital in -- I believe you all had a witness from, I think it was Michigan or somewhere, who was focused on rural hospitals -- certainly doesn't have the

same resources that Stanford University has. And there's a risk, if the accreditation standards are designed for Stanford, that they may not fit the rural hospital's needs.

BY [redacted]

Q Do the standards right now fit the Stanfords of the world and not the rural hospitals?

A I don't know. You have to talk to the people who oversee and administer those hospitals.

Q So the risk you just said was more of a hypothetical risk?

A It was one that I think a prior witness that you had at the committee had expressed.

Q Got it.

A Yes.

[redacted] Got it. Okay. Thanks.

BY [redacted]

Q And who is that establishes those standards? Because you mentioned that you'd have to go ask the rural hospitals, but who establishes standards?

A For the training of residents?

Q Yeah.

A The ACGME establishes the accreditation standards.

Q And they do so based on what?

A I don't know.

Q Okay. Okay. Would you suspect that they have experts?

A I believe the ACGME is run by primarily program directors and former program directors from various institutions who have participated in the training of residents before.

Q Okay. Let me go back to when you were an internal medicine resident. What's a procedure that you commonly performed?

A A paracentesis. So it would be a procedure to remove fluid from the peritoneal cavity of a patient who had liver failure.

Q Okay. Can you walk us through how you learned how to perform that procedure?

A Yeah. So when I was an intern, I would go with the senior resident, and they would perform the procedure, and they would instruct me on the steps to take to perform the procedure effectively and safely for the patient.

I would watch them do it once, the next time we'd go together, then they would have me perform the procedure while they watched and provided guidance on the procedure.

BY [redacted]

Q Can I ask, there was no, like, book reading material, you just went and watched the first time? There was nothing before that?

A Yeah. That's, I would say, how the vast majority of medical training occurs.

Q No reading at all, just watching the --

A For procedures.

Q Okay.

A Uh-huh.

BY [redacted]

Q And you just went and performed it immediately on the individual? You didn't -- are there procedures where there's practice in labs in any way? Labs meaning with dummies or things like that.

A Yeah. I recall one instance where we had a model, like a fake skin kind of

setup with, like, the spinal bones in it and practiced lumbar puncture procedure on that model.

Q Okay. And so tell me a little bit more about the lumbar puncture. First of all, define what it is.

A A lumbar puncture is a procedure where a needle is inserted into the spinal canal in order to extract fluid for, often, diagnostic testing.

Q Okay. And so take me through that process of learning how to do it again.

A So -- well, depending on where you are in your training and the need that --

Q We're talking about the first time you are --

A Right.

Q -- approaching this procedure, period.

A Yeah. So the -- if on day 4 of your intern year you have a patient who needs a lumbar puncture, you're going to learn this by going and watching your senior resident doing it and then ultimately doing it yourself.

The performance of the procedure in a kind of educational setting or trial will happen at some point during that year, but the timing and scheduling of that isn't necessarily day 1. It could be month 9 or something.

So everybody's experience varies a bit based on the needs of the patients they're caring for.

BY [redacted]

Q One quick question. You said so there is an educational component throughout -- at some part of that year?

A Uh-huh.

Q Okay.

A Yes.

Q Earlier when you were talking to the majority, you said -- I think you used even the term "minuscule" when describing the educational parts of residency. Is that still what you believe, it's minuscule?

A I did not say "minuscule." I said it was a minimal time commitment compared to the practice of medicine in the hospital.

[redacted] Got it. Thanks.

BY [redacted]

Q Okay. How important is standardization when it comes to some of these fundamental procedures like you were just describing in terms of, if you're an internal medicine physician in North Carolina, should you be able to perform basically the same procedure in California? Is that something that we want as a society?

A Yes.

Q Okay. Do you believe that patient outcomes would vary more widely if individual programs were not held to standardized educational requirements?

A I don't know.

Q Is it fair to say that medical standards are trying to make the practice of medicine safe across the board?

A Yes.

Q Okay. Are there risks if the programs were to deviate significantly from the national standards?

A I suppose there would.

Q Right. Standards when it comes to FDA approval is probably something you know a lot about --

A Yes.

Q -- for pharma. Why do we have standards within that -- in that context?

A The FDA has an interest in ensuring the efficacy and safety of medicines and has a legal requirement to do so from the laws which have been passed over the years to establish the current function of the FDA.

Q Right. And would you say that a corollary of that is that, just as the drugs that we put into our bodies are safe and effective, that you want to make sure that the person administering them has the requisite knowledge and skill to do so effectively?

A I think -- I don't know that that's a perfect corollary. There certainly are different standards that the FDA employs for diseases which impact a large number of patients compared to those which are extraordinarily rare and impact a small number of patients.

There are different procedures that the FDA has for approving drugs on an accelerated basis particularly for diseases of high medical need. For example, a rare cancer indication --

Q For a baseline sort of something that doesn't fall into that category of an emergency medical need, would the general proposition hold that you want to have a requisite floor in terms of the skill and quality of the physician, as well as the baseline in terms of the operation of the drug?

A Yes.

Q Fantastic. Okay. In 2022, you left your Stanford fellowship program. Is that correct?

A No. In 2022, I was placed on unpaid administrative leave by Stanford on December 17th.

Q Okay. And this departure was over the contract dispute that you explained previously. Is that correct?

A Yes.

Q Okay. Can you just, again, briefly summarize the nature of the dispute in a nutshell?

A Yes. I had agreements with Stanford that I would conduct my fellowship research training with a pharmaceutical company as an employee of that pharmaceutical company, and after having formed those agreements with the pharmaceutical company and with Stanford, Stanford subsequently objected to me being paid by the company. And that led to 6 months of the conversations as I described before and then ultimately me being placed on unpaid administrative leave for reasons other than anything we had discussed up to that point.

Q Understood. In your communications with Stanford GME leadership, what regulation did they allege you violated?

A The most specific claims were detailed in the leave -- I'm sorry -- the letter which placed me on unpaid administrative leave on December 17th, which stated that I was in violation of a policy in acceptance of a title, of the word "director," which was a title that they were aware of in April and in May prior to me accepting that and having been -- explicitly giving me permission to accept that title. So that struck me as odd.

The second was Stanford said that my confidentiality and intellectual property agreement assigning my intellectual property contributions to Gilead for the work I did at Gilead was in violation of Stanford's intellectual property policies. I had no intellectual property agreements with Stanford, so that too struck me as somewhat strange.

Q Was there any violation of the ACGME regulations alleged, and if so, which one?

A The third claim Stanford said I was in violation of university and ACGME policies and procedures. I asked them to clarify what policies and procedures, and they did not provide any clarification.

Q So they never explained which ACGME regulation was at issue?
A That's correct.
Q Okay. And so what role did ACGME play in your contract dispute with Stanford?
A ACGME did not play a role in my contract dispute with Stanford.
Q Okay. So given that, would it be accurate to say the breakdown occurred within Stanford's administration?
A Yes.
Q Okay. ACGME sets due process regulations for accredited GME programs to follow. Do you believe Stanford Health followed those regulations?
A Did I believe they what? I'm sorry.
Q Stanford Health followed these regulations?
A Oh, Stanford Health. No, no, they did not.
Q Did you make ACGME aware of this potential failure?
A I submitted a complaint to ACGME.
Q Okay. Do you know any of the outcomes associated with it?
A No.
Q Okay. ACGME regulates programs, not residents or the fellows themselves. Do you agree with this statement?
A That's my understanding as well.
Q Okay. In your opinion, why do you think Stanford failed to follow the due process required by ACGME standards?
A So the ACGME standards, as far as I understand, require that Stan -- require that the institutions, the accredited institutions have a due process procedure. Doesn't exactly have any specifics as to what that procedure must entail.

When Stanford established their procedure, they made it part of the contract that is signed between Stanford and the residents and fellows.

My due process procedure had effectively four steps. The first was a -- excuse me -- a review by the chair of medicine, who would -- I spoke to him and he presumably spoke to others at the institution to kind of get both sides of the story. He came to me and said, I have no reservation. You have to go to the next step.

The next step was the chief medical officer. Same kind of thing. I spoke to him. He presumably spoke to others at the institution. He came to me and made an offer to resume my training under the substantially detrimental modifications, which was that I would forego my Gilead salary, in working in both of these capacities, as well as change my title to a consultant, which is not something Gilead would do, and then to facilitate an agreement between Gilead and Stanford, and then to comply with the ACGME policies and the university policy.

I asked him what that meant. He said, we've already answered all your questions. We're not going to talk about this any further. I told him I couldn't accept this offer because it was not in -- it was incongruent with the agreements we had formed before, and I requested that I go to the third step of this grievance procedure, which was a House Staff Review Committee.

At that -- so the House Staff Review Committee, just briefly, is structured three members appointed by the chief medical officer -- usually one resident, one faculty, and one member of the GME Committee.

When I requested this third stage for the House Staff Review Committee, I was told I was not eligible for this because I -- that was only a procedure for individuals who were facing nonadvancement determination. And Stanford said because they had offered me a contract, I technically wasn't facing nonadvancement determination. I

could simply accept that contract and continue to advance in the --

Q Is this dispute with Stanford ongoing?

A It's still ongoing, yeah.

Q Okay. Did ACGME ever prevent you from accepting the position at Gilead or completing your fellowship elsewhere?

A No.

Q Okay.

A Except through the transfer rules that they have, that I would need Stanford to sponsor my transfer to a new institution.

Q Did you ever make --

A And I did not --

Q Did you ever make an effort to have Stanford --

A No. I'm still involved in active litigation against Stanford.

Q Okay.

[redacted] So the answer's no, you didn't try to actually get --

Dr. Melehani. The answer's no.

[redacted] Thank you.

Dr. Melehani. Yeah.

[redacted] We'll go off the record here.

[redacted] We can go off the record. Thank you.

[Recess.]

[1:20 p.m.]

[redacted]. All right. Let's go back on the record.

BY [redacted]

Q Dr. Melehani, thank you again for testifying. I want to begin by talking a bit about what we covered in the last hour --

A Yes.

Q -- with the minority questioning.

You mentioned in the last hour that you've never worked for the ACGME, but you participated in a residency that was accredited by the ACGME, correct?

A Yes.

Q And a fellowship as well --

A Yes.

Q -- for a few years?

A Uh-huh.

Q And how many years in total did you participate in ACGME accredited program?

A So I was disrupted in my fifth year of the program, yeah.

Q So half a decade of participation. So you had familiarity with the surveys that they conduct with the residents?

A Yes.

Q And you had conversations during those 5 years about ACGME requirements?

A Yes.

Q So not only do you have exposure to the ACGME rules on their website, but you also have half a decade of experience with the ACGME, correct?

A Yes.

Q Now, you did also mention in the last hour that you received your top choice with Stanford, correct?

A Yes.

Q And in that sense, the Match worked out for your professional goals. Is that right?

A Yes.

Q However, do you recall the salary you received in your first year at Stanford?

A I think ballpark, it was about $72,000.

Q $72,000. And --

BY [redacted]

Q Would you agree that there's a distinction between being satisfied with your specific match or placement and being satisfied with the Match process as a whole?

A Yes.

Q Would you say you were satisfied with the Match process as a whole?

A No.

Q Would you have preferred to have negotiated your specific offer with Stanford that you did ultimately get placed with through the Match?

A Yes. And in doing that, also receiving offers for other employment opportunities at other institutions, to understand, you know, and negotiate those offers all in parallel.

Q Similarly, you were asked about the complications of looking for a job with a partner who was similarly looking for a job. Is that correct?

A Yes.

Q Would you say that having to receive and accept one single offer made that

process substantially more complex than if you had been able to receive multiple offers and decide at that time which area you'd like to have gone to?

A Oh, yes, absolutely. This was a huge point of stress for my wife at the time. She was at UNC Law School, and we were graduating at the same time, so -- which was quite fortunate we were able to move together. But she didn't know where she would have to obtain her license. She didn't know what bar exam she would have to take and what the future would hold for her.

Q You also testified that you found it easier to go through the fellowship process than you did the original residency process. Is that correct?

A That's on account of the type of program I was accepted into where I was effectively guaranteed. Typically, the fellowship application process looks exactly the same as the residency application process.

Q And part of the reason that your fellowship process was less burdensome was because they largely did not follow the Match placement process. Is that correct?

A Yes.

BY [redacted]

Q And going back a little bit to how your match with Stanford aligned with your professional goals, do you believe that if you had the ability to negotiate your contract with Stanford on the basis of competing offers, that that would have increased the salary that you ultimately received?

A Yes.

Q And so in that sense, the Match's restriction on such negotiations impeded your professional goals?

A Yes.

Q In what other ways, just briefly, generally speaking, did the Match impede

your professional goals?

A So as I was going through this fellowship process and then entering into this dispute with Stanford, had that occurred in a normal job setting, in a normal corporation, if I ran into a conflict with my employer -- let's say I was working at a Google or an Apple -- I could go and apply for jobs immediately and start getting jobs at those other companies.

If during that process, though, I began to apply for other residency opportunities -- or other fellowship opportunities, I would require Stanford to both support me in the midst of that dispute while I'm pursuing litigation against them. It doesn't take a wild guess to imagine how that might turn out when you're actively suing your employer and asking for their help at the same time.

Q And is it true that you, under some scenarios, you may have to go back into the Match to get a new position if you had to -- if you wanted to maybe start fellowship all over again?

A Yeah. It's -- it's not entirely clear to me, from my personal circumstance, if I was to reenter, if I could just reenter and complete the 2 and a half years that had been disrupted or if I would have to restart.

The American Board of Internal Medicine has a rule which somewhat addresses this topic of around disruptions in training programs, and they say that you can't have a greater than 6-month disruption in the training program. They don't explicitly clarify, well, what happens if you do have that disruption, but my interpretation of it is that it would require essentially that you restart.

So now I'm 2 and a half years out since that initial disruption when I was placed on unpaid administrative leave. So I'm under the impression, though I haven't tried to go back through the Match, that I would have to go back through the Match to restart

altogether.

Q Do you currently have board certification at some level?

A I'm board certified in internal medicine.

Q And so you were able to do that just based off of your initial residency that you completed at Stanford?

A Yes.

Q So you met the requirements?

A Yes, I met the requirements, uh-huh.

Q You also mentioned in the last hour that you had to take out a $30,000 loan just to have enough resources to kind of complete the application process and kind of getting to residency. Is that right?

A Yes.

Q Could you explain kind of why that was needed and what that actually looks like in practice?

A Yeah. I think at the time there were maybe four or five financial service companies that offered these products, and I think they still do today. They're called residency and relocation loans oftentimes. It's like any loan that you apply, you submit documentation that you are, in fact, a medical student and need the loan for that purpose. You know, there's a credit check, I'm sure, and then they issue you the money.

For me, I needed that money because during the interview process, as I mentioned before, I had to go and individually interview, paying for the flights and hotels at all these locations. And then as I mentioned as well, because I was traveling with and because I was going to be moving with my spouse, her input was important, so she came around as well the second time to visit these places.

BY [redacted]

Q Was the reason you applied to such a large number of different programs and had to go through these expensive application and interview processes because you weren't sure whether somebody would make you an offer and you needed to kind of maximize the number of programs that you could rank and that might potentially rank you?

A So I would say I applied to an average number of programs, which I think was between 12 and 15 for the first round, and I ended up, I think, doing 10 interviews. For internal medicine, I think that's ballpark average.

I recognize having an MD/Ph.D. and excelled in my academic career at UNC that I would be a competitive candidate and wouldn't need to have an enormous slate of applications.

Colleagues and friends who were aiming for more competitive specialties often, as I mentioned, would have considerably more applications, sometimes 30, 40, 50.

Q Do you believe that absent the Match process, you would've potentially been able to limit the number of programs that you applied to and visited, given the iterative nature of offers and potential acceptances?

A Yes, absolutely.

Q And that would've reduced your overall cost of applying, interviewing, and visiting these facilities. Is that correct?

A Yes, that's correct.

[redacted] Would you agree that there are very few markets where someone has to take out thousands of dollars in loans in order just to secure a position?

Dr. Melehani. Yeah. The only thing I can think of is maybe if someone needed to obtain a license to, you know, I don't know, be an electrician or something, they might have to pay a license fee, but it typically isn't something that would cost $30,000, I don't

believe, in any State.

[redacted] And not a loan to do so?

Dr. Melehani. No, I don't believe so.

[redacted] You also -- go ahead.

[redacted] Just real quick, what would you estimate is the total amount of money that you spent on the application and interview process?

Dr. Melehani. I don't -- I don't recall specifically.

[redacted] Do you have a general estimate to how many hours you spent on this process?

Dr. Melehani. Well, if you include all the travel for interviews and things, this was a process which, you know, spanned over weeks, at the same time as I was working as a resident, of course, as well. So it was hundreds of hours, I would say.

[redacted] You discussed in the last hour some of the reasons for the Match originating, including offers that were earlier and earlier in a medical student's studies. Would you say, you know, during your second or third year of medical school that you had information and resources that would provide you with a sufficient level of information in order to kind of make the decisions about where to go in terms of residency?

Dr. Melehani. I'd say it's somewhat difficult. The first 2 years of medical school are really conventionally focused on kind of classroom instructional education, whereas the second 2 years are more practicum-style rotations as a member of the team that I described before.

It's not uncommon that someone will enter those years and, you know, have an intention of maybe going into surgery and then have a terrible experience in the surgery rotation and decide to change their mind. So there is some benefit to getting able to get

your feet wet before having to accept an offer.

[redacted] At that time in your education, there are resources online where you can see information about all of the residency programs, what their -- you know, their location and some of the other characteristics that would be valuable in making your decision, correct, about --

Dr. Melehani. Yes. That information every program has just listed on public websites for you to access.

BY [redacted]

Q The ACGME's main levers for responding to a program that may be deficient in a requirement are to remove accreditation or limit the number of residents that they can have. Is that correct?

A I think they have a probation lever before the removal level, but I believe those are the primary tools.

Q So if, for example, residents were working too many hours over the 80-hour limit because there was an excess workload, do you think that they may fear that by reporting this to the ACGME, that program could lose residency spots and thus increase the workload?

A Yeah. I'm not -- I don't know of any specific examples where they actively took away spots. I know of one example, the neurosurgery program at I believe it's the University of New Mexico, where this kind of overwork and malicious-type program existed, and the ACGME enforced removal of the accreditation, and so all the neurosurgery residents then had to go find new unemployment at that point in time.

Q Would you say that that creates an incentive not to report issues that may arise during that process?

A Yeah. I think there's very much a culture in medical residencies of just

keeping your head down to get through because, once you're done, you can be an independent physician. You have the freedom to apply for whatever jobs you want, to leave whatever jobs you have. And everyone has kind of a fixed time that they're in this residency, so it's sometimes easier just to keep your head down than to file complaints and risk retaliation or risk other actions taken against you.

Q And then, you know, you spoke a little bit in the last hour about the percent of time spent training and being educated versus percent of time practicing and performing procedures.

If you had a general estimate, what would you say is the percentage breakdown that you spent training, reading books, educating, verse actually performing procedures and engaging in the job of being a physician-like resident?

A So, you know, in the course of providing care for patients, there's always new things that come up or new problems that you aren't familiar with. And we had a suite of kind of online resources that are available to all doctors, and so, you know, if I don't know the guidelines on prescribing antibiotics for a hospital-associated pneumonia, I can go and look that up. So there's a lot of kind of self-motivated learning -- learning focused on the problem at hand.

The actual kind of like educational instruction that's provided in an average 14-hour day would amount to about an hour and a half.

BY [redacted]

Q You also spoke about the breakdown between education and your employment in the terms of kind of the larger conversation about salaries in the last hour.

Would you say that -- well, so first of all, how much money did you receive from Stanford again, I guess, your fifth year in your fellowship?

A I think it was about $84,000.

Q $84,000. And then how much did you receive from Gilead that same year?

A 250,000 base, plus roughly 75,000, I think, as a signing bonus, and then also a stock bonus.

Q Do you think that just the fact that you were receiving training as a fellow in one context accounts for that discrepancy, and what other factors could account for the discrepancy in salaries between those two kind of contemporaneous --

A Yeah. So it's -- I think in my job now as a senior medical director at Eli Lilly I'm still learning. I still receive instruction. I attend lectures on statistics, on general principles of statistics, as it applies to clinical trials. And I have mentors, I have supervisors who review my work and provide their perspective and input on that work. And every day I'm learning. I don't think in this line of work there's ever a day where we stop learning.

And so to equate the idea that, well, you're learning so we can pay you less, I certainly don't think Eli Lilly would ever try to pull that. I don't think any company would ever try to pull that. And I think that Stanford does it because they have a system which permits them to maintain control, because the residents can't leave and they have effectively no other option.

[redacted] Would you agree that in most professions there is an element of both education, training, and learning that goes on within the course of a standard job?

Dr. Melehani. Yes.

[redacted] In most professions, are you paid a drastically lower salary in the first portion of that job before your training and learning is complete?

Dr. Melehani. Not that I'm aware.

BY [redacted]

Q I would like to now turn back to our discussion in the first hour about your experience in your fellowship at Stanford.

A Uh-huh.

Q You mentioned in the last hour to minority staff that you issued a complaint regarding the situation to the ACGME, but they never responded.

Did you hear anything from the ACGME about that?

A No, no. And I would also add, I issued a complaint to the -- I can't remember the official name, but essentially the employment division of the Attorney General's Office in the State of California, in kind of the standard processes to file complaints against your employer. And I've heard nothing from any of them.

Q You mentioned also that Stanford offered to have Gilead pay your salary to Stanford, and then they would -- I believe they would take a portion of that as a donation. Is that correct -- or can you explain kind of the donation offer that they presented to you and what that actually looked like?

A Yeah. So two separate things here. I'll go through each of them just so we can lay them out.

The first was Stanford's initial plan, which was Gilead would pay my 83-, or whatever, $84,000 salary to Stanford, and Stanford would then cash the check and issue me a check for $84,000, you know, on an annualized basis, of course. That, Gilead said, isn't going to fly, of course.

What they ended up offering me in November -- this is where the donation thing came in -- was that they would -- Stanford had up to that time been playing me the full-time salary even despite my refusal initially to accept it. And they said, well, we'll give you that money, we'll pay the FICA taxes, but then you have to take it and give it back to us. You have to pay us $84,000 back and you have to pay whatever we paid for

the FICA taxes.

Of course, receiving the $84,000, I would then pay FICA taxes, I would pay State and Federal employment taxes. So I would, in effect, you know, I don't know how much, receive, let's say, 60,000, and then I would have to give back possibly 95,000 or something to Stanford.

So that was the kind of forced donation aspect that they offered on November 1st in writing to me.

Q So, in other words, you would be paying them to work for them?

A Yes.

Q You also -- or I want to just ask, did Stanford ever ask you for backpay for your work as well in addition to this?

A Yes. So when they put me on unpaid administrative leave, they said that they were unknowingly paying me a salary that I was not earning -- or rather they knew they were paying me the salary but unknowing to them, supposedly, it was not in performance of work for them, despite me reporting to Gilead for work every day, having calls from the Gilead office with my program directors on multiple occasions, having my program directors having calls with my managers at Gilead.

So magically they somehow could not piece together that I was working at Gilead during that time. That was obviously sarcastic. That may not come through in the record.

But they -- as one of the conditions of my return to fellowship, they stated I would have to pay them back for the salary that they paid me which I had initially refused.

Q Do you know how much backpay they demanded?

A Yeah. So it was from July 1st to the end of December of that year, and they said I owed them 80 percent of what they paid me, which is roughly $35,000.

Q Did you end up giving them any backpay?

A No. I reminded them that I had initially refused this pay and that they were well aware of the work I was doing at Gilead, and so I did not accept this offer to pay them back.

Q And you stated Stanford ultimately placed you on unpaid administrative leave for 8 months, correct?

A That's correct.

Q And ultimately, Stanford terminated you through a constructive discharge, correct?

A Yes.

[redacted] Just to go back a half a second, had you ever discussed giving backpay to Stanford before that time? Had that ever been something that was discussed along the way?

Dr. Melehani. Not that I recall.

BY [redacted]

Q I want to turn now to the -- you mentioned at some level the AAMC's survey of stipends and benefits and other information-sharing mechanisms that exist in the medical residency market.

A Yes.

Q Can you explain what the AAMC Survey of Resident and Fellow Stipends and Benefits actually is?

A My understanding, they -- so just based on the release of the results of that survey that they provide publicly, but they ask each of the institutions and the programs to report the salaries they pay and I believe the types of benefits that they provide. And then there's a series of questions, like the one I mentioned where they ask, do you pay

everybody the same based on the PGY scale. And then you can see, based on regions, effectively what the mean and median salary is for each of the PGY years across those programs.

Q Are you familiar with FREIDA, the Fellowship and Residency Electronic Interactive Database, operated by the American Medical Association?

A Yes.

Q Do you believe that Stanford's use of the AAMC survey and FREIDA allow it to fix and suppress resident and fellow salaries?

A Yes, I do. And I think one seeming coincidence perhaps or maybe evidence of this attempt to fix is that the difference in salary between Stanford first-year residents who start today and UC San Francisco residents who start today is $150.

Q And in the same region it's $150 difference?

A $150 difference between Stanford and San Francisco.

Q How does Stanford use the AAMC survey and FREIDA to allow it to fix and suppress resident and fellow salaries in practice?

A I don't know how they actively use it. I can speculate that because they have wide-ranging access to the specific details of salaries and benefits for every program across the country through the FREIDA database and through the publishing of these information on public websites, that they can watch what their competitors do and ensure that they move in lockstep with their competitors.

Q What advantage does this provide to Stanford to do this?

A I think if you look in contrast to other healthcare workers whose salary is not publicly shared, there has been, for example, in the physician assistants and nurse practitioners, a substantial rise in salary over the years as there has been a massive drive to recruit these individuals as patient volumes and demand for healthcare services

increase.

So, for example, a newly minted, zero-experience physician assistant or nurse practitioner at Stanford, under a recent job posting, could expect to receive a salary between 150,000 and $180,000. Their work would entail very much the same kind of work I performed as an internal medicine resident. That, however, would be limited to only 36 hours a week, instead of capped at 80 hours a week as it was for me. And they would not have any responsibilities for providing medical care overnight. So their shifts would be three shifts a week, 7 to 7 kind of thing.

To me, the evidence that suggests that Stanford really benefits from this price control on the residents is the fact that, from the time I started residency in 2018 to today, Stanford's internal medicine program expanded by seven residents. At the time I started, there were, I believe, 37, and there were zero physician assistants and nurse practitioners. Today there are 44 internal medicine residents in the core internal medicine program, an increase by 7, and there are roughly 25 physician assistants and nurse practitioners.

So Stanford has gone out and hired 25 individuals at twice the cost for half the amount of time worked when they surely, if they're an economically rational actor, would have preferred to hire residents under this fixed salary, but they were limited, of course, as far as I understand, by the ACGME's control over expansion of programs.

Q So, in other words, Stanford's price fixing allows it to hire and employ more qualified healthcare professionals and pay them less than they would nurse practitioners and physician assistants?

A Yes. And get more from them in terms of the time worked.

Q So to put simply, you believe that Stanford is participating in a price-fixing scheme?

A Yes.

[redacted] Go ahead.

[redacted] Couple quick questions.

BY [redacted]

Q The NRMP does not specifically require residency programs to set salaries at a certain level, do they?

A Correct, they do not.

Q And the ACGME does not specifically require residency programs to set salaries at a certain level. Is that correct?

A That's correct.

Q However, do you believe that the Match and the NRMP's placement processes make it easier for residency programs to coordinate on things like salary decisions?

A Yes.

Q Do you believe that the ACGME's restrictions and cap on the number of positions, other policies, also make it easier for programs to set the salary of their residents at one uniform level?

A Yes.

[redacted] I want to actually go back to those questions.

BY [redacted]

Q So how does the Match's prohibition on wage negotiations allow for the conditions for a price-fixing scheme in the market?

A So the -- I mean, the NRMP in the Match, by -- I'm not so sure that they have a policy that says you can't negotiate your wage. But, in effect, because you only receive one offer and you have to accept that offer once you've agreed to participate in

the Match, then you have no ability to negotiate the wage.

It would be like going to a job interview on your first day -- your first interview, trying to negotiate your wage. You obviously have to kind of sell yourself as a candidate. You have to demonstrate that you're, you know, qualified and that -- receive interest.

I think in any job it's very typical to wait until you receive the offer and then negotiate. So I think that's, in part, how it plays out.

Q So that restriction on, you know, the binding commitment, that nature, those Match restrictions, would you say that those allow hospitals like Stanford to set wages without fear that they're going to have to have individualized negotiations that could disrupt the fixed wage that they set?

A Yes.

Q So do you believe that your additional source of income through your position at Gilead threatened Stanford's participation in its price-fixing scheme?

A Yes.

Q What leads you to that conclusion?

A So while I was directly told by the former director of the internal medicine program that he believes Stanford feared setting a precedent where as a res- -- as a fellow at the time, I, having arranged this research experience and employment with the pharmaceutical company, was able to dramatically increase my salary, over three-fold increase in my salary.

For individuals who were satisfied in having completed their training and didn't feel that the research training component substantially advanced their career, for example, if they were going to go into private practice or something similar, or if they wanted to go into industry and do drug development like I am, they too would opt to go

for a increased salary to see through that fixed period of time that they had to complete in order to satisfy their board-eligibility requirements.

Q You mentioned in the first hour that Stanford said things to you, like that they needed to funnel the money in a particular way, and they needed to pay residents all the same. How did those particular statements, in your view, relate to this price-fixing scheme?

A They were clear expressions of the motivation and effect of what they were aiming to achieve with this price-fixing scheme.

Q Stating that they need to pay everyone the same speaks to uniformity of wages, correct?

A Yes.

Q And do you believe that Stanford's participation in a price-fixing scheme forced you to accept an artificially low salary and prevented you from simultaneously pursuing a position with Gilead?

A Yes.

[redacted] You also testified that they specifically made you aware of previous situations in which a residency program wanted to offer residents a higher wage in order to attract more qualified candidates but were prevented from doing so. Is that correct?

Dr. Melehani. Yes.

[redacted] So as you understand it, Stanford prevented one of its programs from actively negotiating with residents to attract more qualified residents. Is that correct?

Dr. Melehani. Yes.

[redacted] And the reason for that is to maintain uniformity in salaries?

Dr. Melehani. Yes.

[redacted] I'd like to turn to the AAMC's Survey of Resident and Fellow Stipends and Benefits Report specifically, and we have a copy we'll share with you, and we'll mark it as exhibit 1.

[Melehani Exhibit No. 1.
was marked for identification.]

Dr. Melehani. I hope you don't make me read this right now.

[redacted] No. You can familiarize yourself with it. Certainly no need to read the entire issue.

Dr. Melehani. Yeah, yeah. I've seen this before, yes.

BY [redacted]

Q When you're ready, you can just look at the first page there.

A Okay. Ready.

Q On page 1, it states that the report was released in November 2024. And at the bottom of the page, the very bottom, it says that information from the 2024 survey is as of July 1st, 2024. Do you see those words?

A Yes.

Q So, in other words, when the AAMC report is released, the resident and fellow stipend and benefit information it includes is 4 months old, right?

A It's current. The salary doesn't change over the years, so that's the salary as it is.

Q So across -- generally speaking, in the residency market, salaries don't change across the year. Is that right?

A Yeah. Typically, they'll just increase when you advance your PGY year.

Q So, in a sense, providing information as of July in November is, in practice,

real-time information?

A It's real-time information.

Q Let's turn to page 10, and you can see at the top of the page that it's numbered, but page 10 of the document.

A Where -- you said the number's at the top?

Q Yeah. It says -- the top there, they're called Bates numbers. It says DUHS, and then dash HJC, and then it says 000, and then you can follow --

A The 10?

Q Yeah, the 10 is the --

A So this "Methodology" page?

Q Correct, yes.

A Okay.

Q And the second to last paragraph starts with "The 2024 report." It states, The 2024 report includes stipends data from 116,786 residents and fellows as of July 1st, 2024. Resident counts are not yet known for the 2024-2025 academic year. According to the ACGME, the total number of on-duty residents and fellows was 162,644, in academic year 2023 through 2024. This suggests an approximate coverage rate of 71.8 percent of the 2024 report.

Do you see those words?

A Yes.

Q In other words, the AAMC survey includes salary and benefit information for almost three-fourths of the medical residency and fellowship market. Correct?

A Yes.

Q Let's now turn to page 15.

A Okay.

Q At the top of the page it reads, Table 1, Resident/Fellow Unweighted Stipends Nationwide.

Under program year 1, the mean unweighted stipend is $66,712. Do you see that?

A Yes.

Q Given the work that residents perform, do you think that this salary reflects the market value of residents and fellows?

A No.

Q Why exactly?

A Because when I would go get dinner at In-N-Out or Panda Express, I could get a higher salary there.

Q The total annual salary for someone at In-N-Out or Panda Express is higher than that?

A Yeah. I would commonly go into Panda Express. There would be an advertisement on the wall saying that they -- this is in the bay area, of course -- but that they were starting managers at Panda Express at a salary substantially greater than this.

Q And this is a salary for folks who have completed medical school?

A Yes.

Q The average across the Nation?

A This is the salary for the people who provide the majority of care for hospitalized patients in academic training programs.

Q And in some cases, these folks are working, as you said in the prior hour, over 80 hours a week?

A Yes.

Q How does the salary compare to the salaries -- and we've discussed this -- of

other healthcare professionals who perform similar work?

A It's probably less than half in most instances. There may be some geographic variation, but I mentioned the physician assistant and nurse practitioners at Stanford make around 150- to 180- at least is what the advertised range is for that position. And I believe that proportion, that difference between what I was receiving and what they were receiving, is common across the country.

Q Are you aware of any healthcare professionals that receive higher salaries -- or lower salaries than residents?

A There may be assistant physical therapists or others like that who qualify through their associate's degree or a kind of professional-in-training program that results in a certificate that make salaries like this or lower.

Q But none who have received, of course, their medical degree?

A None who have received a professional or advanced degree.

Q So, in other words, you believe that resident and fellow salaries are suppressed?

A Yes.

Q And across the market, what factors do you believe are the primary contributors to the suppression of resident and fellow salaries?

A I believe that there's a coordinated action between the programs in the sharing of salary information for all residents and fellows at their institution, and they take steps to ensure that they move in lockstep.

And I know there are economists who are more qualified than me to comment on this, and I hope you have an opportunity to hear from them. But certainly the pattern of evolution of salaries over the past 50 years in the United States for residents reflects that perfectly.

Q Additionally, this data shows that there's only a $9,000 difference between the 25th percentile and the 75th percentiles of first-year resident earners. Do you see that?

A Yes.

Q In the general physician workforce, is there a greater difference in salaries between the highest and lowest earners?

A Yes. Yes, certainly even between specialties. I think a starting, say, pediatrician might expect to make, depending on their location and nature of their work, around 200- or 220-, whereas a starting neurosurgeon would probably make up to 800,000, sometimes more.

Q So in contrast to 9,000, the difference in some cases is hundreds of thousands of dollars --

A Yes.

Q -- in a licensed physician --

[redacted] Orders of magnitude. Is that correct?

Dr. Melehani. Yes, uh-huh.

BY [redacted]

Q What factors do you believe contribute to the uniformity of resident salaries across percentiles?

A I think the Match program is a main contributor that results in the suppression of salaries because it enforces a single offer on everyone participating in the marketplace, that they're then unable to negotiate, because if they back out from that offer, they would be subject to extreme disciplinary action, unless they received a hardship exemption.

That type of disciplinary action includes notification of all professional medical

societies in the country, international medical societies as well if the candidate is coming from outside the United States. Includes the boards that provide the eligibility and certification under medical specialties, the AAMC, the ACGME, the medical schools themselves. It's an effective blacklisting to back out.

Q Let's turn to the next page, page 16. At the top of the page it reads, Table 2, Resident/Fellow First-Year Stipends Nationwide, Mean Unweighted Stipends and Mean Inflation-Adjusted Stipends.

Do you see those words?

A Yes.

Q Comparing the 2024 mean inflation-adjusted stipend of $7,368 to those of prior years, residents make less in real wages than they did from 2010 to 2021. Is that fair?

A Yes.

Q And then on page 17, the next page, it also demonstrates that residents also make less in real wages than they did even back in 1971, correct?

[redacted] I'm so sorry. Can you speak up a little louder?

[redacted] Oh, I'm sorry.

[redacted] We're having a hard time hearing.

[redacted] Oh, I'm sorry.

[redacted] Thank you.

[redacted] I'll repeat the question.

[redacted] Where are we?

[redacted] Page 17 and 16 --

[redacted] Okay.

[redacted] kind of comparing both of them.

[redacted] Thanks.

[redacted] Yeah. I'll repeat the question.

BY [redacted]

Q So turning first here to page 17, residents make less in real wages than they did in 1971, when compared to the real wages in 2024. Is that correct?

A Yes.

Q What factors do you believe contribute to the stagnation and even a regression in resident salaries across decades?

A I believe it's, as I mentioned, the NRMP and the enforcement of the Match policies, which result in a single offer and the inability to negotiate that offer. I believe it's the control of the ACGME on the number of positions that allow the residency programs to maintain kind of the upper hand in negotiations, if there were ever to be a negotiation to take place, by essentially having a cap on the spots, essentially creating a scarce resource out of one that doesn't have to be scarce. And then also I believe it's the transfer issue, that you can't leave your employer without the employer allowing you to leave.

Further, there's -- embedded in that transfer issue is effectively what amounts to a nonpoach agreement which, of course, is a violation of antitrust laws.

If -- I mean, in reality, Apple and Google and many others did this in the bay area and had to reach a multi-hundred million dollar settlement when they agreed not to poach each others' employees. This is written in the ACGME rules, that they are not going to poach each others' employees.

I will also add, medical care in 1971 is not what it was and not what it is today. What we are responsible for today vastly has increased in complexity and difficulty compared to what it was 50 years ago.

[2:01 p.m.]

BY [redacted]

Q And that difficulty correlates with increased value of the services provided?

A And I think that's also reflected in the CPI numbers that -- both the inflation and the healthcare spending value has gone up substantially, yet salaries do not reflect the value generated by the residents and in addressing that complexity over those 50 years.

Q You mentioned the Match, you mentioned ACGME. Do you also believe that the weight sharing by the AAMC and the AMA contributes to the stagnation and regression in resident salaries?

A Yes. I think the rate sharing in surveys like this in the -- I have not seen it, but there's another survey called the COTH survey or the, I think, Council of Teaching Hospitals, in the direct publishing of salary information. I understand the Department of Justice has explicitly warned healthcare institutions against publishing the exact money they pay, because it provides information that allows your competitors to coordinate activities with you.

And so for Stanford and every other institution to put on the website the dollar and cent amount and the benefit package they offer allows everybody else to move in lockstep.

Q Let's now turn to page 48. So we're going to move quite a bit through the document here.

[redacted] This is table 9 at the top of the page.

Dr. Melehani. Yes.

BY [redacted]

Q Yes, it reads, Table 9, Resident and Fellow Unweighted Stipends for Western

Region, by Institution Type.

Do you see those words?

A Yes.

Q This graph provides resident programs with salary information specific to their geographic region and institution type, correct?

A Yes.

Q Why would a residency program need to know what other programs pay their residents in the same region?

A I think any employer generally wants to try to get the best quality talent they can for the best price they can. And so this information allows them to get that with exact precision.

Q So, in other words, it allows them to ensure that they're not setting their salaries higher than they need to --

A Yes.

Q -- in order to attract competitive talent?

A Yes.

Q And in that way, it acts as a suppressive -- it acts to suppress wages, correct?

A Yes.

Q Under the category of Medical School, it provides salary information for first-year residents from 13 institutions. Is that correct?

A Yes.

Q As a result, the AAMC survey tells Stanford, in the Western region, for every year of residency and fellowship, the mean, the 25th percentile median, and the 75th percentile of salaries for the 13 medical schools in its region of the country within the last 4 months, correct?

A Yes.

[redacted] And as you testified earlier, that's effectively real-time data since salaries don't change throughout the course of a year. Is that correct?

Dr. Melehani. Yes.

BY [redacted]

Q And you also mentioned earlier that the salary difference between Stanford and I believe it was San Francisco is $150?

A Currently, yes. For the first year.

Q Do you believe that this information would help facilitate that uniformity of wages?

A Yes. As well as the publishing of the actual amount. This is, you know, aggregated in a small way. But you could just go to Stanford's website and see exactly what they're going to pay.

Q Let's turn to page 53 of the document. The top is -- it says Table 10 at the top of the page.

A Yes.

Q Toward the top of the page and under the header Table 10, it says -- line 10a says, Percent of institutions whose base stipends are the same across all specialties. Under "Percent Responded Yes" it says 95.9 percent.

Do you see those words?

A Yes.

Q This is the -- you average -- you approximated to 96 percent, but this is the statistics that you've been referencing throughout our conversation today, correct?

A Yes.

Q So, in other words, nearly 96 percent of institutions responding to the AAMC

survey give the same base salaries to all of the residents regardless of their specialties?

A Yes.

Q So a first-year resident in family medicine would receive an identical salary to a neurosurgery resident at such an institution, correct?

A Yes.

Q Do you think paying all residents the same fully accounts for the differences between different specialties?

A No. And I think there's another part to it as well that's worth recognizing. Because there is a shortage of family medicine residents and there's more likely to be empty positions at institution in specialties like family medicine, and so whereas, of course, the work of a neurosurgeon generates more revenue and benefit for those institutions. I think actually the family medicine residents are the ones who lose, because they -- the institutions would be competing for them. And so it's the primary care doctors here who really, really suffer, that their wage is suppressed, despite the institutional need for their services. And instead, the institutions will forego their services altogether and opt to hire a nurse practitioner as an alternative.

[redacted] In other words, the sort of wage-fixing requirement of setting salaries across different specialties actually results in shortages in specialties that perhaps most need an incoming physician workforce. Is that correct?

Dr. Melehani. Yes. Yeah, it creates enormous economic distortions.

[redacted] So not only does it distort the market, would you say it leads to a shortage of physicians in general as a result?

Dr. Melehani. Yes. And maybe to provide -- one of the big complaints about the primary care specialties is that when you get to independent practice, your salary is lowered. And after having invested the entirety of your young adult life to get to the

point where, let's say, as a pediatrician you're now in your mid-thirties and you're making 200,000, which by all accounts is a great salary, you have accepted inherently an opportunity cost of being something different, a different specialty with a higher salary.

Because the salaries are so low during residency and because the stress that that imparts on people, the delay it requires of them in many cases to start a family, to start their life, many people choose and express in surveys and other avenues that they choose not to be primary care doctors because of the salary issues that they face over their life.

BY [redacted]

Q So let's turn to the next page, page 54. At the top of the page under the header Table 11, When was the Last Time Stipends were Adjusted. It reads, As of July 1, 2024, and 71.5 percent, and last year and 18.2 percent.

Do you see those words?

A Yes.

Q So, in other words, nearly 90 percent of institutions responding to the AAMC survey adjust salaries for their residents annually, correct?

A Yes.

Q And this further demonstrates the point that the information in this survey is practically real time because the adjustments in salaries only occur on an annual basis?

A Yes.

Q Or -- and then it also says in the same -- the same graph here or less frequently on an annual basis?

A Yes. Yeah, the salary information is correct.

Q Under the header 11a, Tools used to Decide the Stipend Adjustment Amount. It reads, a Table 11a provides a summary of what tools were used to decide on the stipend adjustment amount.

Below it states 63.0 percent of institutions use the AAMC Resident and Fellow Stipends and Benefits Report as a tool to determine the stipend adjustment amount. Do you see that?

A Yes.

Q So according to table 11, nearly 90 percent of institutions adjust salaries annually. And then according to 11a, 63 percent base those adjustments on the AAMC Resident and Fellow Stipends and Benefits Report. Is that right?

A Yes.

Q And as we've discussed, the AAMC survey includes 4-month old salary or practically real-time salary and benefit information from residency program competitors, correct?

A Yes.

Q So, in other words, 63 percent of surveyed institutions adjust their resident salaries based on the salary information of their competitors, correct?

A Yes, uh-huh.

Q So they're explicit -- they're admitting explicitly in this survey that the majority -- a strong majority of programs are adjusting their salaries based on their competition?

A Yes.

Q Apart from coordinating a wage-fixing conspiracy, do you know of any other reason why the AAMC survey would report what percentages of institutions rely on the AAMC survey when adjusting residents' salaries?

A I can't imagine how this information would be helpful except to coordinate wages between institutions.

Q I'd like to show you another document as an example of the FREIDA

database. This is a screenshot of the FREIDA page, as an example from the University of Alabama Medical Center Program for Internal Medicine, be marked as exhibit 2.

[Melehani Exhibit No. 2.
was marked for identification.]

BY [redacted]

Q This page was accessed from the website on July 7, 2025. Feel free to familiarize yourself with the document, if you'd like. And once you are familiar with it, we'll turn to page 1.

A Okay.

Q Actually, we're going to jump to page 7. And it should be numbered at the bottom of the page there.

A Okay.

Q On page 7 under the title Salary Compensation, the graph shows Year 1 salaries are $60,508, Year 2 salaries are $62,326, and Year 3 salaries are $64,715. Do you see those words?

A Yes.

Q So as seen here, FREIDA provides program specific, detailed salary information down to the dollar. Correct?

A Yes.

Q And that salary information can be as recent as 10 days old, as is the case here?

A Yes.

Q So, in your experience, how could a residency program like Stanford use this information to suppress the salaries of its residents and fellows?

A They -- I think they can easily look at the regional or national competitors,

depending on where they view themselves. So Stanford might want to compete against, you know, the bay area and California-based programs; they might want to compete against programs that they view to be similarly competitive, such as the Harvards and Yales of the world. And they can look at the salary and how that salary changes year over year, dollar to dollar, and ensure that they're moving in lockstep with those changes.

Q And in your view, based off of your experience as a resident at Stanford, as well as your understanding of the market, do you believe that Stanford uses this database and the AAMC survey to create uniformity in suppression of its wages for residents and fellows?

A I do believe that.

Q Are you aware that in 2002, medical residents brought a class action lawsuit against the ACGME, the Match, and participating residency programs, alleging violations of U.S. antitrust laws?

A Yes.

Q More than 20 years later, do you believe that the medical residency labor market has become more or less competitive?

A Less.

Q In what ways has it become less competitive?

A I think the programs, as they did in 2002, continue to kind of create an artificially scarce resource. There's been a substantial rise in the employment of nurse practitioners and physician's assistants, which is a -- essentially an opportunity cost that they are choosing, rather than choosing to hire more residents and rather than competing against each other for that limited pool of residents.

And so as you saw on the other survey we looked at, the salary from the early 2000s to today and inflation-adjusted terms is effectively the same or less. And I would

add that that included a unprecedented global pandemic, which we worked in.

Q One concern that the residents also had in the lawsuit related to employment conditions.

Do you believe that Stanford may be in violation of California labor law by not compensating workers -- their residents for expenses like travel between work sites when a resident or a fellow is assigned to work at multiple hospitals during a shift or continue a shift, and could you explain that?

A Yes. Yeah, so under California law, the employer is responsible for, I think the terminology in some ways is called making whole the employee for the expenses incurred on account of their work. And this I think applies to the private sector. I think there are exemptions for the public sector in some ways. But certainly at Stanford, as a private hospital, Stanford would be obligated to follow that law.

In any given day, I would either be assigned to work at a single hospital or have to travel between two or three hospitals or clinic sites included. So particularly on the weekends, myself and even more so the surgical residents, would oversee care at multiple hospitals. The travel time and expense incurred between those hospitals is the employer's responsibility.

So if I started my workday at Santa Clara Valley Medical Center in San Jose and then drove the approximate I think 30 or so miles to Stanford University Hospital to complete my work in the afternoon, it's that time -- and the IRS has a mileage kind of value to that kind of depreciation and impact to the vehicle and expense -- that Stanford should have been reimbursing me and the other 1,500 residents for.

Q And to be clear, they did not?

A They did not, they have not. And as far as I'm aware, they never have. I filed a complaint with the, as I said, the state's attorney general that oversees

employment matters about this. I've received no response.

Q What factors in medical residency market make it difficult for residents to raise issues of violation of State law, for example its labor laws, when they occur?

A I think there's an overriding fear of retaliation. And I think one good example of this is UT Southwestern did a -- had an independent review, semi independent. They had UT Southwestern faculty from I think their sociology department or their business school look at the residency program. And they surveyed their residents to understand when violations of laws and violations of policies occur, how comfortable do you feel bringing up these violations with your program director, with the institution or otherwise, and do you fear retaliation. And I believe the results of that survey -- this was I believe 2020 -- roughly, 38 to 40 percent of individuals said that they would not bring something up out of fear of retaliation. So that's a big driver.

As I said, the light at the end of the tunnel for most physicians is a great opportunity. It's a great career, it's a great life. But you have to get through this period. And if you raise too much trouble during the residency fellowship period, you could be branded a problem in the institution or you could, at worst, be dismissed.

The news organization STAT, which reports on biotech and medical news, actually did an investigation I think in 2021, 2022 that they published that found -- and this is supported by the ACGME's own data itself -- that Black residents and fellows are summarily dismissed in the programs at a far greater rate than their representation in those programs, often making up roughly 5 percent of the medical residency workforce but representing over 20 percent of those who are disciplined and dismissed from the programs.

So the environment is -- what's the word I'm looking for? It certainly comes across that you don't want to be a problem for your employer and you just need to get

through.

Q I want to turn to the ACGME and specifically kind of its monopoly status over accreditation. We discussed in prior hours about how ACGME is requirement for Federal funding through CMS, as well as a prerequisite for board certification.

If residency programs could receive Federal funding through an alternative means of accreditation, how would this affect the total number of residency programs in position from the United States, first of all?

A So if there was more than one accreditation program, I think there would be unique accreditation programs to serve certain needs of the healthcare system. So we had discussed before that the resources and capabilities of an institution like Stanford, which is I think one of the best funded hospitals in the world, greatly differ than a rural hospital in the United States. And it may be that an accreditation system developed for rural hospitals that ensures the standardization and adequacy of the training of those physicians.

And so I think a competitive environment, one unconstrained by these distortions, would create greater opportunity for medical training and for the American healthcare system and for patients.

[redacted] There have been public complaints about the lack of accommodation for disabilities and women attempting to have children while in residency programs. Could you speak to that issue a little bit and the impact it has on those women and their ability to start a family?

Dr. Melehani. Yeah. I know in my own personal experience, even not as a woman but as someone who had an interest in starting a family, the system itself just isn't terribly accommodating. Oftentimes if you're going to take parental leave, they force you to take your vacation as your parental leave. You know, so you may have

whatever your State-mandated 2 or 3 weeks is, and if you want anything more than that, you're on vacation. To disrupt your training any amount longer than that often will delay your ability to progress in your career without then making up that time later on.

So, you know, in the worst of scenarios where a woman maybe has a baby and then has a medical necessity for herself or for her baby to stay out of work, it's a system that's not terribly accommodating or supportive of those terms.

On the disability side, I had a colleague, and I believe I've provided it to this committee, who herself was diagnosed with a neurologic condition during her residency at Stanford. And ironically, she was also a neurosciences resident. So she had difficulty climbing stairs, she had difficulty standing on her feet for long periods of time. And she sought accommodations from Stanford. And in particular the one thing that stood out was Stanford's call rooms, the places where residents are supposed to sleep at night, are on the fourth floor of the hospital, only accessible by stairs.

And so she was unable to climb the stairs to get to the call rooms to sleep at night, despite working overnight shifts. And she made a simple request of can a call room be designated somewhere for people like myself or others who are disabled and unable to climb the stairs. And Stanford for the longest time, as she describes in this blog post, stonewalled her, effectively provided no communication to her, provided no options to her. And then even made it incumbent upon her to build out, essentially, their disability accommodations program.

[redacted] You mentioned at the beginning of your testimony, in your opening statement, that you believe that the Match antitrust exemption should be repealed.

[redacted] Can you talk louder?

[redacted] Oh, I'm sorry.

You mentioned in your opening statement that you believe the medical residency

Match antitrust exemption in 2004 should be repealed. How do you believe its removal would affect the issues that we have discussed so far today, including the Match itself, wages, and working conditions for residents?

Dr. Melehani. Yeah. So I think if the antitrust exemption was removed, I think courts would very easily find it to be anticompetitive. It's obviously an agreement between the institutions that they agree to participate in the Match program. And so I think a trial would ensue and it would probably be struck down by U.S. courts. So the Match program would have to change. It's hard to anticipate how it might change.

But I think in order to be procompetitive rather than anticompetitive, it would require not limiting individuals to a single offer from an institution that inherently is anticompetitive. So then you could imagine the scenario where perhaps there was still some sort of central portal, maybe a common application for applying for residency programs, just like there is for colleges now, but offers are made. And perhaps even on a similar schedule of time, but such that an individual can receive multiple offers at the same time and then negotiate those offers as they see best fit in their own interest.

I think that would be a huge advancement. I think I would encourage the staff and the members of this committee to go further and to look at the mobility constraints that the ACGME enforces that prohibit people from leaving the program, especially for those people who are subject to abusive conditions in their program.

And I think this is an area that particularly impacts people who come here from other countries to work on visas in these residency programs; that effectively they're being subject to terrible working conditions, perhaps even abusive working conditions, perhaps direct, as identified in this 2019 survey, physical, sexual, or emotional abuse. And they can't leave their program without the program's support, and their visa status depends on it. So they, as one resident I think at Lincoln Medical Center in New York

described it, they are effectively hostages to these programs.

[redacted] I know we're a little bit over our time.

[redacted] We can go off the record.

[redacted] I have two questions. Wait.

[redacted] Oh, I'm sorry.

[redacted] I have two questions left, and then we wouldn't need to take more time. Is that okay?

[redacted] Please.

[redacted] All right, wonderful.

[redacted] Not in that kind of way.

[redacted] No, no.

[redacted] For the record, I said "please" like as in carry on.

[redacted] Would you agree that removal of the Match's antitrust exemption would likely lead to more choice, higher salaries, and likely greater workforce participation within the medical field?

Dr. Melehani. Yes.

[redacted] And then finally, is there anything related to the Match/ACGME wage-fixing conspiracies that we haven't had the opportunity to talk about today that you'd like to discuss with the committee?

Dr. Melehani. I guess to kind of follow on to the last question on this, the other thing is it's not just the salary, right. When you work for an employer, you're evaluating the salary, but as you are working for them, you're also evaluating the working conditions and the opportunity that that work creates for you to advance your career.

There is a culture in medicine that the older generation had it worse. And some people believe that entitles them to create problems for those people that they're

training, effectively kind of a hazing culture in some instances. And this is particularly malignant in surgery programs.

But if a surgical residency program, finding that their employment with their malignant employer was not satisfying their needs for their training and advancing their career, given the opportunity to move programs, they probably would, as any of us would. And that program would have to have a real reckoning with the quality of services that they're providing, with the quality of training, the quality of employment that they're providing.

And I think you would see a massive shift in the culture of medicine, because it would no longer be tolerated that you could just be a jerk to everybody you worked with because you're the superstar attending or you're the superstar surgeon. And it would be a seismic shift, I think, in the culture of medicine that is so greatly needed.

The other thing that I think is very important, we get into this job because we want to help people. And then we spend 3 to 8 years of our life in indentured servitude, effectively, to these corporations. And in some instances and the worst of cases as I've described, those 3 to 8 years, you are abused. You're taken advantage of, and your health, well-being, and wellness is in many cases destroyed. And some residents commit suicide because of this. And no one should have to commit suicide because they can't leave their employer.

The end result of training people in these -- the end result of training people in these malignant programs where they don't have support, where they can't find the path out, where they can't find a path through, is they become doctors who themselves are brunt out, who provide poor care, who have -- who lack compassion for others and for themselves and perpetuate the system. This is core to the American healthcare system and it impacts every single one of us, our families, ourselves, our kids, our parents. You

shouldn't have to go into the hospital and see a doctor who doesn't give a crap about people because he was beat up for 8 years in surgery residency he participated in. And I think that's really what this is about.

[redacted] I know minority staff has a few more questions, but I just want to thank you for taking the time to speak with us today and to thank you for your testimony.

Dr. Melehani. Thank you.

[redacted] Go off the record.

[Recess.]

BY [redacted]

Q Welcome back --

A Thank you.

Q -- after our break. Oh, I'm sorry, it is 2:35.

So you mentioned shortages in family medicine. How does a match figure into that?

A So I think the inability to negotiate and receive competitive offers, which ultimately suppresses wages for residents and fellows, means that when a institution otherwise would fail to fill their family medicine slots in a year -- of which I think there were 800 open positions that no one entered into in the 2025 Match -- it means that -- and in kind of a normal operating economic environment, the institutions probably would be interested in filling those slots and they would make better offers.

Q Right. So --

A So you'd see the family medicine and the primary care salaries rise --

Q Understood.

A -- to fill those slots.

Q So let me just ask, would you be surprised to learn that with family medicine

in 2025 there was a 99 percent overall fill rate --

A Yeah. So --

Q -- and that specifically there were 805 positions in SOAP, and that through SOAP, 753 of those were filled?

A Yeah, that doesn't surprise me. So just to make clear what SOAP is for the record. If you fail to match and if the institutions fail to match, then they go into this scramble procedure where it operates more like a normal employment environment.

Q So you're discounting the relevance of that --

A I'm not discounting the relevance --

Q -- because that's the --

The Reporter. Excuse me. You have to speak one at a time.

Dr. Melehani. Yeah. I'm not discounting the relevance of it. What I'm saying is that it creates a scenario in which the already massive power dynamic between the institution and the resident is further exacerbated, as the resident now is in a position where if they don't find something, anything, they are not going to have a job for the next year.

I'd appreciate it as well if you let me speak, as I let you speak.

[redacted] All right. Just for the record, we're asking the questions, you answer --

Dr. Melehani. We --

[redacted] You're not letting me speak. Now you're not letting me speak. We will ask the questions. We will do our best to let you answer. I would like to note that some of your answers are getting pretty long, so that's why I think we're kind of stepping in to ask other questions. But we will respect that. We ask you to do the same being. Okay?

Dr. Melehani. Yes. That was the agreement we had at the beginning.

[redacted] Do you think that the elimination of the antitrust exemption would have any negative effects?

Dr. Melehani. No.

[redacted] Okay.

[redacted] None at all, no negative effects at all?

Dr. Melehani. No.

BY [redacted]

Q I understand Stanford was your first choice?

A Yes.

Q As a general matter, though, you said you would have preferred, even with Stanford, to have preferred to negotiate in parallel with different schools?

A Yes.

Q How would that work?

A Well, the -- let's see, the top three programs I was considering at the time was Stanford, UC San Diego, and the University of North Carolina. Had I received a substantially better offer from the University of North Carolina than what I had received at Stanford, one that maybe would have enabled me to start the family that I wanted to have earlier in my life and in the time that was dictated by me and my wife rather than by my employer, I might have opted to take UNC instead.

Q Okay. Are you assuming that, when you're in this iterative process, that the different offers would extend for you to be able to get other offers? So, for example, if you were given an offer from one of your lesser schools, meaning not your top choice, and they gave you a very short window in which to respond, and it's not always possible to get an answer from your superior choices, what do you think you would end

up doing in that situation?

A My personal situation, I would let that offer go by.

Q Okay. You would?

A Yes.

Q So you would give up, say, a choice of your third top school?

A It depends on the circumstances of the offer. If it was a compelling offer and I viewed it to provide the opportunity I wanted to advance my career, then I might accept it. But if it was a school that I didn't have much interest in, if it was my twelfth choice, then I certainly would have let it go by.

Q So if it was a lesser school. So can you imagine a scenario in which you got your first choice -- many other resident -- many other classmates of yours in medical school are not in that predicament, correct?

A Uh-huh, yes.

Q Could you imagine a scenario in which you're given an option to go to, say, your third or fourth choice, which is nothing to sneeze at, but it's certainly not your first choice -- could you imagine a scenario in which you're given that option and the timing is such where you have to make a decision before you can find out about your first choice?

A Yes. That's the employment circumstances I face every day in the real world.

Q Okay. And so you would end up -- you can imagine people conceding and going along to taking their fourth choice, rather than waiting out for their first choice because they might be afraid that they're not going to get a match?

A Yes.

Q Okay. Panda Express. Didn't expect Panda Express to come up during this. I think you all earlier said that you also earned about $15 an hour. Is that right?

A So the salary is apportioned on an annualized basis, not based on the number of hours you work, but it's common among residents to look at their hourly reporting and to then calculate down what their hourly wage look like if they were paid hourly.

Q Okay.

A So depending on the week, it could be in some instances as low as $15 an a hour.

Q Would you consider residency as an investment in your career?

A Yes.

Q Okay. So we've talked about your salary a fair amount. How does completing a residency under a fellowship in a field set you up in terms of future earnings?

A So the residency is a requirement to achieve board eligibility and board certification in the specialty of your interest. And oftentimes once you cross that threshold from finishing your residency to starting your first job, you undergo a massive increase in your salary.

Q All right. I think you talked earlier about what a neurosurgeon earning 8- or 900?

A Thousand.

Q Thousand, yes. And then you compare that to family practice, which might be 2- or 3-?

A Yes, I believe so.

Q Okay. And so I think you also characterized the experience of neurosurgeons as residents as being more grueling on average than family?

A Yes.

Q To what extent, if at all, do you think that there's a sense of -- why would you go through this additional training for the neurosurgeon experience? Part of it is that you want to be a neurosurgeon, but is there also some understanding about what your overall lifetime expected earnings are, because it seems as though there's a difference at the back end in terms of what each of these fields earns?

A Yes.

Q Okay. Do you think that's something that is part of people's calculus when they consider which specialty to pursue?

A Yes.

Q We've talked a lot about sharing information regarding salaries. When you were applying for residencies, did you appreciate having that information?

A It wasn't top of mind for me when I was considering residency programs.

Q Wasn't top of mind. But was there some value to the transparency and understanding characteristics of the programs that you were considering applying to?

A For the salary, not so much, because it was effectively the same with minor cost of living adjustments between locations.

Q Okay. As a general matter, did you try to get as much information as you could about each of the programs about which you were seriously considering applying?

A Yes.

Q Okay. You said that similar salaries is evidence of price fixing?

A Similar salaries is, I would say, when representing a substantial economically distorted environment as in this, is suggestive of price fixing.

Q Okay. Are you a lawyer?

A No, I'm not.

Q Are you an economist?

A No, I'm not.

Q Thank you.

BY [redacted]

Q We also talked a lot about your, I guess, dispute with Stanford. Did you communicate with them via email when you were having this dispute?

A Yes.

Q About how frequently were you interacting with them about the dispute?

A Varied depending on the month, but sometimes multiple times a week. Sometimes a week or two might go by where we didn't have many.

Q What was the nature generally of the communication between you and Stanford when you were going through the dispute?

A So prior to May 26th when the dispute started, things were very good. After that, they had put up substantial barriers to me kind of sorting through and getting information that I needed to satisfy their claims or their interests. For example, when asking them about what they wanted a contract between Stanford and Gilead to look like, they did not provide me any information about how that contract should come together or what should be in it.

And then as that progressed into the fall and into the winter, they became increasingly harsh, increasingly bizarre, as I described. And that then began to provoke really a lot of anxiety and even panic attack episodes that I was experiencing, to the point where I had to silence the email alarm on my phone as it was quite triggering every time my email went off, which is -- you know, most of the time it wasn't them, but it nonetheless was triggering, and then seek counseling through therapy.

Q Sorry to hear about what happened at the tail end of that.

You made productions to us voluntarily of some of these communications, right?

A Yes.

Q Did you produce all of them to us?

A I don't have all the emails that I -- I didn't produce all the emails. I think there's -- at least what Stanford sent me was over 990 pages of emails.

Q Okay.

[redacted] We can go off the record.

[Discussion off the record.]

[redacted] You were just asked about the issue of exploding or time limited offers. Would a offer and acceptance deadline rather than a centrally planned placement system address those concerns in a significantly less restrictive way?

Dr. Melehani. Yes.

[redacted] Go off the record.

[Whereupon, at 2:46 p.m., the interview was adjourned.]

Certificate of Deponent/Interviewee

I have read the foregoing ____ pages, which contain the correct transcript of the answers made by me to the questions therein recorded.

_____

Witness Name

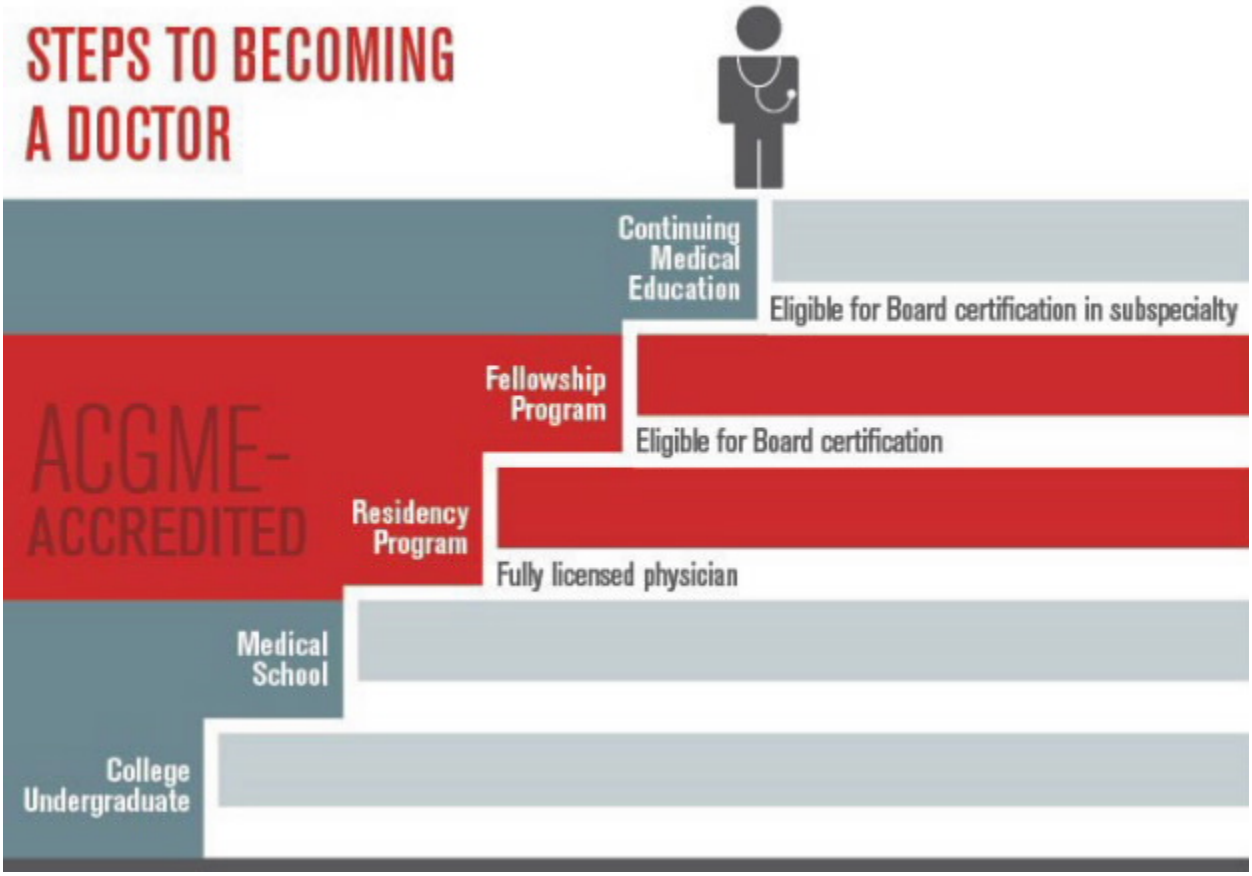
_____

Date

Exhibit 4:
AOA Production – Part 3 – Final
pages 291-299
Overview of American Medical Education

Overview of American Medical Education

Graduate medical education refers to the period of training in a particular specialty (residency) or subspecialty (fellowship) following medical school.



Introduction: The purpose of this overview is to describe the process of medical education required to become a practicing physician in the United States and to help Review Committee members better understand their role in the continuum of physician education.

The use of acronyms is pervasive in medicine, medical education and in program review. These medical organizations have an impact on medical education and so the acronyms are included in the following descriptions. If you want to explore further, there will be links at the bottom of each page to these organizations where you can learn more.

College: Individuals may have a unique path, but for the most direct route, students start their pathway to becoming a physician in the United States while they are in college. Medical education in the United States is different from most countries in the world where medical training occurs in a six-year program that begins immediately after secondary school. The United States is unique in that physician training typically begins after completion of a college degree, which is seen as an important maturation and developmental phase. Students in the United States can study and major in any subject; however, the sciences are popular choices

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because biology, chemistry, physics and some courses in the humanities are required for medical school. Some students take these pre-requisites courses after college graduation if they did not originally study these subjects.

The first step toward application for medical school is taking the Medical College Admissions Test (MCAT) usually during the junior year of college. Developed by the Association of American of Medical Colleges (AAMC),[1] this is a multiple-choice examination about natural, behavioral and social science concepts as well as problem solving. Most students apply for medical school or osteopathic medical school during the summer after the junior years but those who completed their undergraduate degrees in the past, apply for medical school when they decide to change careers. Medical schools conduct applicant interviews in the fall and winter, and students learn of the acceptance decision of these schools between December and May.

Medical School:

In the United States, there are two types of medical schools:

- Allopathic medical schools, accredited by the Liaison Committee for Medical Education (LCME)[2], grant the Medical Doctor (MD) degree. The LCME is a committee that is jointly sponsored by the AAMC and the American Medical Association (AMA)[3] and accredits over 150 medical school programs in the United States and 17 medical schools in Canada.

- Osteopathic medical schools, accredited by the American Osteopathic Association (AOA)[4] Commission on Osteopathic College Accreditation (COCA)[5], grant the Doctor of Osteopathic Medicine (DO) degree. COCA accredits over 35 osteopathic medical schools.

Medical school begins in the fall and the education is typically four years in length, although a few are three years.

The first one and one-half to two years are focused on the basic sciences (e.g. anatomy, biochemistry, pathology and physiology), but also provide medical students with early exposure to patients, patient care, and the healthcare environment. This exposure provides medical students closely supervised education and training in performing a physical examination, medical interviewing, and discussion about diagnosis. Another important element of the medical student's education is exposure to and education of the professional expectations of being a physician. In addition, osteopathic medical schools offer an emphasis on the osteopathic principles and practice to promote the body's natural tendency toward self-healing and health.

At the end of the second year, medical students take examinations that concentrate on the basic sciences. Allopathic medical students take step one of the United States Medical Licensing Examination (USMLE)[6]. USMLE is a three-step examination sponsored by the Federation of State Medical Boards (FSMB) and the National Board of Medical Examiners

[1]American Association of Medical Colleges: https://www.aamc.org/
[2] Liaison Committee on Medical Education: https://www.aamc.org/members/osr/committees/48814/reports_lcme.html
[3] American Medical Association: https://www.ama-assn.org/
[4] American Osteopathic Association (AOA): https://osteopathic.org/
[5] Commission on Osteopathic College Accreditation: https://osteopathic.org/accreditation/
[6] United States Medical Licensing Examination: https://www.usmle.org/

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(NBME)[7]. Osteopathic students may take the USMLE examination, but may also choose to take the Comprehensive Osteopathic Medical Licensing Examination (COMLEX)[8], a three-step examination sponsored by the National Board of Osteopathic Medical Examiners (NBOME). The examinations are stressful for many medical students since these scores are frequently used by residency program directors as a screening criteria for medical knowledge during the application process. The use of this examination as screening criteria is controversial, because it does not take the whole student into account, and is not encouraged by the ACGME.

The third and fourth years of medical school typically include rotations or experiences, called clerkships, in general specialties that include internal medicine, pediatrics, general surgery, psychiatry, obstetrics and gynecology, and may include neurology and emergency medicine. These is also opportunity for elective rotations in more specialties such as anesthesiology or urology and subspecialties which cover a more focused practice within a specialty. Under internal medicine, for instance, nephrology, and critical care are subspecialties

Specialties are referred to as Residency programs while subspecialties are referred to as Fellowship programs.

> **Residency Program[9]**: A structured educational activity comprising a series of clinical and/or other learning experiences in graduate medical education, designed to prepare physicians to enter the unsupervised practice of medicine in a primary or core specialty. There are two types of residency programs: (a) residency programs available for physician admission immediately upon graduation from medical school as described in the Institutional Requirements; and (b) residency programs available for physician admission after completion of prerequisite clinical training as described in the relevant specialty-specific Program Requirements.
>
> **Fellowship Program[10]:** A program that provides advanced training in progressive levels of sub-specialization following completion of training in a core specialty and, if applicable, a related sub-subspecialty. It is a structured educational activity comprising a series of clinical and/or other learning experiences designed to train physicians to enter the unsupervised practice of medicine in a subspecialty.

Medical students often make a decision regarding their choice of specialty by choosing experiences in a number of specialties and subspecialties, not unlike an undergraduate student declaring a major. During the fourth year of medical school, medical students take the second step of the USMLE and/or COMLEX, which includes a written knowledge test and a clinical skills test composed of a panel of simulated patients. This is also when the residency application process begins.

The residency application process begins in the summer before the fourth year. Medical students submit applications to their residency program(s) of interest through the AAMC Electronic Residency Application System (ERAS)[11]. In an effort to secure their position in a residency program, a medical student might apply to 20 or more programs. An applicant can

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[7] National Board of Medical Examiners: https://www.nbme.org/
[8] Comprehensive Osteopathic Medical Licensing Examination/National Board of Osteopathic Medical Examiners: https://www.nbome.org/
[9] ACGME Glossary: https://www.acgme.org/About- Us/Policies-and-Related-Materials
[10] ACGME Glossary: https://www.acgme.org/About-Us/Policies-and-Related-Materials
[11] AAMC Electronic Residency Application Service: https://www.aamc.org/services/eras/

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expect approximately half of those submissions to result in an invitation to interview, depending on the specialty. Medical students quickly discover that some specialties are more popular and competitive, while other specialties have greater availability. Between November and February, medical students participate in interviews while clinical rotations and medical training take less of their time.

In mid-February, upon conclusion of the interviews, medical students select their programs of choice and programs select their candidates of choice through a "matching" organization. The largest matching organization in the United States is the National Residency Match Program (NRMP)[12]. There are also smaller matching organizations and programs, such as the San Francisco Match (SF Match)[13], the military match[14] and the Urology Residency Match Program[15]. Once applicants select their program choices in order of preference, and programs select their applicants of choice in order of preference (also known as a Rank Order List (ROL)), both are in a binding agreement for the match outcome. In mid-March, using a sophisticated computer algorithm, the NRMP considers the ROL and matches applicants to a residency program. The announcement of these assignments occurs on "Match Day", which is a very exciting day for medical students, medical schools, and programs.

Review of the NRMP Match data demonstrates that about half of applicants match to the program of their first choice and three quarters of the remaining applicants match to one of their top three choices. This is true for about 18,000 allopathic and 5000 osteopathic graduates, although the number of graduates increases every year with the growth of new allopathic and osteopathic medical schools. Historically, the application and recruitment season is a time consuming, expensive and grueling experience for the applicants and programs and there is a palpable sense of relief when it is over.

Medical students typically graduate in May and residency programs traditionally begin on July 1st with some programs beginning orientation the end of June.

According to the AAMC (2016), medical school tuition averages $37,000 per year for in-state public schools and $60,000 per year for private schools. The average total cost of attendance for four years, including living expenses, is $244,000 for public schools and $323,000 for private schools. Approximately 75% of all graduating medical students have an average of $190,000 in student loan debt, with approximately 70% of that debt from medical school. As the cost of medical school has risen over the years, this debt is thought to be one reason about why some medical students may gravitate to higher paying specialties. This may shape the numbers and distribution of specialists available for patient care across the U.S. as a whole.

International Medical Graduates: Individuals graduating from a medical school outside of the United States are identified as International Medical Graduates (IMGs). Many are citizens of other countries and are seeking residency training in the United States with many coming from India, the Philippines, Mexico, and Pakistan. Non-citizens IMGs must work carefully through a State Department process to obtain a visa that enables them to train in the United States. There are multiple types of visas, but the most common are the J-1 training visas, sponsored by the

[12] National Residency Match Program: http://www.nrmp.org/
[13] San Francisco Match: https://sfmatch.org/
[14] Medicine + The Military: https://www.medicineandthemilitary.com/officer-and-medical-training/residency-and-match-day
[15] Urology Residency Match Program: https://www.auanet.org/education/auauniversity/for-residents/urology-and-specialty-matches

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Educational Council for Graduate Medical Education (ECFMG)[16] and the H-1 visa, which allows U.S. employers to temporarily employ foreign workers in specialty occupations.

Another contingent of IMGs are citizens of the United States who obtain medical school education from a private, overseas medical school, often in the Caribbean. United States citizen IMGs do not need a visa; however, because overseas medical schools are not accredited by the LCME or the AOA, graduates often find it more difficult to obtain a residency position than those graduating from accredited American schools.

Residency (Specialty) and Fellowship (Sub-specialty) Training: Upon successful completion of medical school, graduates receive a medical degree, but are not yet eligible for a license to practice. As students, they have had exposure to multiple specialties and have developed a strong theoretical framework in medicine and the basic sciences. However, they lack the practical clinical experience to practice independently. In order to gain clinical experience, medical school graduates continue their learning in a residency program. Residency is designed to be primarily a clinical experience where residents take care of patients in a specific specialty. Because of the limited expertise when they enter residency, these residents are initially closely supervised by qualified physicians known as “faculty”. The goal of residency is to gradually provide the physician with increasing responsibility to allow them to progress to the point of practicing without supervision.

The first residency entered out of medical school is usually between three and seven years long and is known as a “core” or residency. Some specialties such as radiology or ophthalmology require a year of general prerequisite clinical training prior to starting the core specialty program. This general clinical training can be the first year of internal medicine or general surgery, known as a preliminary medicine or preliminary surgery year, or in a separate ACGME accredited Transitional year.

Following completion of core residency training, many residents pursue additional training to become subspecialists. This additional training, i known as a fellowship, adds one to three years of subspecialty training after the core residency program. For example, internal medicine and general surgery are core residencies, but cardiology and pediatric surgery are subspecialty fellowships.

Residency and fellowship training is a time of great personal and professional growth. Since stress, uncertainty, and responsibility for patients is a challenge for residents and fellows, each individual must develop resilience and the ability to handle these stresses. Many residents and fellows show signs of burn-out or depression during training. While most successfully recover, complete training, and go on to have successful careers, there is wide recognition that the education and patient care environment must evolve to improve the wellness of residents, fellows, and faculty. While wellness has not always been a focus in medical education, these are important considerations for residents, fellows, practicing physicians and other health care workers.

Life as a Resident: Every specialty has different planned clinical experiences for their residents. This general description will apply only to some specialties and should be read with that in mind.

[16] Educational Commission for Foreign Medical Graduates: https://www.ecfmg.org/

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In general, life as a post-graduate year one (PGY-1) resident, previously known as an intern, is stressful and requires substantial transition and growth. PGY-1s learn to take on the professional role as a physician, caring (directly or for some specialties indirectly) for patients under direct supervision by more advanced residents and faculty members. Direct supervision means that a more senior resident or faculty member is present at all times the PGY-1 is in a clinical setting. More senior residents may include PGY-2 residents up to chief residents (Chiefs), which are residents in their last year of training. Regardless of the level of resident supervising the PGY-1 resident, overall supervision of all residents is provided by an attending or faculty physician. Residents may also work with medical students. While medical students have a limited workload, such as caring for one or two patients at a time, most PGY-1 residents care for four or five times that number on inpatient services.

Typically, residents rotate in “blocks” of one to three months on a service (e.g. internal medicine, pediatrics, surgery) before moving on to a different service (known as a rotation). Each rotation may have a different focus or may be a different subspecialty depending on the specialty and the program’s curricular plan. Rotations may also have a focus, which may include experiences in outpatient or inpatient care. Rotations may also focus on providing care for critically ill patients in intensive care units (ICU) or specialty units such as coronary care units (CCU) or may be organ-based such as pulmonary medicine or transplant surgery. Some specialties, such as radiology or anesthesiology require a general clinical year to sharpen and develop their fundamental clinical skills. Therefore, they may rotate through many specialties as a prerequisite prior to starting the specialty component of their residency.

The PG-2 year allows residents to take more responsibility in the clinical setting and to engage in more decision making, while on carefully planned rotations. Experiences also typically include the supervision of PGY-1 residents, which helps to develop their leadership as a physician.

Experiences at the PGY-3 level and beyond involve a higher level of responsibility and consequently, supervision is usually indirect in many circumstances. Indirect supervision may be accomplished on multiple levels from supervising physicians being in the hospital or clinic, but not in the immediate area of the resident, or depending on the resident’s competency, the supervising physician may be available by telephone. This does not extend into settings such as the emergency department or the operating room, where the supervision of residents and fellows are based on their technical skills and competencies. In these specialties, the supervising faculty member is always present for the key parts of each case or procedure as appropriate.

As residents continue to advance, their learning experiences expand into leading a clinical team, quality improvement initiatives, patient safety education and training, administration and management. During this time, they also continue to take a greater role in teaching more junior residents and medical students.

In most specialties a few of the senior residents have additional leadership and administrative responsibilities and are recognized as “chief residents”. In many surgical specialties, every resident in the last year of training is deemed a chief resident, while Internal medicine and pediatric chief residents spend an additional year in this role after having completed their residency.

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Throughout a resident's education, there is ongoing formative feedback during each rotation and learning experiences. Residents receive a formal assessment of their progress at least twice a year through an assessment tool called Milestones[17]. This semiannual assessment incorporates an assessment of the resident's progress on the Milestones that are relevant to their specialty and which measure the achievement of expected skills and competencies. These are organized into the six Core Competencies of Professionalism, Medical Knowledge, Patient Care, Interpersonal communication, Practice-based learning and System-based practice.

The Milestones assessment is one of the tools used by a residency program's Clinical Competency Committee (CCC). The CCC compiles all assessment information available for each resident and advises the program director as to their analysis and recommendations semi-annually throughout the resident's training. The program director then makes a determination about the training needs of each resident, or their readiness to graduate the program, and meets with them to discuss their findings and educational needs.

Upon completion of core residency, many residents choose to pursue additional training in a subspecialty as a fellow. Not all of these programs have chosen to be accredited by the ACGME and those in this category are referred to as non-accredited fellowships. During this time, fellows focus more on the medical knowledge and patient care competencies specific to their subspecialty. Many fellowships also place a high priority on research or other scholarly activities.

The role of the ACGME What is the role of the ACGME in this process? While medical schools are accredited by the LCME or the AOA, all residency and most fellowship programs in the United States are accredited by the ACGME. The ACGME also accredits sponsoring institutions and organizations that sponsor ACGME accredited residency and fellowship programs. There are a few subspecialties that have chosen to not be ACGME accredited such as most ophthalmology subspecialties

"The mission of the ACGME is to improve health care and population health by assessing and advancing the quality of resident physicians' education through accreditation." This is accomplished by a systematic and thoughtful process of peer review.

Published standards, known as Institutional Requirements and Program Requirements, are determined by experts for each specialty and subspecialty with input from the public. The accreditation process involves review of each accredited sponsoring institution and each residency or fellowship program by a review committee composed of peers in the specialty. The primary role of these specialty Review Committees is to assess and identify the programs that meet the published standards. In the past, the AOA accredited osteopathic institutions, residencies and fellowships, but after a five-year transition, the ACGME provides accreditation for all institutions and programs starting in 2020.

Board Certification: At the end of residency or fellowship training, most physicians strive to become board certified. The vast majority of physicians in America are board certified by a member board of the American Board of Medical Specialties (ABMS)[18] or the American Osteopathic Association (AOA). The requirements for ABMS board certification include successful completion of an ACGME-accredited residency, and for subspecialties, successful

[17] Milestones: https://www.acgme.org/What -We-Do/Accreditation/Milestones/Overview
[18] American Board of Medical Specialties: https://www.abms.org

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completion of an ACGME-accredited fellowship. Some specialties require that individuals achieve a minimum number of cases or procedures during their training. The requirements for AOA board certification include successful completion of an AOA-accredited or ACGME-accredited residency or fellowship. There are a number of physicians certified by non-ABMS or non-AOA certifying boards which may or may not require specified ACGME training. Board certification may be a requirement for hospital privileges or insurance credentialing.

Originally, board certification was conferred once and valid for a physician's entire career. However, in recent years, the member boards of ABMS (also known as allopathic certifying boards) have begun a program of Maintenance of Certification (MOC) or Continuous Certification (CC), and osteopathic certifying boards have Osteopathic Continuing Certification (OCC). MOC, CC, and OCC include activities that demonstrate a certified physician is continually learning, is current in the medical and scientific literature, and actively involved in quality improvement efforts. MOC, CC, and OCC are controversial as some physicians question the value of the current programs, arguing that they are too expensive and time consuming and not relevant to actual practice. As such, the certifying boards have reassessed and undertaken process modifications to ensure that there is value in the certifying processes.

Licensure and Practice: To practice in the United States and its territories, physicians must have a medical license. Medical licenses are under the jurisdiction of, and granted by each state or territory. The licensing requirements vary by state but all 70 licensing jurisdictions require at least one or two years of ACGME-accredited residency. Some states do, but most states do not require completion of the residency. Though each state is independent, the licensing boards are all members of the Federation of State Medical Boards (FSMB) which serves as a non-binding forum for these organizations to discuss topics of mutual interest. Physicians renew their license every one or two years.

Once physicians are in independent practice, the state license typically requires physicians to complete between 20 and 60 continuing medical education (CME) credits every year. The Accreditation Council of Continuing Medical Education (ACCME)[19] and the Council on Osteopathic Continuing Medical Education (COCME)[20], among other organizations are, responsible for accrediting the organizations that provide CME courses.

Physicians may have their license restricted or revoked if the state board believes the physician may be unfit to practice in some respect. Some of these reasons include substance abuse, physical or mental health disorder, or criminal behavior.

Hospital Credentialing and Privileges: Many physicians work in hospitals or group practices which require that they demonstrate minimal training and credentials. This may require documentation of their successful medical school, residency and fellowship training, a certain number of documented cases or procedures in a case log, peer recommendations, and other credentials. Throughout a physician's career each time they change jobs or hospital sites, here must be a verification of their education and training. Therefore, programs are frequently asked to confirm their graduate's successful completion of the residency or fellowship program.

[19] Accreditation Council of Continuing Medical Education: https://www.accme.org
[20] Council on Osteopathic Continuing Medical Education: https://osteopathic.org/cme/

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Physicians renew their hospital privileges every two years as required by The Joint Commission (TJC)[21], one of several organizations that accredit hospitals, clinics and other patient care sites.

Practicing physicians work to meet board certification, licensure and hospital requirements continuously through life-long learning. Learning may be motivated by continuing requirements, by personal interest, or by the changing needs of their patients and communities. As the practice of medicine advances and evolves, physicians work hard to stay up-to-date on the medical needs of the public. Along with its partner organizations, the ACGME ensures the educational pathway stays relevant, timely, and rigorous as physicians learn to provide effective care for patients.

[21] The Joint Commission: https://www.jointcommission.org

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Exhibit 5:
AOA Production – Part 3 – Final
pages 134-139
The Single Accreditation System: Risks to the Osteopathic Profession

The Single Accreditation System: Risks to the Osteopathic Profession

Mark Cummings, PhD

Abstract

In August 2014, the American Osteopathic Association (AOA) and the American Association of Colleges of Osteopathic Medicine (AACOM) signed a memorandum of understanding with the Accreditation Council for Graduate Medical Education (ACGME) to create the Single Accreditation System (SAS) for graduate medical education (GME) in the United States. The AOA made the decision that it would close its GME accreditation system in response to dramatic growth in colleges of osteopathic medicine, a shortfall in osteopathic GME positions with increasing dependence on the ACGME system, ACGME policy decisions that adversely impacted osteopathic students, and declining osteopathic student interest in primary care.

Osteopathic teaching institutions bore responsibility for meeting ACGME accreditation standards between 2015 and 2020, including determining institutional sponsorship, which program applications to submit, program size, educational leadership, and whether to pursue Osteopathic Recognition. Approximately 692 of 954 (72.5%) eligible osteopathic GME programs in 2014–2015 obtained ACGME accreditation by June 1, 2020. There were sharp reductions in surgical and subspecialty programs and a significant drop of DOs in educational leadership positions. A low percentage of ACGME-accredited programs applied for Osteopathic Recognition.

In closing its GME accreditation system and joining the ACGME, the AOA gave up control of its direct relationship with osteopathic residents, fellows, and teaching institutions to gain critical GME opportunities. In this article, the author considers whether this gain will offset the risks taken by the AOA, including decreased DO leadership opportunities and role models, lower than expected interest in Osteopathic Recognition, and possible decreased DO interest in osteopathic organizations and osteopathic specialty board certification. Time and the choices of current and future DO trainees in ACGME programs will determine the future of the osteopathic profession—and whether these risks were worth taking.

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Editor's Note: An Invited Commentary on this article by T.J. Nasca et al appears on pages 1097–1099.

June 30, 2020, marked the conclusion of the 5-year process for programs and institutions in the American Osteopathic Association (AOA) osteopathic graduate medical education (GME) system to apply for accreditation by the Accreditation Council for Graduate Medical Education (ACGME).[1] This process was set in motion in August 2014, when the AOA and the American Association of Colleges of Osteopathic Medicine (AACOM) signed a memorandum of understanding with the ACGME and created the Single Accreditation System (SAS) for GME in the United States. Of the 8 benefits of the SAS identified on the ACGME's website, 5 refer to educational uniformity, efficiencies, and collaboration and 3 mention specific advantages for osteopathic medical education.[2] In this article, I will discuss the factors behind this decision by the AOA and AACOM and consider the potential risks to the future of the osteopathic profession.

Osteopathic Reasons for the SAS

What motivated the osteopathic profession to shut down its GME accreditation system? Multiple factors came into play. First and foremost, the rapid growth in the number and class sizes of colleges of osteopathic medicine (COMs) was overwhelming osteopathic GME. In 2013, there were 37 COM teaching sites; at the time of writing in February 2021, there were 58.[3] In 2014, the year the AOA agreed to the SAS, there were 5,153 COM graduates but just 2,988 positions offered in the AOA Match, the majority in primary care specialties.[4] That year, 2,064 (40.1%) COM graduates matched with an AOA program. Some of the 924 vacant positions were filled in the AOA's post-Match scramble. However, the majority of 2014–2015 COM graduates (2,738 [53.1%]) applied to the National Resident Matching Program (NRMP) Main Residency Match.[5] Even if the AOA had filled all of its funded positions in 2014–2015, it could have accommodated only 58% of the COM graduates. With osteopathic GME failing to keep pace with COM growth, the osteopathic profession's reliance on the ACGME system to train DOs was expected to continue and increase. Consolidating GME with the ACGME in the SAS immediately took the pressure off the AOA to ensure that all DO graduates had opportunities for postgraduate training.

The second important factor was the 2013 ACGME policy change eliminating recognition of AOA GME as an equivalent.[1] This meant that DOs who took an osteopathic internship no longer met the general postgraduate year 1 (PGY-1) requirement of some ACGME residencies. To qualify for these, DOs had to repeat PGY-1 in an ACGME program. Furthermore, DOs who took osteopathic residencies were not qualified for entry into ACGME subspecialty programs.

Third, the majority of AOA programs were in primary care, but osteopathic students' professional interests are no

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longer in primary care.[6] In the AACOM's 2019–2020 survey of entering COM students, only 15% of respondents indicated a career preference for family medicine, general internal medicine, or general pediatrics.[7]

While other factors also played a role, the realities of a significant shortfall in GME positions due to dramatic COM growth with increasing dependence on the ACGME system to train DOs, ACGME policy decisions that adversely impacted osteopathic students, and declining osteopathic student interest in primary care created the stimulus for the AOA and AACOM to agree to the SAS.

Features of the SAS

The consolidation of the 2 GME systems was not a match of equals. On paper, the AOA in 2014–2015 had 1,205 programs and 14,335 positions, but many of them were inactive.[8] For the same year, the ACGME had 9,768 programs with 118,366 positions.[9] As the smaller entity, the AOA made most of the concessions. Under the SAS agreement,[1] all AOA programs and training institutions had 5 years to apply for and achieve ACGME initial accreditation, by June 30, 2020, to remain in GME. The not inconsiderable costs of meeting the more rigorous ACGME accreditation standards were borne by the osteopathic teaching institutions. All institutional and program accreditation decisions were made by the ACGME, with DO representation. The changes required of the ACGME were related mostly to accommodations—adding DOs to its administrative and educational bodies and recognizing osteopathic neuromusculoskeletal medicine as a specialty. The bottom line is that the ACGME organizational structure remained largely unchanged while the AOA agreed to make major changes and, in the end, cease its GME accreditation functions.

Decisions regarding program applications rested solely with osteopathic training institutions. Nonphysicians, primarily CEOs and CFOs of osteopathic teaching hospitals, with input from medical educators, determined institutional sponsorship, which program applications to submit to the ACGME, which faculty to name as the designated institutional official (DIO) and program directors, program size, and whether to seek Osteopathic Recognition (discussed below). The AOA's ceding control of the mechanics of program applications gave osteopathic training institutions the potential to generate outcomes detrimental to the future of the osteopathic profession through their independent decisions.

Lost Osteopathic GME Leadership

Osteopathic training institutions did not make a priority of preserving DO leadership in the SAS. (Under AOA policies, all programs, with rare exceptions, were headed by DOs.) Some specialties kept a high percentage of DO residency program directors, but others witnessed a stark decline by June 1, 2020 (Table 1). Evident in this decline were the larger, popular specialties of internal medicine and general surgery, which had MD program directors for 47/93 (50.5%) and 24/48 (50.0%) of programs, respectively. Nearly all specialties were affected to some degree, as 174 (31.1%) of 560 residency programs listed MD program directors. The trend of lost osteopathic leadership was even more pronounced in subspecialty programs, where more than half of the program directors (67/132, 50.8%) were MDs (Table 2). This also carried over to the position of DIO: Of the 94 sponsors who applied for ACGME institutional accreditation, only 39 (41.5%) had a DO in their DIO position.[10] These losses do not include the roughly 262 DO program directors of AOA programs that did not achieve ACGME accreditation (discussed below) nor take into account the large percentage of former DO program directors of the 175 AOA/ACGME programs (i.e., those accredited by both the AOA and ACGME) that already had a named ACGME program director.

Lost Osteopathic GME Programs

The AOA and AACOM could only sit on the sidelines and watch as program applications were submitted to the ACGME by osteopathic training institutions. One outcome is that undersubscribed, inactive, and/or unfunded programs were weeded out. In 2014–2015, the AOA had 119 internship programs.[8] By June 1, 2020, the number of ACGME-accredited transitional programs was 40 (Table 1).

There are 3 main categories of lost AOA GME programs: (1) those that withdrew their applications from the ACGME accreditation process; (2) those that decided not to seek ACGME accreditation, and (3) those that had no ACGME equivalent.

Surgical programs feature prominently among those that withdrew their applications for ACGME accreditation.[11] Of the 8 AOA neurological surgery programs that applied, 4 (50.0%) subsequently opted to withdraw. In addition, 6 (11.1%) of 54 general surgery programs, 2 (13.3%) of 15 otolaryngology programs, and 1 (12.5%) of 8 ophthalmology programs withdrew. This decline in surgical training opportunities does not include those programs that elected not to submit an ACGME application. In 2014–2015, the AOA had 107 programs in these 4 specialties, but in 2020, only 72 (67.3%) had achieved ACGME accreditation (Table 1). The loss of 35 (32.7%) of the AOA programs in these sought-after residencies represents a significant setback both for DO graduates and for the programs' former DO program directors and teaching faculty.

The AOA also had conjoint subspecialty programs—what the ACGME calls multidisciplinary subspecialty programs—in 8 disciplines in 2014–2015.[8] Although 7 of these disciplines had ACGME equivalents, no osteopathic training institution submitted an ACGME application for a multidisciplinary subspecialty program in 5 of the 7 disciplines. In the remaining 2 disciplines, programs and opportunities declined. Sports medicine had 24 AOA subspecialty programs and 71 fellows in 2014–2015, but only 7 of these programs had ACGME accreditation on June 1, 2020. Similarly, hospice and palliative medicine had 5 subspecialty programs accredited by the ACGME, in contrast to 15 AOA programs with 34 fellows in 2014–2015 (Table 2).

Over the years, the AOA developed programs unique to osteopathic medicine, including programs in specialties and subspecialties without equivalents in the ACGME system (e.g., otolaryngic allergy), as well as residencies that combined 2 specialties into a single program (e.g., family medicine/emergency medicine).[8] Another type of combined program linked internal medicine with an additional year of training in osteopathic neuromusculoskeletal medicine. All of these unique programs without ACGME equivalents had to close.

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Table 1

AOA Residency Programs That Applied for ACGME Accreditation Under the Single Accreditation System (SAS), as of June 1, 2020 [a]

Specialty	AOA programs in 2014–2015, no. [b]	ACGME applications, no.		ACGME-accredited programs in 2020, no.	ACGME program director, no.	
		Submitted	Withdrawn		DO	MD
Anesthesiology	14	11	2	9	8	1
Dermatology	31	26	0	26	24	2
Diagnostic radiology	16	10	2	8	6	2
Emergency medicine	59	51	4	47	40	7
Family medicine[c]	252	131	9	122	96	26
Internal medicine[c]	137	99	6	93	46	47
Neurological surgery	12	8	4	4	2	2
Neurology	11	10	0	10	9	1
Obstetrics–gynecology	34	29	2	27	21	6
Ophthalmology	15	8	1	7	3	4
Orthopedic surgery	44	41	1	40	29	11
Osteopathic neuromusculoskeletal medicine	9	29	3	26	26	0
Otolaryngology	21	15	2	13	12	1
Pediatrics[c]	22	7	0	7	3	4
Physical medicine and rehabilitation	6	4	0	4	3	1
Plastic surgery	8	3	0	3	2	1
Psychiatry[c]	25	16	0	16	5	11
Surgery	59	54	6	48	24	24
Urology	11	11	1	10	5	5
Transitional/internship	119	43	3	40	22	18
Total no. (%)	905	606	46/606 (7.6)	560/606 (92.4)	386/560 (68.9)	174/560 (31.1)

Abbreviations: AOA, American Osteopathic Association; ACGME, Accreditation Council for Graduate Medical Education.

[a]By June 1, 2020, ACGME review committees had met and taken action on all pending AOA program and training institution applications ahead of the June 30, 2020, SAS deadline for ACGME initial accreditation. *Data sources:* Author's analysis of ACGME data.[11] AOA data reprinted from Martinez and Biszewski[8] in *The Journal of the American Osteopathic Association* with consent of the American Osteopathic Association. © 2020 American Osteopathic Association.

[b]These numbers reflect the minimum number of AOA residency programs in 2014–2015 that were eligible to apply for ACGME accreditation. The AOA accredited additional new osteopathic GME programs beyond 2014–2015, which could apply for ACGME accreditation. Submission of applications by AOA programs to the ACGME began on July 1, 2015. Osteopathic specialties and programs that did not or could not submit applications to the ACGME are not included in this table.

[c]Some specialties (e.g., family medicine, internal medicine, pediatrics, psychiatry) already had a number of programs accredited by both the AOA and the ACGME (AOA/ACGME programs). The approximately 175 programs that already carried ACGME accreditation did not apply and they retained their program director of record. These programs are included only in the counts of AOA programs in the first column of this table.

In 2014–2015, the AOA reported having 1,205 programs.[8] A small number of new programs received AOA accreditation between 2015–2016 and 2019–2020. Tables 1 and 2 list the 1,129 AOA programs (905 residency and 224 subspecialty programs, broken down by specialty) that could apply for ACGME initial accreditation in 2014–2015. Not listed in the tables and excluded from this count of 1,129 are the roughly 76 AOA programs that could not apply because of a lack of a recognized ACGME equivalent and those specialties and subspecialties for which an ACGME equivalent existed but no programs applied. Subtracting the approximately 175 residency programs already accredited by both the AOA and the ACGME, which did not need to apply,[12] from 1,129 left at least 954 AOA programs eligible to apply to the ACGME at the start of the SAS in July 2015.

By June 1, 2020, all ACGME Review Committees had met and registered accreditation decisions on pending SAS applications; no new ACGME accreditation decisions on SAS applications were registered in June 2020. In total, 745 AOA programs applied,[11] 53 (7.1%) withdrew, and 692 (92.9%) achieved ACGME accreditation in the SAS. At a minimum, 692 (72.5%) of the 954 AOA programs eligible in 2014–2015 eventually achieved ACGME accreditation while 262 programs (27.5%) programs either did not apply or withdrew from the accreditation process.

Losses to Osteopathic Organizations

In the mid-1990s, the AOA created an accreditation entity called the osteopathic postdoctoral training

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Table 2

AOA Subspecialty Programs That Applied for ACGME Accreditation Under the Single Accreditation System, as of June 1, 2020 [a]

Subspecialty	AOA programs in 2014–2015, no. [b]	ACGME applications, no.		ACGME-accredited programs in 2020, no.	ACGME program director, no.	
		Submitted	Withdrawn		DO	MD
Allergy and Immunology	2	2	0	2	2	0
Anesthesiology						
Pain medicine	3	1	0	1	0	1
Dermatology						
Micrographic surgery and dermatologic oncology	4	3	0	3	0	3
Family medicine						
Geriatric medicine	15	1	0	1	1	0
Hospice and palliative medicine	15	5	0	5	4	1
Sports medicine	24	7	0	7	6	1
Internal medicine						
Cardiovascular disease	29	26	0	26	9	17
Clinical cardiac electrophysiology	1	1	0	1	0	1
Critical care medicine	7	6	0	6	4	2
Endocrinology	6	6	1	5	1	4
Gastroenterology	20	22	0	22	12	10
Geriatric medicine	9	3	1	2	2	0
Hematology and oncology	6	5	1	4	1	3
Infectious disease	5	2	0	2	2	0
Interventional cardiology	13	11	0	11	5	6
Medical oncology	2	1	0	1	0	1
Nephrology	10	3	0	3	2	1
Pulmonary disease	2	1	0	1	0	1
Pulmonary critical care	13	13	1	12	6	6
Rheumatology	4	4	0	4	3	1
Obstetrics–gynecology						
Female pelvic medicine and reconstructive surgery	2	1	0	1	0	1
Gynecologic oncology	3	4	1	3	1	2
Maternal–fetal medicine	5	4	1	3	1	2
Reproductive endocrinology and infertility	3	1	1	0	0	0
Orthopedic surgery						
Hand surgery	1	1	0	1	1	0
Psychiatry						
Child and adolescent psychiatry	5	1	0	1	1	0
Geriatric psychiatry	2	1	0	1	0	1
Surgery						
Surgical critical care	5	2	0	2	1	1
Vascular surgery	8	1	0	1	0	1
Total no. (%)	224	139	7/139 (5.0)	132/224 (58.9)	65/132 (49.2)	67/132 (50.8)

Abbreviations: AOA, American Osteopathic Association; ACGME, Accreditation Council for Graduate Medical Education.

[a] By June 1, 2020, ACGME review committees had met and taken action on all pending AOA program and training institution applications ahead of the June 30, 2020, SAS deadline for ACGME initial accreditation. *Data sources:* Author's analysis of ACGME data[1]. AOA data reprinted from Martinez and Biszewski[2] in *The Journal of the American Osteopathic Association* with consent of the American Osteopathic Association. © 2020 American Osteopathic Association.

[b] These numbers reflect the minimum number of AOA subspecialty programs in 2014–2015 that were eligible to apply for ACGME accreditation. The AOA accredited additional new osteopathic GME programs beyond 2014–2015, which could apply for ACGME accreditation. Submission of applications by AOA programs to the ACGME began on July 1, 2015. Osteopathic subspecialties and programs that did not or could not submit applications to the ACGME are not shown in this table, including the 5 AOA conjoint subspecialty programs mentioned in the text: addiction medicine, dermatopathology, pediatric emergency medicine, sleep medicine, and undersea and hyperbaric medicine.

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institution (OPTI) to assist and oversee compliance with AOA accreditation. In most instances, OPTIs operated out of COMs. Every osteopathic GME program was obligated to be sponsored by an OPTI, and the OPTI itself had to meet AOA accreditation standards.[13] As an intermediate entity between the AOA and osteopathic training hospitals, the OPTI acted as the local manager of GME. Under the terms of the SAS, OPTIs qualify as ACGME sponsors.[1]

Only 9 (45.0%) of the 20 OPTIs listed on the AOA website applied for ACGME institutional sponsorship by June 20, 2020.[10,14] In most cases, individual hospitals and COMs opted to apply as institutional sponsors under their own names, in effect eliminating their OPTIs from their relationships with the ACGME. For example, the Statewide Campus System (SCS), the largest OPTI, oversaw 35 member hospitals, 214 AOA-approved programs, and 1,937 trainees in 2016.[15] In June 2020, the SCS was an ACGME institutional sponsor of only 1 program.[10] Within a short period of time, OPTIs moved from the center of osteopathic GME to the periphery. To exist in the future, OPTIs will need to reinvent themselves and find ways to provide value to their teaching hospitals to retain them as members.

Osteopathic specialty colleges face a similar situation. Before the SAS, they served as a hub for osteopathic GME and a base for information and services for both program directors and trainees. Residents and fellows were required to be members,[16] giving specialty colleges the opportunity to provide educational services to them with the hope that they would continue as members when they entered practice. The SAS eliminated the membership requirement, making contact with DOs in ACGME programs more difficult for the specialty colleges. Their former educational services are no longer needed, and competing MD specialty organizations are also wooing DOs. Like the OPTIs, the specialty colleges lost the advantages of a closed GME system and faced challenges in remaining viable organizations. Osteopathic state associations and organizations that provide continuing medical education programs aimed at DOs have similar concerns about their future.

Osteopathic Recognition

Osteopathic Recognition deserves special attention. As part of the SAS agreement, the ACGME agreed to establish a unique status to identify programs with an emphasis on osteopathic medicine.[1] All ACGME-accredited programs have the option to apply and meet established criteria to earn this designation, which is designed to indicate a continuation of osteopathic education and training beyond medical school. The hope of the osteopathic profession was that DOs would gravitate to these GME programs, enhance their manipulative skills, and maintain their osteopathic identity.[17] Teaching institutions decide whether to apply for Osteopathic Recognition.

As of June 20, 2020, 236 former AOA and current ACGME programs had applied for Osteopathic Recognition, the majority in family medicine (147 programs) and internal medicine (32 programs).[18] Not all applicants for Osteopathic Recognition were former AOA programs. Even if all 122 former AOA family medicine residencies acquired Osteopathic Recognition, existing ACGME family medicine programs would still account for at least 25 (10.6%) of the Osteopathic Recognition programs. Few non–primary care programs and only a handful of subspecialty programs applied. These application data suggest that former osteopathic training institutions have a less than compelling interest in Osteopathic Recognition for their programs outside of primary care.

The foundation of osteopathic medicine rests on its educational programs in osteopathic neuromusculoskeletal medicine. Yet, the training of future osteopathic specialists within the ACGME system is off to a slow start. As of June 1, 2020, there were 26 ACGME-accredited residencies in osteopathic neuromusculoskeletal medicine. However, only 3 (11.5%) of these programs participated in the 2020 NRMP Match, offering 10 positions, of which 8 were filled.[19] COMs and Osteopathic Recognition programs depend heavily on the advanced skills of these specialists for instruction and the promotion of osteopathic principles and practices. A failure to train a sufficient number of osteopathic specialists will have a decidedly negative impact not only on the future of these programs but also on generating qualified faculty and meeting the public demand. This is another instance in which independent decisions of former osteopathic training institutions have the potential to affect the future of the osteopathic profession.

Discussion

The timeline for the SAS transition has run its course, and this new accreditation system has been adopted for all U.S. GME programs. Government agencies now have to interact with only 1 GME accreditation organization. Patients can take comfort in the knowledge that both DOs and MDs train in the same GME programs, and they need not question the adequacy of osteopathic GME. For the osteopathic profession, however, the jury is still out. The biggest advantage of the SAS is the resolution of the longstanding problem of too few AOA GME positions. COM total enrollment in 2000 was 10,817, but, with the rapid increase in new COMs and new training sites, grew to 31,663 in 2019.[9] Responsibility for GME now rests with the ACGME, which currently has the capacity to absorb these COM graduates. The unanswered question is whether the benefits of securing these training opportunities for COM graduates will offset the risks to the future of the osteopathic profession.

What are these risks? There has already been a significant decline of DOs in GME leadership positions. Moving forward, DO residents and fellows will have fewer osteopathic role models, and opportunities for DOs to become DIOs and program directors will become more competitive. June 2020 data should serve as a benchmark for the number of DOs in GME leadership positions. Future research should examine increases or declines overall and by specialty.

The same metric should be applied to Osteopathic Recognition. The low percentage of eligible AOA programs that have applied for Osteopathic Recognition reflects the choices of training institutions in determining their GME priorities. If this already low number declines further and if the existing ACGME-accredited osteopathic neuromusculoskeletal medicine residencies do not continue to be supported by their training institutions, the potential exists for an erosion in the number of osteopathic practitioners and a further decrease in training opportunities in osteopathic

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medicine, especially in non–primary care specialties.

DO residents graduating from ACGME programs have the option of taking their board certification exams through AOA specialty certifying boards, American Board of Medical Specialties (ABMS) member boards, or both. Even before 2015, the majority of DOs in ACGME programs opted for the ABMS pathway.[9,12,13] The risk for the osteopathic profession is that this trend will continue and even increase. If most DOs pursue ABMS certification, it will make it difficult for osteopathic certifying boards to survive, especially in smaller non–primary care specialties. Future DO choices on board certification will be a telling indicator of loyalty to and identification with the osteopathic profession.

For osteopathic medical students, the biggest risk is a continuation of past and current patterns in residency selection. DO graduates have experienced difficulties being selected into competitive ACGME residencies.[6] In the 2020 NRMP Match, for example, 17 (4.9%) of the 348 positions filled in otolaryngology and 3 (1.3%) of the 232 slots filled in neurological surgery went to DOs.[9] These results include positions in former AOA programs that obtained ACGME accreditation. With not all osteopathic GME surgical programs achieving ACGME accreditation, as noted above, and with MD graduates able to apply to former AOA programs—many now with MD program directors—DOs face even more daunting odds in these, and other, competitive specialties. If integration and acceptance of DO graduates by MD program directors do not occur, the past and current patterns of steering DOs into ACGME primary care specialties will continue.

The trends of today can change in the future, however. Efforts by the AOA[17] and AACOM[13] to promote training opportunities in osteopathic principles and practices may prompt additional training institutions to apply for Osteopathic Recognition and to support and fund residency programs in osteopathic neuromusculoskeletal medicine. Having closer working relationships with MD GME supervisors may provide DOs with opportunities to demonstrate their fitness for and obtain more GME leadership positions. MD program directors of competitive residencies may see fewer differences in the credentials of residency applicants from COMs and MD-granting schools, and current imbalances may be addressed over time. DO residents in ACGME programs may seek opportunities to forge stronger connections with osteopathic organizations as they form their professional identity, both during and following completion of their training.

In sum, the osteopathic profession has risked losing its identity by moving from a failing, closed accreditation system to a collaborative, open GME environment that will test the loyalty of its former training institutions and of DOs who graduate from ACGME programs. Time and the choices of current and future DO trainees in ACGME programs will determine the future of the osteopathic profession—and whether these risks were worth taking.

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Teaching and Learning Moments
Enlightened Institutions of Higher Learning

The story is common. I was raised in the western United States. My maternal relatives were an original settling Spanish family in the 1700s (yes, they were colonialists). My paternal relatives, a wealthy family of privilege and education, immigrated from Mexico in 1916 as political refugees and became migrant farm workers in Colorado. My paternal grandmother instilled a culture of education in the family, which is why all 3 of her children attended college in the 1950s. Although my parents were bilingual, they refused to teach me Spanish so that I would speak unaccented English; both were punished in school for speaking Spanish (e.g., slapped on the knuckles or ordered to put their lunch money on the teacher's desk). In the 1970s, when La Raza Chicano protests started in our city, my parents sat me down. They started with, "*Mijo*, *that* because our family does *that* with education. So, I put my head down and worked harder.

Upon receiving my medical school acceptance letter, I enjoyed 5 minutes of joy and then my imposter syndrome soared. Nonetheless, the next day I went to the Sears and Roebuck catalog counter to order my white coat. The pleasant Caucasian saleswoman said, "Oh, you are going to work in a pharmacy?" I answered, "No, I am going to be a doctor." She said, "Oh, you mean you are working in a pharmacy." So, I put my head down, placed my order, and worked harder.

As junior faculty in a western public medical school, I was fortunate to gain NIH research funding early in my career. After my first academic promotion, one of my grants was ending and my chairman asked, "What are you going to do for your salary when that happens?" Knowing that I was the only faculty member with significant grant funding in a department with only 2 minority faculty, I was shocked at his question. So, I put my head down, was awarded grants that brought the institution more than $10 million over my career, and worked harder.

When we started a new electronic medical record, I noticed in the Skin Findings section of the physical exam a prewritten documentation option that said "normal for ethnicity." Confused by what this meant, I pointed it out to hospital, department, and even diversity leadership, but I received no answer. It remains an option in the medical record and is teaching our learners that patients have no individuality. So, I put my head down, saw more patients, and worked harder.

A few years ago, I was in Tulsa presenting at the Beyond Flexner conference and met a Caucasian friend for dinner. We walked to a small BBQ restaurant that was busy, but we were quickly served. The next night I went back to the same restaurant. It was not busy, so I walked in and sat at a table. I sat for 30 minutes without a menu, without water, without any acknowledgement. It reminded me of a photo posted on social media by a person of color; in it, the person had written in ketchup on the table "Waited 45 minutes, no service." So, I put my head down, ordered room service back at the hotel, practiced my presentation, and worked harder.

In a rush to make a statement on antiracism, our medical school leadership released a letter in support of diversity. My name was omitted. I am an associate dean, a leader in the medical school, yet I was forgotten in the release of the letter. Realizing that other names had been omitted, leadership quickly released a revised letter with names added; again, my name was omitted. So, I put my head down, wrote this essay, and worked harder.

Systemic and institutional racism present in many ways—some subtle, some not so subtle—at all levels. Leadership apologized to me, and I tried to explain that it was not about omission (of my name), but how they perpetuated systemic and institutional racism and what that can trigger from past experiences. Even in a public institution with a strong social mission, we are failing at building a faculty that reflects the patients we serve; less than 20% of our faculty are minority, whereas our patient population is greater than 50% minority. Whether it is the disbelief that a dark-skinned Hispanic person could be purchasing a white coat to be a doctor, setting higher career performance standards for minority faculty, or assuming that all individuals of a certain ethnicity have the same skin—these are all part of a commission of systemic and institutional racism.

People are not born racists; these are learned behaviors. Over time and generations, these learned behaviors have manifested in institutional and systemic racism, teaching our medical learners and demonstrating to our patients that the commission of racism is acceptable.

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Exhibit 6:
SJC-AMA-000000001
Report 2 on the Council of Medical Education

HOD ACTION: Recommendations in Council on Medical Education 2 adopted as amended and the remainder of the report filed.

REPORT 2 OF THE COUNCIL ON MEDICAL EDUCATION (A-24)
The Current Match Process and Alternatives (Resolution 302-A-23)

EXECUTIVE SUMMARY

This report was written in response to Resolution 302, brought forth by the Resident and Fellow Section at the 2023 Annual Meeting of the House of Delegates. This resolution was referred for study. Now AMA Policy D-310.944, it asks that that the American Medical Association "study alternatives to the current residency and fellowship Match process which would be less restrictive on free market competition for applicants."

This report summarizes the history of The Match® and time before The Match, differentiates between the application process versus The Match, explains aspects of The Match process as well as independent match processes, and offers perspective from the National Resident Matching Program® (NRMP®). The Council on Medical Education understands the concerns presented by the authors of Resolution 302-A-23 and their frustrations related to lack of control over their own destinies. This report illuminates the importance of ongoing communication and transparency by the NRMP as well as collaboration among all invested parties. Further, this report makes clear that there are no currently identified alternatives other than an unstructured, open market approach, which the Council believes would be detrimental to the majority of trainees in comparison to the current Match process. Thus, attention should be focused on what can be done to improve The Match and other specialty matches rather than focusing on its replacement, as a match process continues to be the best solution for trainees at this time.

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HOD ACTION: Recommendations in Council on Medical Education 2 adopted as amended and the remainder of the report filed.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 02-A-24

Subject: The Current Match Process and Alternatives (Resolution 302-A-23)

Presented by: [redacted], MD, MPH, Chair

Referred to: Reference Committee C

INTRODUCTION

At the 2023 Annual Meeting of the House of Delegates, Resolution 302-A-23 entitled "Antitrust Legislation Regarding the AAMC, ACGME, NRMP and Other Relevant Associations or Organizations" asked "that our American Medical Association study alternatives to the current residency and fellowship Match process which would be less restrictive on free market competition for applicants." The Resident and Fellow Section (RFS), authors of the resolution, noted concerns related to preservation of the process of free market competition, antitrust laws, and The Match®. Their resolution stated, "The Match poses significant anticompetition concerns and the procompetitive effect of streamlining residency job applications and increasing percentage of position filled needs to be outweighed by the anticompetitive effect of the lack of negotiation power of residents."[1.]

The resolution, now American Medical Association (AMA) Policy D-310.944, was referred for study. This report seeks to address this directive by providing historical context, differentiating between the application process versus The Match, explaining aspects of The Match process as well as independent match processes, and offering perspective from the National Resident Matching Program® (NRMP®). It seeks to illuminate what can be done within the confines of The Match to make it better and clarify that there are no currently identified "alternatives" other than the free market approach. To provide context, The Match is defined by the NRMP as "a computerized mathematical algorithm, 'the matching algorithm,' to place applicants into the most preferred residency and fellowship positions at programs that also prefer them."[2] It is intended to favor the rank list of the applicant.

BACKGROUND

History of The Match

The trainee internship experience began in the late 1800s and was formalized shortly thereafter. Such positions began to outnumber the students available. "In the early 1900s, competition among hospitals for interns and among medical students for good internships led to increasingly early offers of internships to students. By the 1940s, appointments were often made as early as the beginning of the junior year of medical school. ...From 1945 through 1951, efforts were made to enforce a uniform date for accepting offers. However, students were still faced with offers having very short deadlines, compelling them to accept or reject offers without knowing what other offers might be forthcoming."[3] Such challenges led to the creation of a centralized clearinghouse to allow for students to benefit from uniform appointment dates while reducing congestion and pressure.

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The clearinghouse was created by the National Interassociation Committee on Internships, who later changed its name to the National Intern Matching Program (NIMP). It included national organizations such as the AMA (Council on Medical Education), American Hospital Association, Association of American Medical Colleges (AAMC) and federal hospitals involved in resident training.[4] Dissatisfaction among students led to proposals of algorithms that were felt to be more equitable.

The NIMP was established as a 501c(3) and operated through the 1960s. In 1966, the Millis Commission Report, authorized by the AMA Council on Medical Education, examined medical education in the U.S., particularly the length and quality of graduate medical education. It supported a broader move to integrated residency training.[5] The NIMP became the NIRMP in 1968. The organization, in 1972, revised its participation requirements such that The Match expanded to include all first-year resident positions and required all institutions participating in The Match to select U.S. senior students in allopathic medical schools through it. By 1975, the NIRMP had become the NRMP.

The NRMP oversees The Match, which is the mathematical algorithm to match applicants and programs to their most preferred ranked choices. In 2012, researchers Lloyd Shapley and Alvin Roth won the Nobel Prize in Economics for developing the "theory of stable allocations and the practice of market design" which led to the development of the algorithm used for The Match. They "pioneered theoretical concepts to understand and solve the matching problem and clarified those ideas and applied them to engineer algorithms that are now widely used in the real world."[6] The current algorithm has been used since 1998. The Match continues to be updated to address the changing needs of applicants and to yield a favorable match while producing a stable outcome.

In the past, osteopathic medical students could also participate in the American Osteopathic Association (AOA) national match process through the National Matching Services (NMS). Starting in July 2015, the AOA and the Accreditation Council for Graduate Medical Education (ACGME) began a transition to a single accreditation system (SAS) to combine the AOA and NRMP match programs. Between 2015 and 2020, AOA programs applied for accreditation to the ACGME, and if granted, these programs could take residents through the NRMP match. By 2020, most AOA programs had transitioned to the SAS or had withdrawn and were no longer taking new residents but were allowed to complete the training of the residents remaining in their programs under AOA accreditation until the last resident finished. The intent of the SAS was to foster inclusion for osteopathic medical students as well as residents at former AOA programs. Data from 2020-2023 indicates that Doctor of Osteopathic Medicine (DO) applicants have an increased match rate from 90.7% to 91.6%, which also correlates with the opening of more DO schools.[7]

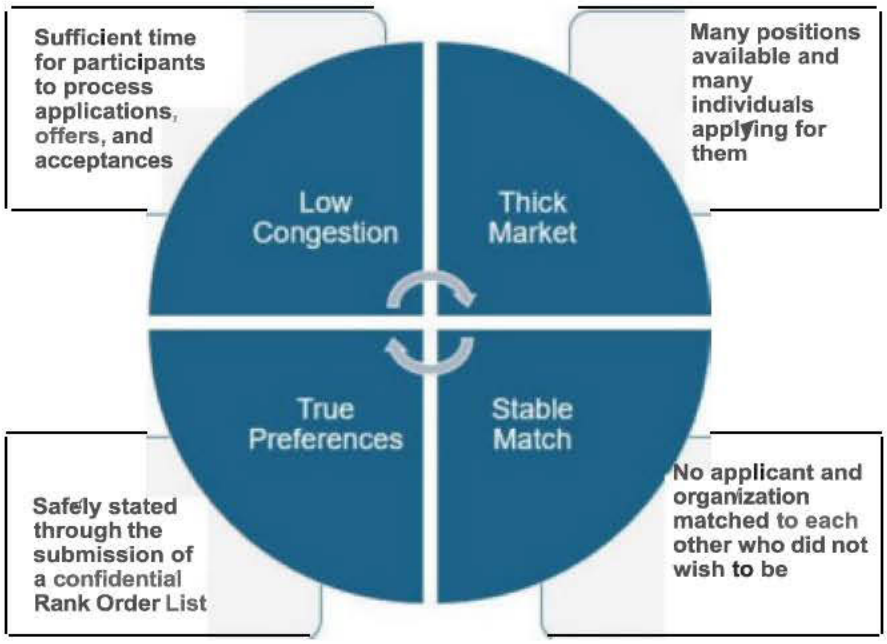
The Match process

The intention of The Match is to make the best possible match for all participants and ensure the uniform process is fair, efficient, transparent, and reliable. Referred to as the Main Residency Match, it is part of a larger undertaking that begins with applying to and interviewing with training programs. Most applicants use the Electronic Residency Application Service® (ERAS®), a product of the AAMC, to apply to programs per their chosen specialty. This centralized online application service delivers applications and supporting documents to residency programs. Next, applicants register for The Match in the NRMP's Registration, Ranking, and Results® (R3®) system. Applicants are invited to interview per the criteria set by each program. Both applicants and programs submit their rank order preferences in the R3 system by a predetermined deadline, usually in early March. The NRMP runs their matching algorithm according to the preferences submitted and all parties are notified of the results later that month. Matched applicants and

programs enter into an agreement. Unmatched applicants and programs may elect to participate in the NRMP's Supplemental Offer and Acceptance Program (SOAP) during Match Week. See Appendix A for an infographic of this process. The NRMP website provides data on the Main Residency Match (including 2023) as well as research reports, survey reports, and research briefs.

The NRMP's Main Residency All In Policy asserts that if a program is registering for the Main Residency Match®, then they must register and attempt to fill all positions through the Match (or another national matching plan).[8] This policy only applies to those positions a program wishes to fill. Programs planning to participate in The Match cannot offer positions outside The Match. If that were to happen prior to program registration and activation, then the program is ineligible to enroll in The Match (unless the NRMP grants an exception). Per the Fellowship Match All In Policy, Specialties Matching Service® (SMS®) Match sponsors may *voluntarily* implement the All In Policy for their fellowship matches. AMA Policy D-310.977(6) "does not support the current 'All-In' policy for the Main Residency Match to the extent that it eliminates flexibility within the match process."[9]

In its current form, the NRMP contends that The Match process is uncongested, defers acceptance, promotes true preferences, and establishes a thick market "which allows for multi-specialty applications and couple matching (including for mixed-specialty couples)."[10] It is built upon the following core components:



Principles of Market Design. Copyright National Resident Matching Program. Reprinted with permission.

Independent match processes

According to the NRMP, "U.S. medical school graduates and students and graduates of international medical schools can be offered positions outside of the Main Residency Match provided it is in a program that does not participate in the Match and thus not subject to the All In Policy. No applicant can accept a position outside of the Match after the Rank Order List Certification Deadline."[11] Some programs choose to participate in an early match process, and the percentage of outside-the-match offers varies by specialty.[12] Not all are affiliated with the NRMP.

For example, students in the Health Professions Scholarship Program and the Uniformed Services University of the Health Sciences who wish to apply for military PGY-1 positions go through a similar process overseen by the Joint Service Graduate Medical Education Selection Board. While they still use the ERAS system, military medical students complete a different application that includes ranking programs. Deadlines also differ, as materials are submitted late August through mid-October, and results are announced in mid-December. The military does not use a computer-generated algorithm, rather it is a process of discussions and negotiations. An applicant can be placed in a program that they did not even rank.[13] Other examples include:

- Preventive Medicine and Public Health: First implemented in 2017, the American College of Preventive Medicine (ACPM) oversees their own match called the Residency Standardized Acceptance Process (SAP).[14]

- Plastic Surgery and Ophthalmology: The San Francisco Residency Match, more commonly referred to as SF Match, is a residency and fellowship matching service that has been used by several specialties and subspecialties for over 40 years. It includes residencies in plastic surgery and ophthalmology, overseen by the American Council of Academic Plastic Surgeons and Association of University Professors of Ophthalmology respectively. It also currently includes 25 fellowship matches, ranging from abdominal transplant surgery to rhinology.

- Urology: For over 30 years, the American Urological Association , in conjunction with the Society of Academic Urologists, has overseen the Urology Residency Match Program.

- Neuromuscular medicine: Starting in 2020, the American Association of Neuromuscular & Electrodiagnostic Medicine started its own standardized match process called the Neuromuscular Fellowship Application Portal that uses an online hub through which residents submit application materials, communicate with programs, and receive offers.[15] The first cycle hosted a partial match process, whereby programs submitted rank lists but applicants did not rank programs. The following cycle was a full match process.[15]

DISCUSSION

Before The Match and other match processes

The time before The Match and other match processes presented real challenges, added stress to the residency application process, and fueled unequal treatment. One reflection written about the time before The Match noted, "Medical students and hospitals once negotiated directly with each other. Competition for talent was fierce amid a tight labor market, with residency programs extending offers to medical students up to two years before graduation. This process had significant downsides: Students had to deal with exploding offers and felt pressure to commit to a program before getting sufficient exposure to different medical specialties. Medical students, residents, and hospitals all backed reform."[16] While The Match offered solutions to those who experienced life before it, a new generation of residency applicants has questioned its efficacy.

Perceived challenges faced by residency applicants

As summarized in the introduction, the RFS, as authors of the original resolution, noted concerns about lack of negotiation power of residents. Consternations were also raised regarding the possibility of residency/fellowship out-of-match offers being better than those in The Match;

however, there is no data to support this notion. Discussions of these concerns among trainees are evident on social media platforms and the internet. For example, The Student Doctor Network, "a non-profit educational website dedicated to building a diverse doctor workforce," has hosted forums that debate this very issue.[16] In a 2021 forum called "What are the alternatives to the Match? What do you think would happen if it were abolished?", trainees raised several points for consideration. They shared that it is within the realm of possibility that programs would have zero incentive to increase wages to be more competitive if The Match went away. Without The Match or some unified system of application, programs could try to fill their spots earlier and such timing may not align with the applicant's desired specialty training. In the non-physician job market, a candidate often has to make a decision about accepting a position without knowing the full extent of the employment details.[17] The NRMP and other matches are not involved in any negotiations or agreements between programs and applicants, and if what a program is willing to offer to an applicant is unacceptable to the applicant, the applicant can simply not include that program in their rank list.

The impact of The Match on competition for residency positions

Another concern raised by the RFS is alleged lack of competition. In 1890, Congress passed The Sherman Act, the first antitrust law, followed in 1914 by two additional antitrust laws—the Federal Trade Commission Act (which formed the FTC) and the Clayton Act. Challenges to The Match were brought forth in a class-action lawsuit in 2002, alleging The Match as violating the Sherman Antitrust Act as described in the AMA Journal of Ethics.[18] However, U.S. Code 37b was passed into law in 2004, entitled "Confirmation of antitrust status of graduate medical resident matching programs," to "confirm that the antitrust laws do not prohibit sponsoring, conducting, or participating in a graduate medical education residency matching program, or agreeing to do so; and ensure that those who sponsor, conduct or participate in such matching programs are not subjected to the burden and expense of defending against litigation that challenges such matching programs under the antitrust laws."[19]

Concern was also raised about The Match possibly having a negative impact on resident salaries. A 2006 economic study by Bulow and Levin is frequently cited to support this claim[20]. However, Bulow and Levin also noted that The Match "was developed for efficiency reasons, and on that score, it appears to do quite well."[20] Research published since the Bulow-Levin paper does not support their conclusions. Agarwal noted that "The Match is not the likely cause of low salaries."[21] According to Konishi & Sapozhnikov, "competitive salary vector is the best-case scenario for applicants in the decentralized market. [… T]he reference salary vector adopted by Bulow and Levin (2006) for the decentralized market outcome might not have a strong justification and could be regarded as rather optimistic."[22] Also, it is important to consider that most resident salaries are funded by clinical revenues from the sponsoring institution and federal government sources, particularly Medicare graduate medical education funds from a budget set by Congress. Since clinical revenue and institutional funding can vary by specialty and setting, disparities in pay may result, even across residency programs at the same institution unfortunately.

Resolution 308 implied that a free-market approach may be more beneficial for trainees. As described earlier in this report regarding the history of The Match and the era before its implementation, the free market posed many problems. Returning to such a process would not likely improve the challenges experienced previously. Economists agree that a free-market approach is not without flaws.[23,24] For example, "Apart from agriculture, few real-world markets are perfectly competitive."[25] Roth asserts that a centralized matching system can improve the welfare of all participants in that market and, depending on its design, can address the problems of unraveling and the congestion.[26] It seems that further analysis of what works well and what does

not work well is warranted in order to improve The Match process. As described in this report, the NRMP and others are committed to continued review and improvement.

The Council on Medical Education recently addressed mechanisms to advocate for the needs of residents in its report, "Organizations to Represent the Interests of Resident and Fellow Trainees" (CME 5-I-23), which was adopted at the Interim 2023 Meeting. It also reviewed duty hour standards; work conditions; the impact of private equity; and the roles of government agencies, accreditors, medical staff organizations, associations, and unions. The adoption of that report signifies renewed efforts to advocate for the interests of trainees.

Coalition for Physician Accountability recommendations

The Coalition for Physician Accountability (CPA) is comprised of representatives from national organizations (including the AMA) responsible for the oversight, education, and assessment of medical students and physicians throughout their medical careers. In April 2021, the CPA's Undergraduate Medical Education-Graduate Medical Education Review Committee (UGRC) released 28 recommendations for comprehensive improvement of the UME-GME transition. The UGRC was comprised of several workgroups, one of which focused on the mechanics of the application/selection process from the graduate medical education perspective. The final recommendations were categorized according to themes and refer to the residency application process as well as The Match and other matching processes. Two themes of note address an equitable, mission-driven application review (Recommendations #14-20) as well as optimization of the application, interview, and selection processes (Recommendations #21-24). Specifically, Recommendation #23 states that "Innovations to the residency application process should be piloted to reduce application numbers and concentrate applicants at programs where mutual interest is high, while maximizing applicant placement into residency positions. Well-designed pilots should receive all available support from the medical community and be implemented as soon as the 2022-2023 application cycle; successful pilots should be expanded expeditiously toward a unified process."[27]

Recent NRMP proposals

The NRMP maintains that it is committed to considering ways to inform the transition to residency or improve the matching process. In 2021, the NRMP issued a statement on the feasibility of an early match. Specifically, NRMP was asked to pilot the Early Result and Acceptance Program (ERAP) proposed for obstetrics and gynecology. This pilot program was created through a grant provided by the AMA's Reimagining Residency program. The NRMP concluded that an early match would disadvantage applicants, and that changes to the process could potentially cause behavior changes that could negatively affect outcomes for all participants.[10]

To consider the feasibility of a proposed Two-Phase Main Residency Match (that would replace The Match and SOAP), the NRMP Board of Directors opened a call for comment period in August-September 2022. The goal was to "alleviate some of the stressors inherent in the current transition to residency based on available evidence."[28] After considering the over 8,000 responses to the call, the NRMP Board of Directors decided to not pursue the proposal as written, stating that "Although the benefits/advantages articulated by the community are significant, the risks/disadvantages are considered of greater consequence."[29] The AAMC hosted several listening sessions with their constituency to discuss this two-phase proposal and issued a statement concluding that a long-term evaluation plan would be needed with a focus on "learners and equity."[30] The AAMC also noted that ERAS would still play a role in a two-phase match and recommended further discussions.

AMA ENGAGEMENT

The AMA has been actively engaged in monitoring this process, is in regular communication with the NRMP, and actively participates in the CPA. The AMA Medical Student Section (MSS) and RFS each offer to their members the opportunity to apply to represent the AMA on the NRMP Board. Both AMA sections have solicited for or nominated members every year for at least the last ten years. The NRMP board offers three seats for student directors and three seats for resident physician directors. The NRMP no longer has designated AMA seats for students or residents due to a change in their bylaws in 2017. To promote effective communication, fostering relationships among key parties is vital. The AMA will continue to look for opportunities to collaborate with the NRMP and other matching organizations.

Through the AMA's ChangeMedEd initiative, efforts are underway across the continuum with visionary partners to create bold innovations. Specifically, Reimagining Residency is a grant program dedicated to promoting systemic change in graduate medical education (GME). "It supports bold and innovative projects that provide a meaningful and safe transition from undergraduate medical education to graduate medical education."[31] Several Reimagining Residency projects directly address the transition from undergraduate medical education (UME) to GME. "Right Resident, Right Program, Ready Day One," a collaboration with the Association of Professors of Gynecology & Obstetrics (APGO), raises cross-specialty standards for the residency application and interview process. It promotes signaling to reduce the number of applications submitted by formalizing communication about true preferences. APGO has also developed an Alignment Check Index (ACI). This adjunct to AMA's FREIDA platform seeks to better align applicant preferences and characteristics with those being sought by specific residency programs. A project at New York University (NYU), called the "Transition to Residency Advantage," builds on experience with UME coaching to train a cadre of GME coaches and then effect a learner-driven warm handoff from UME to GME. Two additional projects, the "California Oregon Medical Partnership to Address Rural Disparities in Rural Education and Health" (COMPADRE) and the University of North Carolina's "Fully Integrated Readiness for Service Training" (FIRST) are creating pathways to rural practice that entail dedicated pathways from medical school to residency that meet the needs of those areas. Also, the AMA helps to inform future GME advocacy by addressing concerns regarding the challenges faced by the current GME system. A 2023 compendium of such GME advocacy initiatives is available for review.

Council on Medical Education efforts

Since 2012, the Council on Medical Education has offered several reports that address residency and The Match as listed below. Additional Council reports can be accessed in the AMA Council Report Finder database.

- Organizations to Represent the Interests of Resident and Fellow Trainees" (CME 5-I-23)
- Optimizing Match Outcomes (CME Report 3-A-21)
- Standardizing the Residency Match System and Timeline (CME Report 3-A-19)
- The Transition from Undergraduate Medical Education to Graduate Medical Education (CME Report 5-I-19)
- Options for Unmatched Medical Students (CME Report 5-A-17)
- Standardizing the Allopathic Residency Match System and Timeline (CME Report 6-A-17)
- Resident and Fellow Compensation and Health Care System Value (CME Report 4-A-16)
- Transparency in the National Resident Matching Program Match Agreement (CME Report 12-A-12)

Relevant AMA Policy

The AMA has ample policy in support of trainees that address such topics as The Match, other match processes, residency application process, and graduate medical education. These policies exemplify the AMA's commitment to closely monitor these issues and engage with the NRMP and others to optimize successful, equitable matching. See Appendix B for the following full policies:

- Study of the Current Match Process and Alternatives D-310.944
- Residents and Fellows' Bill of Rights H-310.912
- Preliminary Year Program Placement H-310.910
- Closing of Residency Programs H-310.943
- Protection of Resident and Fellow Training in the Case of Hospital or Training Program Closure D-310.948
- Residency Interview Schedules H-310.998

Of note, Policy D-310.977 "National Resident Matching Program Reform" includes the following clauses that state the AMA:

> (4) will continue to review the NRMP's policies and procedures and make recommendations for improvements as the need arises, to include making the conditions of the Match agreement more transparent while assuring the confidentiality of the match;
> (5) will work with the Accreditation Council for Graduate Medical Education (ACGME) and other appropriate agencies to assure that the terms of employment for resident physicians are fair and equitable and reflect the unique and extensive amount of education and experience acquired by physicians;
> (6) does not support the current the "All-In" policy for the Main Residency Match to the extent that it eliminates flexibility within the match process;
> (7) will work with the NRMP, and other residency match programs, in revising Match policy, including the secondary match or scramble process to create more standardized rules for all candidates including application timelines and requirements;
> (8) will work with the NRMP and other external bodies to develop mechanisms that limit disparities within the residency application process and allow both flexibility and standard rules for applicants;

Additional related policies, such as those listed below, can be accessed in the AMA Policy Finder database:

- Strengthening Interview Guidelines for American Indian and Alaska Native Medical School, Residency, and Fellowship Applicants H-295.852
- Mitigating Demographic and Socioeconomic Inequities in the Residency and Fellowship Selection Process D-310.945
- Eliminating Questions Regarding Marital Status, Dependents, Plans for Marriage or Children, Sexual Orientation, Gender Identity, Age, Race, National Origin and Religion During the Residency and Fellowship Application Process H-310.919
- Strategies for Enhancing Diversity in the Physician Workforce D-200.985
- US Physician Shortage H-200.954
- Collective Bargaining: Antitrust Immunity D-383.983
- AMA's Aggressive Pursuit of Antitrust Reform D-383.990
- Antitrust Relief for Physicians Through Federal Legislation H-383.990
- Antitrust Relief H-383.992

SUMMARY AND RECOMMENDATIONS

The Council on Medical Education understands the concerns presented by the authors of Resolution 302-A-23 and their frustrations related to lack of control over their own destinies. This report describes the origins of The Match and its current state as well as information about independent match processes. It also clarifies the difference between the AAMC's ERAS application process versus NRMP's Match process, acknowledges challenges, and summarizes recent considerations and recommendations. This report illuminates the importance of ongoing communication and transparency by the NRMP as well as collaboration among all invested parties. Further, this report makes clear that there are no currently identified alternatives other than an unstructured, open market approach, which the Council believes would be detrimental to the majority of trainees in comparison to the current Match process. Accordingly, attention should be focused on what can be done to improve The Match and other specialty matches rather than focusing on its replacement, as a match process continues to be the best solution for trainees at this time.

The Council on Medical Education therefore recommends that the following recommendations be adopted and the remainder of this report be filed. That our AMA:

1. AMA Policy D-310.977, "National Resident Matching Program Reform" be amended by addition to read as follows. Our AMA:

   (20) Encourages the piloting of innovations to the residency application process with aims to reduce application numbers per applicant, focus applicants on programs with reciprocal interest, and maximize residency placement. With support from the medical education community, successful pilots should be expanded to enhance the standardized process.

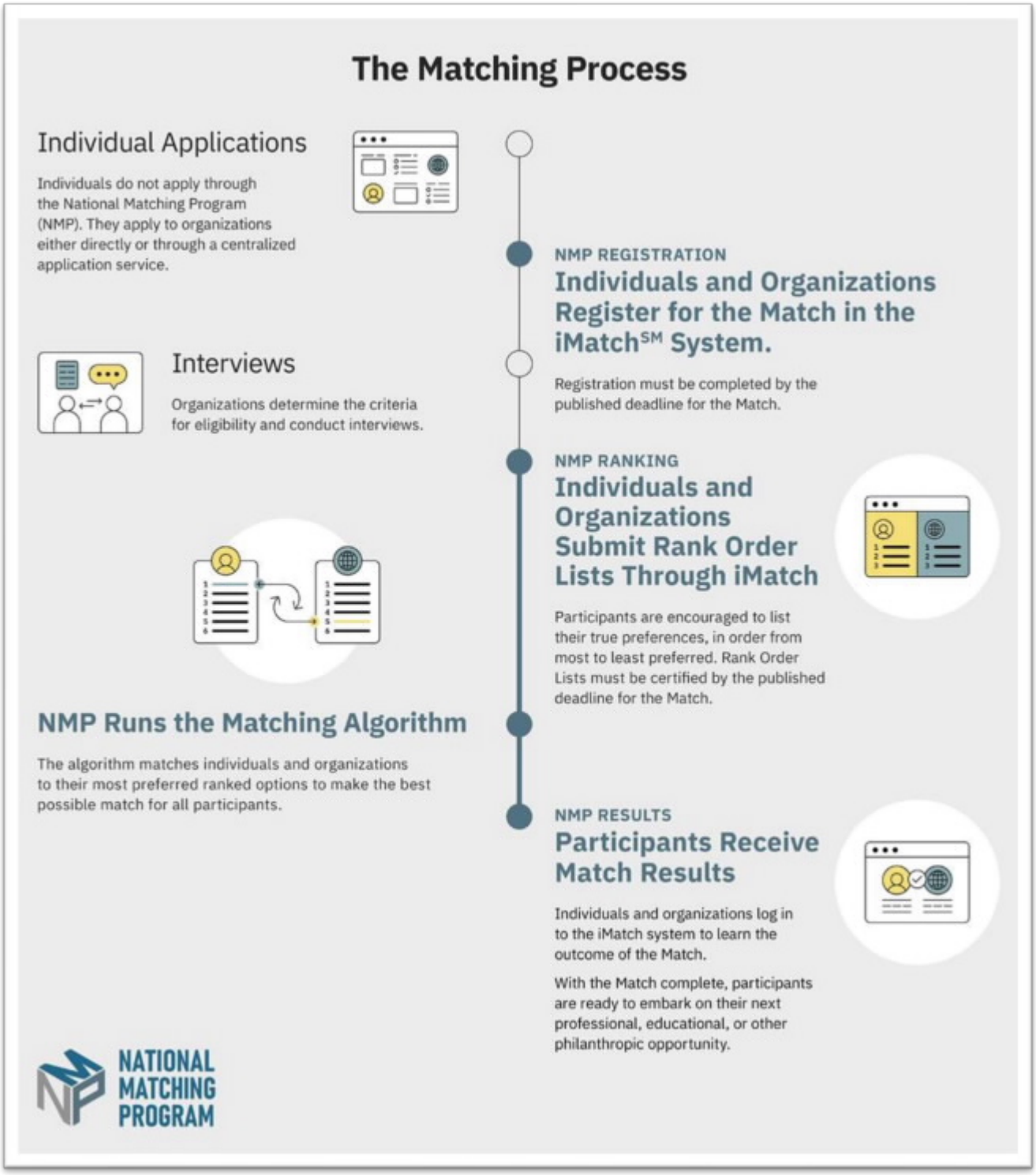
   (21) Continues to engage the National Resident Matching Program® (NRMP®) and other matching organizations on behalf of residents and medical students to further develop ongoing relationships, improve communications, and seek additional opportunities to collaborate including the submission of suitable nominees for their governing bodies as appropriate. (Modify Current HOD Policy)

2. Reaffirm AMA Policies H-310.900 "Resident and Fellow Physicians Seeking to Transfer GME Program" and H-310.912 "Residents and Fellows' Bill of Rights." (Reaffirm HOD Policy)

3. Rescind AMA policy D-310.944, "Study of the Current Match Process and Alternatives," as having been accomplished by this report. (Rescind HOD Policy)

Fiscal note: $1,000

APPENDIX A: THE MATCH PROCESS



How a Match Works. Copyright National Resident Matching Program. Reprinted with permission.

APPENDIX B: RELEVANT AMA POLICY

National Resident Matching Program Reform D-310.977
Our AMA:
(1) will work with the National Resident Matching Program (NRMP) to develop and distribute educational programs to better inform applicants about the NRMP matching process, including the existing NRMP waiver and violations review policies;
(2) will actively participate in the evaluation of, and provide timely comments about, all proposals to modify the NRMP Match;
(3) will request that the NRMP explore the possibility of including the Osteopathic Match in the NRMP Match;
(4) will continue to review the NRMP's policies and procedures and make recommendations for improvements as the need arises, to include making the conditions of the Match agreement more transparent while assuring the confidentiality of the match;
(5) will work with the Accreditation Council for Graduate Medical Education (ACGME) and other appropriate agencies to assure that the terms of employment for resident physicians are fair and equitable and reflect the unique and extensive amount of education and experience acquired by physicians;
(6) does not support the current the "All-In" policy for the Main Residency Match to the extent that it eliminates flexibility within the match process;
(7) will work with the NRMP, and other residency match programs, in revising Match policy, including the secondary match or scramble process to create more standardized rules for all candidates including application timelines and requirements;
(8) will work with the NRMP and other external bodies to develop mechanisms that limit disparities within the residency application process and allow both flexibility and standard rules for applicants;
(9) encourages the National Resident Matching Program to study and publish the effects of implementation of the Supplemental Offer and Acceptance Program on the number of residency spots not filled through the Main Residency Match and include stratified analysis by specialty and other relevant areas;
(10) will work with the NRMP and ACGME to evaluate the challenges in moving from a time-based education framework toward a competency-based system, including: a) analysis of time-based implications of the ACGME milestones for residency programs; b) the impact on the NRMP and entry into residency programs if medical education programs offer variable time lengths based on acquisition of competencies; c) the impact on financial aid for medical students with variable time lengths of medical education programs; d) the implications for interprofessional education and rewarding teamwork; and e) the implications for residents and students who achieve milestones earlier or later than their peers;
(11) will work with the Association of American Medical Colleges (AAMC), American Osteopathic Association (AOA), American Association of Colleges of Osteopathic Medicine (AACOM), and National Resident Matching Program (NRMP) to evaluate the current available data or propose new studies that would help us learn how many students graduating from US medical schools each year do not enter into a US residency program; how many never enter into a US residency program; whether there is disproportionate impact on individuals of minority racial and ethnic groups; and what careers are pursued by those with an MD or DO degree who do not enter residency programs;
(12) will work with the AAMC, AOA, AACOM and appropriate licensing boards to study whether US medical school graduates and international medical graduates who do not enter residency programs may be able to serve unmet national health care needs;
(13) will work with the AAMC, AOA, AACOM and the NRMP to evaluate the feasibility of a national tracking system for US medical students who do not initially match into a categorical residency program;
(14) will discuss with the National Resident Matching Program, Association of American Medical Colleges, American Osteopathic Association, Liaison Committee on Medical Education, Accreditation Council for Graduate Medical Education, and other interested bodies potential pathways for reengagement in medicine following an unsuccessful match and report back on the results of those discussions;
(15) encourages the Association of American Medical Colleges to work with U.S. medical schools to identify best practices, including career counseling, used by medical schools to facilitate successful matches for medical school seniors, and reduce the number who do not match;
(16) supports the movement toward a unified and standardized residency application and match system for all non-military residencies;

(17) encourages the Educational Commission for Foreign Medical Graduates (ECFMG) and other interested stakeholders to study the personal and financial consequences of ECFMG-certified U.S. IMGs who do not match in the National Resident Matching Program and are therefore unable to get a residency or practice medicine;
(18) encourages the AAMC, AACOM, NRMP, and other key stakeholders to jointly create a no-fee, easily accessible clearinghouse of reliable and valid advice and tools for residency program applicants seeking cost-effective methods for applying to and successfully matching into residency; and
(19) will work with appropriate stakeholders to study options for improving transparency in the resident application process.

Study of the Current Match Process and Alternatives D-310.944
Our American Medical Association will study alternatives to the current residency and fellowship Match process which would be less restrictive on free market competition for applicants.

Residents and Fellows' Bill of Rights H-310.912
1. Our AMA continues to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows: a) adequate financial support for and guaranteed leave to attend professional meetings; b) submission of training verification information to requesting agencies within 30 days of the request; c) adequate compensation with consideration to local cost-of-living factors and years of training, and to include the orientation period; d) health insurance benefits to include dental and vision services; e) paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year; and f) stronger due process guidelines.
2. Our AMA encourages the ACGME to ensure access to educational programs and curricula as necessary to facilitate a deeper understanding by resident physicians of the US health care system and to increase their communication skills.
3. Our AMA regularly communicates to residency and fellowship programs and other GME stakeholders this Resident/Fellows Physicians' Bill of Rights.
4. Our AMA: a) will promote residency and fellowship training programs to evaluate their own institution's process for repayment and develop a leaner approach. This includes disbursement of funds by direct deposit as opposed to a paper check and an online system of applying for funds; b) encourages a system of expedited repayment for purchases of $200 or less (or an equivalent institutional threshold), for example through payment directly from their residency and fellowship programs (in contrast to following traditional workflow for reimbursement); and c) encourages training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment in advance or within one month of document submission is strongly recommended.
5. Our AMA will partner with ACGME and other relevant stakeholders to encourage training programs to reduce financial burdens on residents and fellows by providing employee benefits including, but not limited to, on-call meal allowances, transportation support, relocation stipends, and childcare services.
6. Our AMA will work with the Accreditation Council for Graduate Medical Education (ACGME) and other relevant stakeholders to amend the ACGME Common Program Requirements to allow flexibility in the specialty-specific ACGME program requirements enabling specialties to require salary reimbursement or "protected time" for resident and fellow education by "core faculty," program directors, and assistant/associate program directors.
7. Our AMA encourages teaching institutions to offer retirement plan options, retirement plan matching, financial advising and personal finance education.
8. Our AMA adopts the following "Residents and Fellows' Bill of Rights" as applicable to all resident and fellow physicians in ACGME-accredited training programs:

RESIDENT/FELLOW PHYSICIANS' BILL OF RIGHTS

Residents and fellows have a right to:

A. An education that fosters professional development, takes priority over service, and leads to independent practice.

With regard to education, residents and fellows should expect: (1) A graduate medical education experience that facilitates their professional and ethical development, to include regularly scheduled didactics for which they are released from clinical duties. Service obligations should not interfere with

educational opportunities and clinical education should be given priority over service obligations; (2) Faculty who devote sufficient time to the educational program to fulfill their teaching and supervisory responsibilities; (3) Adequate clerical and clinical support services that minimize the extraneous, time-consuming work that draws attention from patient care issues and offers no educational value; (4) 24-hour per day access to information resources to educate themselves further about appropriate patient care; and (5) Resources that will allow them to pursue scholarly activities to include financial support and education leave to attend professional meetings.

B. Appropriate supervision by qualified physician faculty with progressive resident responsibility toward independent practice.

With regard to supervision, residents and fellows must be ultimately supervised by physicians who are adequately qualified and allow them to assume progressive responsibility appropriate to their level of education, competence, and experience. In instances where clinical education is provided by non-physicians, there must be an identified physician supervisor providing indirect supervision, along with mechanisms for reporting inappropriate, non-physician supervision to the training program, sponsoring institution or ACGME as appropriate.

C. Regular and timely feedback and evaluation based on valid assessments of resident performance.

With regard to evaluation and assessment processes, residents and fellows should expect: (1) Timely and substantive evaluations during each rotation in which their competence is objectively assessed by faculty who have directly supervised their work; (2) To evaluate the faculty and the program confidentially and in writing at least once annually and expect that the training program will address deficiencies revealed by these evaluations in a timely fashion; (3) Access to their training file and to be made aware of the contents of their file on an annual basis; and (4) Training programs to complete primary verification/credentialing forms and recredentialing forms, apply all required signatures to the forms, and then have the forms permanently secured in their educational files at the completion of training or a period of training and, when requested by any organization involved in credentialing process, ensure the submission of those documents to the requesting organization within thirty days of the request.

D. A safe and supportive workplace with appropriate facilities.

With regard to the workplace, residents and fellows should have access to: (1) A safe workplace that enables them to fulfill their clinical duties and educational obligations; (2) Secure, clean, and comfortable on-call rooms and parking facilities which are secure and well-lit; (3) Opportunities to participate on committees whose actions may affect their education, patient care, workplace, or contract.

E. Adequate compensation and benefits that provide for resident well-being and health.

(1) With regard to contracts, residents and fellows should receive: a. Information about the interviewing residency or fellowship program including a copy of the currently used contract clearly outlining the conditions for (re)appointment, details of remuneration, specific responsibilities including call obligations, and a detailed protocol for handling any grievance; and b. At least four months advance notice of contract non-renewal and the reason for non-renewal.

(2) With regard to compensation, residents and fellows should receive: a. Compensation for time at orientation; and b. Salaries commensurate with their level of training and experience. Compensation should reflect cost of living differences based on local economic factors, such as housing, transportation, and energy costs (which affect the purchasing power of wages), and include appropriate adjustments for changes in the cost of living.

(3) With regard to benefits, residents and fellows must be fully informed of and should receive: a. Quality and affordable comprehensive medical, mental health, dental, and vision care for residents and their families, as well as retirement plan options, professional liability insurance and disability insurance to all residents for disabilities resulting from activities that are part of the educational program; b. An institutional written policy on and education in the signs of excessive fatigue, clinical depression, substance abuse and dependence, and other physician impairment issues; c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined amount of paid vacation leave, sick leave, family and medical leave and educational/professional leave during each year in their training program, the total amount of which should not be less than six weeks; e. Leave in compliance with the Family and Medical Leave Act; and f. The conditions under which sleeping quarters, meals and laundry or their equivalent are to be provided.

F. Clinical and educational work hours that protect patient safety and facilitate resident well-being and education.

With regard to clinical and educational work hours, residents and fellows should experience: (1) A reasonable work schedule that is in compliance with clinical and educational work hour requirements set forth by the ACGME; and (2) At-home call that is not so frequent or demanding such that rest periods are significantly diminished or that clinical and educational work hour requirements are effectively circumvented. Refer to AMA Policy H-310.907, "Resident/Fellow Clinical and Educational Work Hours," for more information.

G. Due process in cases of allegations of misconduct or poor performance.

With regard to the complaints and appeals process, residents and fellows should have the opportunity to defend themselves against any allegations presented against them by a patient, health professional, or training program in accordance with the due process guidelines established by the AMA.

H. Access to and protection by institutional and accreditation authorities when reporting violations.

With regard to reporting violations to the ACGME, residents and fellows should: (1) Be informed by their program at the beginning of their training and again at each semi-annual review of the resources and processes available within the residency program for addressing resident concerns or complaints, including the program director, Residency Training Committee, and the designated institutional official; (2) Be able to file a formal complaint with the ACGME to address program violations of residency training requirements without fear of recrimination and with the guarantee of due process; and (3) Have the opportunity to address their concerns about the training program through confidential channels, including the ACGME concern process and/or the annual ACGME Resident Survey.

9. Our AMA will work with the ACGME and other relevant stakeholders to advocate for ways to defray additional costs related to residency and fellowship training, including essential amenities and/or high cost specialty-specific equipment required to perform clinical duties.

10. Our AMA believes that healthcare trainee salary, benefits, and overall compensation should, at minimum, reflect length of pre-training education, hours worked, and level of independence and complexity of care allowed by an individual's training program (for example when comparing physicians in training and midlevel providers at equal postgraduate training levels).

11.The Residents and Fellows' Bill of Rights will be prominently published online on the AMA website and disseminated to residency and fellowship programs.

12. Our AMA will distribute and promote the Residents and Fellows' Bill of Rights online and individually to residency and fellowship training programs and encourage changes to institutional processes that embody these principles.

Preliminary Year Program Placement H-310.910

1. Our AMA encourages the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, and other involved organizations to strongly encourage residency programs that now require a preliminary year to match residents for their specialty and then arrange with another department or another medical center for the preliminary year of training unless the applicant chooses to pursue preliminary year training separately.

2. Our AMA encourages appropriate stakeholders to explore options to decrease the burden upon medical students who must apply to separate preliminary PGY-1 and categorical PGY-2 positions.

3. Our AMA will work with the Accreditation Council for Graduate Medical Education to encourage programs with PGY-2 positions in the National Resident Matching Program (NRMP) with insufficient availability of local PGY-1 positions to create local PGY-1 positions that will enable coordinated applications and interviews for medical students.

4. Our AMA encourages the NRMP, the San Francisco Match, the American Urological Association, the Electronic Residency Application Service, and other stakeholders to reduce barriers for medical students, residents, and physicians applying to match into training programs, including barriers to "couples matching," and to ensure that all applicants have access to robust, informative statistics to assist in decision-making.

5. Our AMA encourages the NRMP, San Francisco Match, American Urological Association, Electronic Residency Application Service, and other stakeholders to collect and publish data on a) the impact of separate matches on the personal and professional lives of medical students and b) the impact on medical students who are unable to successfully "couples match" with their significant others due to staggered entry into residency, utilization of unlinked match services, or other causes.

Closing of Residency Programs H-310.943

1. Our AMA: (a) encourages the Accreditation Council for Graduate Medical Education (ACGME) to address the problem of non-educational closing or downsizing of residency training programs; (b) reminds all institutions involved in educating residents of their contractual responsibilities to the resident; (c) encourages the ACGME and the various Residency Review Committees to reexamine requirements for "years of continuous training" to determine the need for implementing waivers to accommodate residents affected by non-educational closure or downsizing; (d) will work with the American Board of Medical Specialties Member Boards to encourage all its member boards to develop a mechanism to accommodate the discontinuities in training that arise from residency closures, regardless of cause, including waiving continuity care requirements and granting residents credit for partial years of training; (e) urges residency programs and teaching hospitals be monitored by the applicable Residency Review Committees to ensure that decreases in resident numbers do not place undue stress on remaining residents by affecting work hours or working conditions, as specified in Residency Review Committee requirements; (f) opposes the closure of residency/fellowship programs or reductions in the number of current positions in programs as a result of changes in GME funding; and (g) will work with the Centers for Medicare and Medicaid Services (CMS), ACGME, and other appropriate organizations to advocate for the development and implementation of effective policies to permit graduate medical education funding to follow the resident physician from a closing to the receiving residency program (including waivers of CMS caps), in the event of temporary or permanent residency program closure.
2. Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) to establish regulations that protect residents and fellows impacted by program or hospital closure, which may include recommendations for:
A. Notice by the training hospital, intending to file for bankruptcy within 30 days, to all residents and fellows primarily associated with the training hospital, as well as those contractually matched at that training institution who may not yet have matriculated, of its intention to close, along with provision of reasonable and appropriate procedures to assist current and matched residents and fellows to find and obtain alternative training positions that minimize undue financial and professional consequences, including but not limited to maintenance of specialty choice, length of training, initial expected time of graduation, location and reallocation of funding, and coverage of tail medical malpractice insurance that would have been offered had the program or hospital not closed;
B. Revision of the current CMS guidelines that may prohibit transfer of funding prior to formal financial closure of a teaching institution;
C. Improved provisions regarding transfer of GME funding for displaced residents and fellows for the duration of their training in the event of program closure at a training institution; and
D. Protections against the discrimination of displaced residents and fellows consistent with H-295.969.
3. Our AMA will work with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, National Resident Matching Program, Educational Commission for Foreign Medical Graduates, Centers for Medicare and Medicaid Services, and other relevant stakeholders to identify a process by which displaced residents and fellows may be directly represented in proceedings surrounding the closure of a training hospital or program.
4. Our AMA will work with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, National Resident Matching Program, Educational Commission for Foreign Medical Graduates, Centers for Medicare and Medicaid Services, and other relevant stakeholders to:
A. Develop a stepwise algorithm for designated institutional officials and program directors to assist residents and fellows with finding and obtaining alternative training positions;
B. Create a centralized, regulated process for displaced residents and fellows to obtain new training positions; and
C. Develop pathways that ensure that closing and accepting institutions provide liability insurance coverage to residents, at no cost to residents.

Protection of Resident and Fellow Training in the Case of Hospital or Training Program Closure D-310.948
Our AMA will:
1. ask the Centers for Medicare & Medicaid Services (CMS) to stipulate in its regulations that residency slots are not assets that belong to the teaching institution;
2. encourage the Association of American Medical Colleges (AAMC), American Association of Colleges of Osteopathic Medicine (AACOM), and National Resident Matching Program (NRMP) to develop a process

similar to the Supplemental Offer and Acceptance Program (SOAP) that could be used in the event of a sudden teaching institution or program closure;
3. encourage the Accreditation Council for Graduate Medical Education (ACGME) to specify in its Institutional Requirements that sponsoring institutions are to provide residents and residency applicants information regarding the financial health of the institution, such as its credit rating, or if it has recently been part of an acquisition or merger;
4. work with AAMC, AACOM, ACGME, and relevant state and specialty societies to coordinate and collaborate on the communication with sponsoring institutions, residency programs, and resident physicians in the event of a sudden institution or program closure to minimize confusion, reduce misinformation, and increase clarity;
5. encourage ACGME to revise its Institutional Requirements, under section IV.E., Professional Liability Insurance, to state that sponsoring institutions must create and maintain a fund that will ensure professional liability coverage for residents in the event of an institution or program closure; and
6. continue to work with ACGME, interested specialty societies, and others to monitor issues, collect data, and share information related to training programs run by nonprofit and for-profit entities and their effect on medical education.

Residency Interview Schedules H-310.998
1. Our AMA encourages residency and fellowship programs to incorporate in their interview dates increased flexibility, whenever possible, to accommodate applicants' schedules. Our AMA encourages the ACGME and other accrediting bodies to require programs to provide, by electronic or other means, representative contracts to applicants prior to the interview. Our AMA encourages residency and fellowship programs to inform applicants in a timely manner confirming receipt of application and ongoing changes in the status of consideration of the application.
2. Our AMA will: (a) oppose changes to residency and fellowship application requirements unless (i) those changes have been evaluated by working groups which have students and residents as representatives, (ii) there are data which demonstrates that the proposed application components contribute to an accurate representation of the candidate, (iii) there are data available to demonstrate that the new application requirements reduce, or at least do not increase, the impact of bias that affects medical students and residents from underrepresented minority backgrounds, and (iv) the costs to medical students and residents are mitigated; and (b) continue to work with specialty societies, the Association of American Medical Colleges, the National Resident Matching Program and other relevant stakeholders to improve the application process in an effort to accomplish these requirements.

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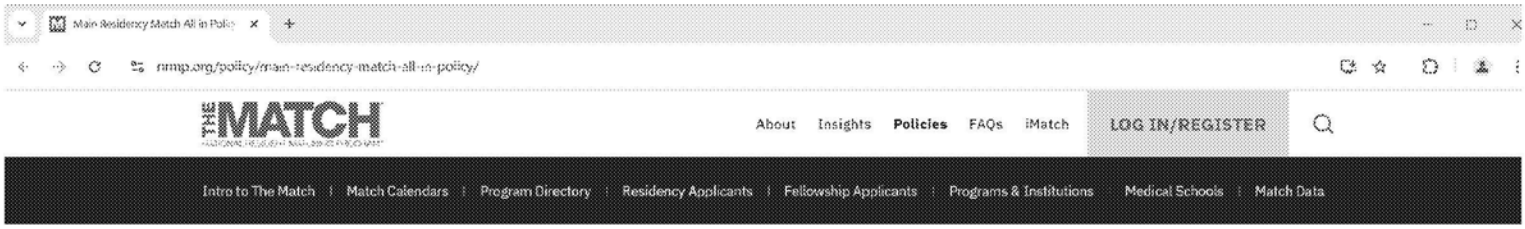
Exhibit 7:
NRMP_00002740
Main Residency Match All In Policy



Main Residency Match All in Policy

November 12th, 2021

If you still have questions, our team is available to assist you. Contact us for additional support.

Support	Policy	Billing
866-653-NRMP	202-400-2235	202-400-2238

Under the NRMP All In Policy, any program registering for the Main Residency Match® must register and attempt to fill all positions through the Match or another national matching plan. The Policy applies to those positions a program wishes to fill, which may be fewer than the number of positions for which the program is accredited. Programs planning to participate in the Match cannot offer positions outside the Match prior to program director registration and program activation. If a position is offered outside the Match prior to program registration and activation, the program is ineligible to enroll in the Match unless the program has been granted an exception to the All In Policy by the NRMP for the position in question.

Positions the All In Policy Applies To

The All In Policy applies to positions for which the NRMP offers matching services:

- All PGY-1 positions as well as all PGY-2 positions in specialties accredited to begin at either the PGY-1 or PGY-2 level, regardless of whether the program begins in the PGY-1 or PGY-2 year
- PGY-2 positions that are "reserved" for applicants eligible to begin advanced training in the year of the Main Residency Match
- PGY-3 positions in Child Neurology

Positions NOT subject to the All In Policy include:

- PGY-2 or higher positions in specialties accredited to begin only at the PGY-1 level
- PGY-3 or higher positions (excepting Child Neurology) in specialties accredited to begin at either the PGY-1 or PGY-2 level

Exceptions to the All In Policy

All requests for exceptions to the All In Policy must be submitted in writing. Exceptions can be approved for:

Military appointees to civilian programs: Positions reserved for applicants placed in civilian training programs as part of the Joint Service Graduate Medical Education Selection Board, or Military Match, can be approved for exceptions to the All In Policy. Such exceptions are based on 1) pre-existing arrangements between the civilian training programs and military branch GME offices and 2) confirmation of those positions needing exception as transmitted from the military GME office directly to the NRMP. Applicants who are provided funding by their military branch but not placed through the Military Match process into a civilian training program do not qualify for exceptions to the All In Policy. Those positions must be filled through the Match, and programs can create special tracks for military-funded applicants in the R3 system.

Other Exceptions: Exceptions are not approved for international medical graduates needing visas.

Exceptions for programs in rural and medically underserved areas are considered on a case-by-case basis. The R3 system is flexible and can accommodate special circumstances in the Match, including

- International medical graduates with funding from their home countries
- Combined clinical-research programs where the first year is not clinical training

Requests for exceptions submitted by Rural Scholars, Family Medicine Accelerated Track, and Innovative Programs must be submitted using the All In Exceptions Form. All other requests may be submitted by email at policy@nrmp.org or by U.S mail.

Once approved for an exception, programs are permitted to submit the All In Attestation form for up to three years provided the program director and DIO annually affirm that the structure and function of the program have not unchanged. Forms must be submitted to the NRMP no later than November 30. Please return completed forms and requested documentation to policy@nrmp.org.

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Exhibit 8:
NRMP_00002743
Violations of NRMP Match Participation Agreements

POLICY

Policy Name:	**Violations of NRMP Match Participation Agreements: Reporting, Investigation, and Disposition**		
Affected Parties:	**Applicants, Programs, Sponsoring Institutions, and Medical Schools**		
Approval Authority:	Chief Executive Officer/ Board of Directors	**Adopted:**	June 2021 Revised: August 2023
Responsible Office:	Match Compliance	**Contact:**	[redacted]@nrmp.org

1. Policy Statement

To protect the integrity of the matching process, the NRMP requires all Match participants to conduct themselves professionally, ethically, responsibly and in accordance with the terms of the Match Participation Agreement (MPA). Applicants, school officials, program directors, institution officials, or any other person may report suspected violations. The policy applies to the Main Residency Match® (the Match), the Supplemental Offer and Acceptance Program® (SOAP), and all Specialty Matches (i.e. Fellowship Matches). The NRMP takes seriously all reports of alleged or suspected violations of the MPA and may initiate an investigation for any reported or suspected violations. If a violation is confirmed, the NRMP may initiate sanctions or other remedial actions.

2. Reason for Policy

a. To provide guidance to Match/SOAP participants, including applicants, school officials, program directors, institution officials, as well as any person who may suspect or report violations of the MPA.

b. To outline the general process for investigating alleged or suspected violations of the MPA.

c. To state the sanctions or other remedial actions that may be imposed upon a finding of violation.

3. Definitions

a. **Breach:** Failure to comply with a duty imposed by the MPA which is owed to another Match/SOAP participant(s) or to the NRMP. A breach may include, but is not limited to: failure to provide complete, timely, and accurate information during the application, interview or Match process; discrepancies in graduation credentials; attempts to subvert eligibility requirements; attempts to subvert the matching process or the SOAP; failure to offer or accept appointments as required by the results of a Match outcome; and any other irregular behavior or activity that occurs in connection with registration, the submission or modification of a rank order or SOAP preference list, or a Match/SOAP participant's commitment to honor any Match/SOAP outcome.

b. **Disposition of Match Violation Investigation:** A letter generated on behalf of the Review Panel upon the conclusion of an alleged or suspected violation(s) investigation that outlines the findings and decisions of the Review Panel. Parties who receive the disposition have a period of time to contest the findings of the Review Panel through the arbitration process.

c. **Final Disposition of Match Violation Investigation:** An outcome letter that is sent after the timeline for parties to contest the Review Panel's findings has expired. Any applicable sanctions begin with the issuance of this letter.

d. **Match Participant:** Any individual, program, institution, or medical school participating in a Match, either for residency or fellowship appointment, in any Match year.

e. **Match Participation Agreement (MPA):** The contractual arrangement between the NRMP and a Match/SOAP participant that affirms their agreement to adhere to Match/SOAP policy and establishes a binding commitment between an applicant and a program.

f. **Preliminary Report of Match Violation Investigation:** A report generated by the NRMP that summarizes the information gathered in response to an alleged or suspected violation(s).

g. **Final Report of Match Violation Investigation:** A report generated by the NRMP upon the conclusion of an alleged or suspected violation(s) investigation that accompanies the Disposition of Match Violation Investigation.

h. **Remedial Action(s):** Process improvement directive(s) to programs, institutions, and medical schools in the absence of a confirmed violation of the MPA if it is determined that conditions may have contributed to an alleged or suspected violation or may contribute to a violation in the future. Remedial actions may also be incorporated into the Review Panel decision, and may accompany sanctions, when a violation is confirmed. Failure to comply with remedial action(s) may result in a new investigation and imposition of sanctions.

i. **Review Panel:** A sub-committee of the Policy Review Committee of the NRMP Board of Directors, composed of individuals appointed by the NRMP Board of Directors, that reviews the investigation of all alleged or suspected violation(s) and determines the disposition of the findings.

j. **Sanction:** The imposition of a penalty based on the outcome of an investigation.

k. **Violation:** A confirmed breach of the applicable MPA by a Match/SOAP participant.

l. **Waiver:** The release of Match/SOAP participants from the binding commitment following a Match or acceptance of an offer through the SOAP.

4. The Policy

a. An alleged or suspected Match/SOAP violation(s) by an applicant, program, institution or medical school (herein referred to as 'parties'), must be reported through the NRMP website.

   i. Individuals submitting a report may request their identity remain anonymous. The NRMP will make every effort to keep anonymous the identity of individuals when requested; however, the NRMP does not guarantee an individual's identity will not be discovered through the normal course of communication with the parties about the alleged or suspected violation.

   ii. An alleged or suspected violation may be reported anonymously. In such case, the NRMP will not attempt to provide acknowledgement of receipt of the report or any other follow-up to the reporter.

b. The NRMP will review reports of an alleged or suspected violation to determine if an investigation is warranted.

   i. If the NRMP determines there is no basis for an investigation, the reporting individual will be notified of the determination, if practicable.

   ii. If the NRMP determines a potential violation of the MPA may have occurred, the NRMP may investigate alleged or suspected breaches of the MPA.

c. The NRMP has sole discretion to determine if a violation(s) of the MPA occurred.

d. The NRMP has sole discretion to determine the sanctions or other remedial action(s) applied to Match/SOAP participants if an investigation confirms a violation(s) of the MPA. Failure of parties to comply with sanctions may result in a new investigation and imposition of new sanctions.

e. The NRMP may request or require remedial action(s) by programs, institutions, and medical schools in the absence of a confirmed violation of the MPA if it is determined that conditions may have contributed to an alleged or suspected violation or may contribute to a violation in the future. Failure of parties to comply with a remedial action(s) may result in a new investigation and imposition of sanctions.

f. It is the NRMP's sole discretion whether individuals reporting alleged or suspected Match/SOAP violations, who are not a party to the issue, will receive follow up communication specific to the disposition of the outcome. Individuals who are not a party to the review or investigation will not receive copies of the Preliminary Report of Match Violation Investigation or the Disposition of Match Violation Investigation and may not contest the outcome of the decisions made by the NRMP or the Review Panel. Disposition shall be described as:

    i. Alleged or suspected violation under initial review.

    ii. Alleged or suspected violation not substantiated by review of the applicable Match/SOAP policy; therefore, the case has been closed.

    iii. Potential violation of Match/SOAP policy under review or investigation.

    iv. Final Disposition of Match Violation Investigation: Upon review of all relevant documents and statements pertaining to the alleged or suspected violation of Match/SOAP policy, a violation was/was not confirmed, and the case has been closed.

g. At any time before the Match results are released, the NRMP may withdraw from a Match any applicant or program for which the NRMP has clear and convincing evidence that such applicant or program is ineligible for the Match or has engaged in a breach of the MPA and that absent immediate withdrawal from the Match, the integrity of the Match is threatened.

    i. If an applicant or program is withdrawn from a Match pursuant to this section, the NRMP shall note in the R3 system that the applicant or program is the subject of a "pending action." The designation shall remain in place until the applicant or program has waived or exhausted the opportunity to contest the adverse action as outlined in Section 8 of this policy.

    ii. The NRMP's authority to withdraw an applicant or program from a Match is in addition to its authority to impose sanctions for violations of the applicable MPA.

h. All communication to and from the NRMP throughout the course of a violations report and investigation must be submitted and/or transmitted electronically, in writing.

i. Absent an applicable legal requirement to the contrary, the NRMP treats as confidential all communications and other information submitted, collected, or generated in connection with the investigation, including all information constituting or concerning any deliberations with respect thereto, except for such information that the NRMP routinely provides to the parties under these Policies and Procedures or in the normal course of the matching process.

5. Investigation Procedures

a. The NRMP will review reports of an alleged or suspected violation of the MPA to determine if a violation may have occurred and will determine the parties involved.

b. If an alleged or suspected violation is determined to have potentially occurred, the NRMP will:

   i. Notify the parties of the alleged or suspected violation, using their last known email address, and provide a summary of the issue under investigation.

   ii. Request that each party provide a written statement and any supporting documentation outlining their knowledge of the alleged or suspected violation.

      a. Each party must respond to the request for statement(s) and supporting documentation within the timeline outlined in the NRMP's communication.

      b. Failure to respond to a request for a written statement or supporting documentation will not delay or halt the investigation of the alleged, suspected, or confirmed violation.

      c. Failure to respond to a request for a written statement or supporting documentation may result in the NRMP determining that the party has engaged in a violation of the MPA.

   iii. Evaluate and/or further investigate the information received during the investigation and determine if a violation occurred.

c. If, upon review of the statements and materials received, the NRMP determines:

   i. An alleged or suspected violation did not occur, the case will be closed. All parties will be notified of the disposition of the case.

   ii. An alleged or suspected violation by a program, institution, or medical school may have occurred, but has been addressed in a manner that prevents recurrence, the NRMP may elect not to investigate further. However, the NRMP may levy remedial action(s) to address the conditions determined to cause or contribute to the alleged or suspected violation(s). All parties will be notified of the disposition of the case.

   iii. An investigation is warranted due to an alleged, suspected, or known violation, a Preliminary Report of Match Violation Investigation documenting the nature of the allegation(s), summarizing the statements made by each party, and summarizing the applicable Match/SOAP policy will be distributed to the involved parties.

      a. Each party will have ten (10) business days to review and respond to the Preliminary Report of Match Violation Investigation and to provide any additional relevant information.

      b. Once ten (10) business days have concluded, a revised report incorporating the response(s) to the Preliminary Report of Match Violation Investigation will be prepared for consideration by the Review Panel.

d. Following review of the revised Preliminary Report of Match Violation Investigation, the Review Panel will determine whether, based on the information received, a violation has occurred and, if so, will determine if sanctions and/or remedial action(s) should be imposed.

i. If the Review Panel determines that no violation occurred, the NRMP will document the decision in a Final Disposition of Match Violation Investigation and all parties will be notified.

ii. If the Review Panel determines that a violation(s) has occurred, the NRMP will document the confirmed violation(s) and summarize any sanctions or remedial action(s) levied by the Review Panel (as outlined in Sections 6 and 7 below) in the Disposition of Match Violation Investigation. The NRMP will notify only the subject of the Disposition of Match Violation Investigation.

iii. The subject may contest the findings of the Disposition of Match Violation Investigation through arbitration as outlined in Section 8 of this policy.

a. If the subject contest the Review Panel decision, the NRMP shall note in the R3 system that the investigation has a "pending action." The designation shall remain in place until the party has waived or exhausted the opportunity to contest the adverse action as outlined in Section 8 of this policy.

b. If the timeline to contest expires without action by either party, the Disposition of Match Violation Investigation shall be reclassified as the Final Disposition of Match Violation Investigation and all parties will be notified.

e. An investigation shall be deemed complete when:

i. The Disposition of Match Violation Investigation has been issued and the time frame for contesting the report has expired;

ii. The Final Disposition of Match Violation Investigation has been issued; or

iii. In the event arbitration has been pursued, the Arbitrator has issued its award, and the Final Disposition of Match Violation Investigation has been issued consistent with the award.

6. Sanctions

a. Applicants

i. Investigations confirming a violation(s) of the MPA by an individual applicant during the Main Residency Match or any fellowship Match may result in:

a. Copies of the Final Disposition of Match Violation Investigation being issued to:

1. The applicant's medical school official, with a request that the report be placed in the applicant's permanent file;

2. The Educational Commission for Foreign Medical Graduates (ECFMG) if the applicant is a student/graduate of a foreign medical school;

3. The NRMP institutional official and the director of the program to which the applicant matched or in which the applicant accepted a position during SOAP;

4. The NRMP institutional official or director of the program to which an applicant has applied or switched, if applicable and if known to the NRMP;

5. The applicant's residency program if the violation occurred in a fellowship Match;

6. The American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA) or other certifying body;

7. The Federation of State Medical Board (FSMB) if the applicant will be permanently identified as a Match violator or has been permanently barred from future NRMP matches;

8. State medical licensure boards; and

9. Any other party the NRMP deems relevant to its investigation and the outcome of the Review Panel, including the NRMP Board of Directors.

b. Designation as a Match violator in the R3 system for one-to-three years, or permanently with term limits included to identify the length of time the action is in effect;

c. Being barred from subsequent NRMP Matches for one-to-three years, or permanently with term limits included to identify the length of time the action is in effect;

d. Being barred for one year from accepting an offer of a position or a new training year, regardless of the start date (or renewing a training contract for a position at a different level or for a subsequent year), in any residency or fellowship training program sponsored by a Match-participating institution and/or starting a position or a new training year in any program sponsored by a Match-participating institution if training would commence within one year from the date of issuance of the Final Disposition of Match Violation Investigation.

1. All programs at a sponsoring institution, regardless of the program's Match participation status, and the sponsoring institution, are prohibited from offering a position to an applicant who has been barred from accepting or starting a position (or a new training year), because of a confirmed violation of the applicable Match Participation Agreement. If a program or sponsoring institution offers a position to such applicant despite the bar, or if an applicant accepts such a position, despite the bar, the NRMP will initiate an investigation to determine whether the applicant, program and/or sponsoring institution have violated their respective MPA.

2. An institution that participates in any NRMP Match is prohibited from discussing, interviewing, or offering a position in any of the programs sponsored by the institution, regardless of the program's Match participation status, to any applicant who is ineligible to accept a position who has matched to a concurrent year position through the Matching Program or who is ineligible because of a denied waiver or a confirmed violation by the applicant. Such prohibition applies to all positions which have a start date within one year after the date of the NRMP's waiver decision or Final Disposition of Match Violation Investigation confirming a violation by the applicant.

e. Investigations confirming a violation(s) of the MPA by an individual applicant during SOAP may result in being barred from participation in SOAP for one (1) year. Repeat violators may be barred from the Match.

b. Programs

i. Investigations confirming a violation(s) of the MPA by a program during the Main Residency Match or any fellowship Match may result in:

a. Copies of the Final Disposition of Match Violation Investigation being issued to:

1. The NRMP institutional official for transmittal to the institution's graduate medical education committee;

2. The Chair of the institution's graduate medical education committee;

3. The Accreditation Council for Graduate Medical Education (ACGME) for distribution to the respective Review Committee (RC) or the relevant accrediting body for the specialty;

4. The respective specialty program director association;

5. Any federal or state regulatory agency that may have enforcement over the matter; and

6. Any other party the NRMP deems relevant to its investigation and the outcome of the Review Panel, including the NRMP Board of Directors.

2. Designation as a Match violator in the R3 system for one-to-three years, or permanently with term limits included to identify the length of time the action is in effect;

3. Being barred from subsequent NRMP Matches for one-to-three years, or permanently with term limits included to identify the length of time the action is in effect.

c. Sponsoring Institutions

i. Investigations confirming a violation(s) of the MPA by a sponsoring institution during the Main Residency Match or any fellowship Match may result in:

a. Copies of the Final Disposition of Match Violation Investigation being issued to:

1. The ACGME institutional official for transmittal to the institution's graduate medical education committee;

2. The Chair of the institution's graduate medical education committee;

3. The chief executive officer or applicable role of the sponsoring hospital or university;

4. The Accreditation Council for Graduate Medical Education (ACGME) for distribution to the Institutional Review Committee (RC) or the relevant accrediting body for the specialty;

5. Any federal or state regulatory agency that may have enforcement over the matter; and

6. Any other party the NRMP deems relevant to its investigation and the outcome of the Review Panel, including the NRMP Board of Directors.

2. Designation as a Match violator in the R3 system for one-to-three years, or permanently with term limits included to identify the length of time the action is in effect.

d. Medical Schools

i. Investigations confirming a violation(s) of the MPA by a medical school during the Main Residency Match or any fellowship Match may result in:

a. Copies of the Final Disposition of Match Violation Investigation being issued to:

1. The Dean of the medical school;

2. The Dean of Student Affairs of the medical school;

3. The NRMP School Official;

4. The President of the university of which the medical school is a part;

5. The Liaison Committee on Medical Education (LCME) or the American Osteopathic Association Commission on Osteopathic College Accreditation (COCA), or other private accrediting entities whose jurisdiction would extend to the adverse action, as appropriate;

6. Any state regulatory agency with enforcement jurisdiction relevant to the adverse action such as the state board of education or state and/or regional accrediting body or licensing agency;

7. Any other party the NRMP deems relevant to its investigation and the outcome of the Review Panel, including the NRMP Board of Directors.

e. The NRMP has sole discretion to determine which of the sanctions described above shall be applied in the event a party violates the applicable MPA. Failure to comply with sanctions may result in a new investigation and imposition of new sanctions.

7. Remedial Actions

Remedial actions identify and establish accountability and encourage process improvement measures for programs, institutions, and medical schools who have, or may have, committed a violation of the MPA. Remedial actions may be combined with sanctions for confirmed violations. Application of these measures are solely at the discretion of the NRMP.

a. Remedial Actions for programs and institutions may include:

i. Notification of the alleged, suspected, or confirmed violation(s) to the institution's Graduate Medical Education Committee (GMEC) and documentation by the GMEC addressing the remedial action items.

ii. Notification to affected or potentially affected parties (e.g., program faculty and staff, current residents or fellows) of the alleged, suspected, or confirmed violation and/or outcome.

1. If the issue is such that incoming residents will be adversely affected, the program may be required to document notice to each individual.

iii. Evidence of an action plan addressing the violation(s), including a plan for monitoring and sustained improvement, approved by the institution's GMEC.

iv. Documentation of institution and program policy(s) and/or processes pertaining to Match policies. Examples may include:

1. Communication (e.g., prevention of coercive questioning)

2. Right to privacy (e.g., notification of an applicant/program's right not to be recorded without their written consent)

3. Provision of accurate information (e.g., failure to disclose program and/or institutional eligibility requirements)

4. Onboarding and binding commitment (e.g., released resident before the 45th day of training)

5. Program/faculty development as appropriate, which may include education pertaining to:

a. Match policy

b. Policies, processes, and education pertaining to diversity, equity, and inclusion

c. State and Federal Law pertaining to recruitment and employment

d. Recruitment and interview processes and communication

b. Remedial Actions for medical schools may include:

i. Notification of the alleged, suspected, or confirmed violation(s) to the Office of the Dean with documentation addressing the remedial action items requested.

ii. Notification to affected or potentially affected parties (e.g., medical school faculty and staff) of the alleged, suspected, or confirmed violation and/or outcome.

iii. Evidence of an action plan addressing the violation(s), including a plan for monitoring and sustained improvement, approved by the Office of the Dean.

iv. Documentation of medical school's policy(s) and/or processes pertaining to Match policies.

c. Remedial actions may:

i. Have an established timeline for response and remediation; and

ii. May require progress reports for those issues requiring extended remediation timelines.

8. Contesting a Panel Review Report

Nothing in these Policies and Procedures shall prevent any party to a MPA from seeking arbitration to contest a Disposition of Match Violation Investigation under the terms of such Agreement. If a party seeks arbitration, the penalties imposed on and the distribution of the Disposition of Match Violation Investigation will be suspended until the arbitration has concluded.

a. Any party seeking to contest a Review Panel decision must:

   i. Notify the NRMP in writing of the intent to seek arbitration within ten (10) business days from that party's receipt of the Disposition of Match Violation Investigation; and,

   ii. must file a written demand for arbitration with the American Arbitration Association (AAA) within thirty (30) calendar days of receipt of the Review Panel Report.

b. If notice of a party's intent to seek arbitration is not received by the NRMP within (ten) 10 business days from that party's receipt of the Disposition of Match Violation Investigation , or if the party does not file a demand for arbitration, including all paperwork and payment of fees (including the Initial Filing Fee and Case Service Fee) using the Standard Fee Schedule provided by the AAA, within thirty (30) calendar days of receipt of the Disposition of Match Violation Investigation , that party is deemed to have waived their right to contest the Disposition of Match Violation Investigation and is barred from later filing a demand for arbitration or seeking other relief.

c. An application for arbitration must be submitted under the Commercial Rules of the AAA. Filing with the AAA is considered complete only when the demand for arbitration has been submitted to the AAA on the appropriate AAA form together with associated fees and has been time/date stamped by the AAA. The arbitration hearing shall commence within six (6) months of filing the demand for arbitration or at another time agreeable to the NRMP.

d. All notices, reports, and other communications under these Policies and Procedures shall be transmitted electronically by email, through the NRMP website, or by mail and shall be deemed received (a) when delivered personally; (b) when received if deposited in the U.S. Mail, postage prepaid, sent registered or certified mail, return receipt requested; (c) 24 hours after being delivered to a nationally recognized and receipted overnight courier service; (d) 24 hours after being sent by e-mail or through the NRMP website, unless the sending party is notified that the e-mail address is invalid or that the message was not delivered; or (e) when sent by facsimile, provided the sending party has received confirmation that the facsimile was transmitted successfully, to the NRMP at the address shown in Section A or to any other party at the address on file at the NRMP or designated by written notice to the NRMP.

9. Resources

a. Office of Match Compliance [redacted]@nrmp.org or [redacted]
b. Office of Match Operations [redacted]t@nrmp.org or [redacted]
c. Waiver Policy (Policies | NRMP)
d. All In Policy (Policies | NRMP)
e. NRMP Privacy Statement (Privacy Statement | NRMP)
f. Match Agreement and Resources (Policies | NRMP)

Exhibit 9:
AOA Production – Part 3 – Final
pages 109-114
SOAP Candidate Email

[redacted]

From: [redacted]
Sent: Tuesday, March 23, 2021 4:37 PM
To: [redacted]
Cc: DO-Discrimination
Subject: Changes to the SOAP Process

Categories: Blue Category

[***This email was sent from someone outside of the AOA. Always use caution when opening attachments or clicking links.***]

Attention [redacted],

I appreciate your apology to those of us who endured the SOAP last week. As you mentioned, this time in a student doctor's life is supposed to be one of the most exciting, important, and joyous times that person will experience in their entire career as a physician. However, it comes with uncertainty, stress, and often the great unknown of how, when, and where you will have to uproot your entire family to complete your residency training. While I know this is something that is known to students from the beginning of their training, the closer you get to Match Week, the more challenging it becomes to control that stress and anxiety. Fortunately for most students Match Week is full of excitement and memories of the week will be treasured for a lifetime. However, for students like myself, Match Week has become a week we hope to forget, filled with disappointment, regret, let downs, and a myriad of other depressing adjectives to describe how the most important day of your life gets ripped out from underneath you.

Before I explain the changes I think could be made to the entire Match and SOAP process, I would like to demonstrate to you how my situation went, so hopefully you can walk in my shoes for a brief second in time and empathize that changes need to be made. Prior to matriculating at [redacted], I had always envisioned on becoming an OB/GYN. Since the time I was 5 years old, I always knew I wanted to deliver babies and care for women. However, my road to medical school was not the easiest, and certainly not the most straight forward. I will not bore you will the sequence of events that have been my life for the last [redacted] years, but I will tell you they were not an easy [redacted] years and there were countless times along the way when I questioned whether or not I should continue to pursue a career in medicine and even questioned why someone seemed to be making my life so difficult.

To tell you a little about myself, I am the [redacted], [redacted], and I grew up competing in the sport of [redacted] since the age of [redacted] I was recruited by various Division I colleges across the United States, and ended up taking my talents as a Division I student-athlete to the [redacted] While at [redacted] I completed by B.S. in Biology, with a minor in Chemistry [redacted]. I was on the [redacted] where I competed in [redacted] I was the Assistant Coach [redacted] and remained a volunteer coach and [redacted] after my coaching contract ended. While coaching at the [redacted], I also completed my M.S. in Education [redacted]. I have worked a number of different jobs in the last 15 or so years, some of which include [redacted]. I have worked in fields of [redacted], all with the goal of one day becoming a physician. I began volunteering at [redacted] years old with my [redacted] that provides food, clothing, and toiletries to the underserved communities in [redacted]. I continued volunteering with our [redacted], as well as other agencies and community support networks even throughout my medical education. I applied to medical school three times, the third application cycle was the first time I ever got an interview. Fortunately, my accolades

that I had worked so hard to achieve were able to land me two interviews that third application cycle. Oddly enough, I was initially waitlisted at both programs, but was offered a position in the [redacted] class at [redacted] a mere 15 days before the first day of school.

Now if there is anything that I have learned in my [redacted] years of life, it is we are all supposed to be where we end up, and whatever is the most difficult way to go through something, I usually end up having to take that path. I joked with my classmates that the Pandemic happened because the higher powers knew I needed to get into residency this year. My Deans even pulled me aside one day and apologized on behalf of society, as it seemed like I had accepted everyone's bad luck over the last four years. I laughed it off and told him that I was used to it by now, and that I always plan for the worst, but am pleasantly surprised when things work out.

When it came time for applying for residency, I applied to 154 programs -- 140 OB/GYN and 14 Family Medicine (FM). I followed the direction of the school to apply to over 70+ OB/GYN programs and to apply to FM as a back-up. Just like applying to medical school, it was a struggle all over again. I applied to 154 programs, and only got 8 interviews -- 1 OB/GYN and 7 FM. I was rejected by 78 total programs, and I didn't hear anything back from 69 of the programs -- no waitlist, no rejection letter, nothing.

When it came time to do the rank list, I knew all the data showed that the longer your rank list is, the higher your probability is to match with the algorithm. I was confident I had made a good impression with the OB/GYN program I interviewed at, a preceptor had called on my behalf, and the program put off the notion they were very interested in having me and had told me they moved me up their rank list. I knew if I put any of the Family Medicine positions down, I would most likely matched to FM, and inevitably there would be open spots in OB/GYN in the SOAP, due to the inequity in interviews this application season because of the virtual nature of the interviews. So, I gambled. I ranked three programs on my rank list, after talking over all the options with my spouse, my colleagues, and some preceptors. I ranked the program I interviewed at, one that gave me an in-person end of rotation interview, and one that was near where we lived that I hadn't heard from. And guess what? I didn't match.

Like I previously said, whatever is the most challenging way to do something, I usually end up going that route, so it was really no surprise to me that I ended up needing to SOAP during Match Week. It truly was no surprise to me when the system crashed and we didn't receive any notification from ERAS or NRMP in a timely fashion. It really didn't surprise me that times were moved to the following day and that we now had a shorter window for programs to look at applications, which meant I was most likely going to be "weeded out" again. And it was truly no surprise when I applied to 40 more programs and only heard back from 2, neither of which were OB/GYN.

I guess from the apology that you sent out you can empathize the emotional toll last week took on most of us that ended up needing to SOAP, but I feel as if it is not something you can truly understand until you, yourself have been rejected by close to 190 programs and hundreds of residents and attendings. Feelings of hopelessness and inadequacy rang through most of us last week that were "stuck" in the SOAP. We submitted our applications, communicated back and forth with our home institution, and then were advised to do nothing else, but wait. Wait for programs to reach out to you. Wait for an interview offer. Wait to see if anyone was going to take the gamble on you as an applicant.

After much reflection in the last week or so, I have asked myself countless times: Why Me? Am I that bad of an applicant that no one wants me? Why can't programs see all my great evaluations and diverse background? Did they not have enough room for what seems on paper to be a privileged white female? What did I do to deserve 190 programs not even wanting to take a chance on me? And my favorite questions of all: Could this have been prevented? Would this have been a different situation had ACGME and AOA not merged?

Obviously, I can't go back in time and change board scores, or my rank list, but what I can do is let you know how students felt going through The SOAP process and how osteopathic students, like myself, felt they were disproportionally affected during this application cycle.

- As with most years, more DO applicants are advised to have a "back-up" plan when it came time to applying for residency and making their rank list, even if the back-up specialty was not something the student wanted to pursue. This usually is one of the contributing factors of why DO applicants often are represented in higher proportions in Primary Care fields.
- Additionally, in regard to the application and interview process, many DO students have been faced with confrontation from program directors regarding the COMLEX examination schedule with comments such as the following: "I don't know how to interpret those results" or "Why do you have your own exam anyway, when the residency programs are merged?"
    - My response to you and to AGCME and AOA administration is that NBOME exams have been in existence since 1936, if Program Directors do not know how to interpret percentile performance or do not understand the difference between the two degree paths, maybe they are not suited for the role they are currently in.
- Additionally, with DO applicants only comprising about ~18% of those who matched in 2020 and 2021, based on the NRMP data, many DO applicants feel the value of their Match and SOAP experience may be neglected because the vast majority of those participating in the match are MD candidates.
- Many allopathic medical schools, who are affiliated with large hospital systems or are funded by large hospital systems, often have opportunities to remain at their home institution in a preliminary position for PGY-1 year in the event the MD candidate does not match.
    - For example, if a MD candidate applying orthopedic surgery at the University for Kentucky does not match, their home institution may have a number of preliminary surgery positions available to those MD students at the University of Kentucky who do not match initially.
    - Due to the fact most osteopathic medical schools do not have an affiliated hospital system, for which their school is funded, there often are limited affiliations or agreements for students to partake in preliminary positions in the event an applicant does not match.

I am a proud fourth year medical student at the [redacted] Campus. I will graduate as part of the [redacted] class that will have graduated from the [redacted] Campus. I am someone who did not match. I am someone who SOAPed, and the only thing I can seem to get out of this entire process is 1) There must be some reason I need to be in [redacted], and 2) I need to be the person who advocates for change of The Match and The SOAP processes. I have included a list of changes that I have discussed with colleagues, preceptors, and other individuals who participated in the SOAP. I hope you take these recommendations into consideration when evaluating what The Match and The SOAP process looks like for the future. However, I think the only way you are truly going to change The SOAP is if you change the entire Match process first.

Recommendations/Suggestions to Change The Match and The SOAP:

1. **While The SOAP process desperately needs attention, The Match process needs to be changed first.**
    a. This year there were a number of inequities when it came to interviewing for residency. With some applicants getting far more interviews than others, some programs not contacting students, program directors telling students they believe many programs will go unmatched, etc. there are a number of problems with The Match that I will address below.
2. **The residency application process continues to perpetuate financial injustices within our community.**
    a. While a number of medical students may have parents who are financially stable and able to contribute to their child's medical education, a significant number of medical students are faced to deal with the growing financial strain that is the medical education process. Hundreds of thousands of dollars are put into completing medical education and for individuals, such as myself, we are left to make decisions of whether to apply to more places to maximize our odds of matching or pay your electric bill, gas bill, mortgage, etc.

b. Additionally, while we agree to pay for the application fee, there is an agreement that the AAMC will do everything in their power to make sure we match in the NRMP Match. However, for students that do not match, that money really has been wasted in a sense because they did not benefit from the investment.

3. **All notification of interview offers, interview rejections, and waitlist status should be centralized on one platform.**
    a. For example, each program or position you applied to on ERAS should have a list below it with information of all communication between that student and the program. That might look something like this:

Application Received	10/21/2020
Current Status (as of 11/08/2020)	Interview
Interview Offered	11/07/2020
Interview Accepted by Student	11/08/2020
Interview Date	**12/13/2020**

    b. For someone that is waitlisted it might look like this:

Application Received	10/21/2020
Current Status (as of 12/01/2020)	Waitlisted
Notification of Waitlist	12/01/2020

4. **All interview scheduling should take place in one platform.**
    a. This would eliminate emails back and forth to programs trying to schedule a date, or constantly checking 2+ different platforms for interview calendar information.
    b. Thalamus has a much better platform for scheduling interviews. I would highly recommend partnering with Thalamus to include their platform or style of platform within the ERAS system.
5. **Students should be limited by a TOTAL number of interviews they can accept, regardless of how many specialties they have applied to this application cycle.**
    a. For example, if the cap is 25 interviews per student per application cycle, if they applied to OBGYN and FM programs, they can only accept 25 total interviews. Not 25 max in OBGYN and 25 max in FM.
    b. This eliminates financial inequities that have become a significant problem across all aspects of medical education.
6. **If interviews are capped at a particular number, have a running total or additional tab found within ERAS with each interview scheduled for that applicant listed, the date of the interview, and the number of remaining interviews they are allowed to accept.**
    a. For example, it could look something like this:

Interview #	Program Name	Specialty	Interview Date
1	Cleveland Clinic/Case Western	OB/GYN	11/21/2020
2	Case Western/University Hospitals	OB/GYN	12/01/2020
3	Western Reserve Hospitals	Family Medicine	11/17/2020
4	OhioHealth - Doctors Hospital	Family Medicine	12/03/2020

    b.
    c.

Total Interviews Scheduled	4
Total Interviews Remaining	21

d.

7. **Develop a more inclusive way for students who end up going through the SOAP to feel they achieve the same accomplishments as their peers.**
    a. Right now students who SOAP, often feel left out from the excitement from the rest of their colleagues. In some instances, they are left out of Match Day celebrations. There needs to be more celebration for those that end up accepting a position in the SOAP.
8. **Allow students to reach out to programs throughout the SOAP process.**
    a. Right now, students, institutions, preceptors, etc. cannot do anything to promote the student in the SOAP, until the student has been contacted by the program.
    b. There needs to be an option to either 1) be able to reach out to the program directly, or 2) be able to reach out to an applicants top 3 programs in the SOAP.
9. **Introduce an Early Acceptance Program for residency programs.**
    a. Similar to applying to medical school, allow students to submit applications to their top 3 programs at the beginning of the application cycle.
    b. This might look like the following:
        i. Students complete their application and upload all required documents by Oct. 15.
        ii. However, students only submit their application to their TOP 3 programs.
        iii. This process could be a 2-3 week process of programs reviewing the students that ranked them in their TOP 3, and then offering interviews.
        iv. After the 2-3 week time period, the normal process resumes.
10. **Remove USMLE and LEVEL scores from the application.**
    a. Include the date they were completed, and whether or not they passed or failed.
    b. No matter which state you apply for license, you will have to complete the appropriate board requirements. Including score is irrelevant to the student, as all students will have to pass all board exams to become board eligible.
    c. Providing board scores only provides another area for programs to easily "weed out" potential applicants, when in actuality the evaluations and performance in the classroom is much more reflective of the entire nature of the student.
11. **Require programs to notify all students who applied to their program of their current status with the program by a particular date.**
    a. Many students, including myself, had programs they applied to during the application cycle, but never actually heard back from any of them.
    b. Programs should have to provide students of their current status whether that is: *under review, interview offered, interview rejected, or waitlisted.*
    c. For example, this year OB/GYN programs were supposed to notify all students of their current status with the program by December 23.

I appreciate you taking the time to read my email and I truly am sorry for its length, but I feel to truly empathize with those that underwent the SOAP, you need the full picture. Additionally, I appreciate you allowing students to contribute their recommendations and suggestions when evaluating the current process of The Match and The SOAP and I hope you truly value student opinions, as the process is much different than it was for you when you participated in the The Match. Now, I will not do the extra leg work today to even see if you gentlemen matched when you went through the residency process or if you SOAPed, but I want you to look back when you found out where you would be doing your residency training. Were you excited? Did you jump for joy? Did you hug your parents, spouse, brothers or sister, or classmates? Now take a step into my situation -- I was robbed of those joyous moments, joy that I will never get to experience like the rest of my classmates. I was rejected by 190 programs. I got left off our school's Match Day Celebration presentation because I didn't match. My mom didn't get to see me jump

for joy or smile with all the excitement in the world. Instead, she got to see how truly broken I was after the last four years and how disappointed I was in myself, my school, and the organizations that were supposed to be allowing all medical students to participate in GME.

I want to thank you again for taking the time to read my long-winded email and please do not hesitate to contact me via phone or email if you have any follow-up questions or concerns. I have and always will be a strong advocate for my patients, my classmates, and myself, I just hope you both truly do the same.

I look forward to hearing from you. Have a great rest of your day!

[redacted]

Core Rotation Site: [redacted]

Exhibit 10:
DUHS-HJC000001
AAMC Survey of Resident/Fellow Stipends and Benefits Report – 2024

AAMC
Tomorrow's Doctors, Tomorrow's Cures®

Survey of Resident/Fellow Stipends and Benefits Report

2024

November 2024

Information from the 2024 survey is as of July 1, 2024.

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Information from the 2024 survey is as of July 1, 2024.

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Background

Since 1968, the Association of American Medical Colleges (AAMC) has published the AAMC Survey of Resident/Fellow Stipends and Benefits. The purpose of the survey is to provide benchmarking data to help the academic medicine community in evaluating resident and fellow stipends and benefits.

In even years, the survey fields a long-version which includes questions on stipends and benefits (such as in 2024). In odd years, the survey fields a short-version which does not include benefit questions (such as in 2023).

Respondents and affiliated institutions are eligible for special reports based on the resident/fellow data. If you would like to request a special analysis, please visit the AAMC website at https://www.aamc.org/data-reports and click on 'Request Data to submit your request. If you have questions or feedback about this report, please email residentstipends@aamc.org.

What's New?

The 2024 AAMC Survey of Resident/Fellow Stipends and Benefits updated the institution type categories in the survey in accordance with the updated sponsoring institution and participating site types published by the ACGME effective July 1, 2023 (https://acgmehelp.acgme.org/hc/en-us/sections/360007504314-Reference-Materials, “Data Dictionary for Sponsoring Institution and Participating Site Types”). Based on these updated institution types, the 2024 report includes updated categories when breaking out data by institution type: General Hospital & Specialty Hospital, Health System & Consortium, Medical School, and Other. For more information on what is included in these report categories, please reference the Methodology section below.

The following updates were made to report tables based on updates in the 2024 survey:

- Tables 11 When was the Last Time Stipends were Adjusted and 11b Entities or Individuals with Ultimate Approval Authority over Stipend Adjustments were updated to include additional response option(s) added to the 2024 survey.

- Tables 12 Whether Residents/Fellows are Unionized, 12a Number of Years Residents/Fellows have been Unionized, and 12b Type of Resident/Fellow Union have been added to the report based on new questions in the 2024 survey. Sponsoring institutions were eligible to answer the questions for Tables 12a and 12b if they responded “Yes” to whethe residents/fellows were unionized. Table numbers in the report have been updated due to the addition of these tables.

- Tables 19 Life Insurance and Disability Insurance Premiums All Respondents, 20 Portion of Respondents by Level of Coverage for Selected Resident/Fellow Benefits by Institution Type, and 21 Whether Institutions Provide Funds or Tools to Residents/Fellows All Respondents were updated to remove the paid by department response option. In the 2024 survey for these questions, institution was defined as the sponsoring institution, GME office, or clinical/residency program department.

- Table 23 Fully Paid Leave for Medical, Parental, or Caregiver Leave All Respondents was updated to a single response category for medical, parental, or caregiver leave.

- Table 25 Annual Vacation and Other Paid Leave for Residents was updated to include a General PTO response option.

Lastly, some table numbers and table order have been updated in order to reduce the number of worksheets in the file and sort by similar topic.

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Methodology

The 2024 AAMC Survey of Resident/Fellow Stipends and Benefits launched on July 15, 2024. The survey was administered to 827 Accreditation Council for Graduate Medical Education (ACGME) accredited sponsoring institutions. Invitations were sent to DIOs at sponsoring institutions with associated programs for which the DIO's contact information was known. The survey included a question for the sponsoring institution to provide the type of institution, as classified by the ACGME categories. This self-reported institution type was used to aggregate the survey data by institution type.

For the purposes of the 2024 AAMC Survey of Resident/Fellow Stipends and Benefits Report, the AAMC rolled up the 23 ACGME institution types into four groups: general hospital & specialty hospital, health system & consortium, medical school, and other institutions. According to the ACGME's Glossary of Terms at https://www.acgme.org/portals/0/pdfs/ab_acgmeglossary.pdf, a sponsoring institution is "The organization (or entity) that assumes the ultimate financial and academic responsibility for a graduate medical education program consistent with the ACGME Institutional Requirements."

The instrument collected data as of July 1, 2024. Unless stated otherwise, all respondents were eligible to answer each question. Institutions were required to provide the ACGME institution type classification, the profit status of the sponsoring institution, and an institution category question. For all other questions, the institution was not required to answer the question. Refer to the institution count in each table to determine how many institutions responded to a particular question. Compensation statistics for stipends are provided only when at least five institutions are represented. For weighted average stipends, compensation statistics are provided when at least five institutions are represented and at least five residents/fellows are reported.

In total, 827 institutions were invited to the survey (208 AAMC-member and 619 non-member institutions). A total of 369 institutions responded to the survey (a 44.6% response rate for all institutions). Following data verifications and the remova of for-profit institution responses, there was usable information for 341 non-profit sponsoring institutions in the report. The 341 non-profit sponsoring institutions included in the report include a total of 140 AAMC-member and 201 non-member institutions (or a 67.3% response rate for AAMC-member institutions in the report, and a 32.5% response rate for non-member institutions in the report).

Of the 341 sponsoring institutions with usable information, 119 were general hospitals & specialty hospitals (or 34.9% of those submitting usable stipend data), 93 were health systems & consortiums (or 27.3% of those submitting usable stipend data), 70 were medical schools (or 20.5% of those submitting usable stipend data), and 59 were other (or 17.3% of those usable submitting stipend data).

The 2024 report includes stipends data for 116,786 residents and fellows as of July 1, 2024. Resident counts are not yet known for the 2024-2025 academic year. According to the ACGME, the total number of on-duty residents and fellows was 162,644 in academic year 2023-2024. This suggests an approximate coverage rate of 71.8% for the 2024 report.

Some tables in the report display unweighted means while other tables display weighted means. Unweighted means are means where each institution has the same weight, regardless of the size of the institution's training program. Weighted means are means that are weighted by the number of residents and fellows.

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The 341 survey respondents are organized into several different cohort groupings which are displayed throughout the tables in this report. The institution types that are used throughout this report have been classified based on the sponsoring institution's response to the type of institution classification question within the survey:

- All respondents labeled 'Total' in the report (341 respondents).
- All respondents at general hospitals and specialty hospitals labeled 'General Hospital & Specialty Hospital' in the report (119 respondents). This cohort includes sponsoring institutions with the institution types of General Hospital and Specialty Hospital.
- All respondents at health systems and consortiums labeled 'Health System & Consortium' in the report (93 respondents). This cohort includes sponsoring institutions with the institution types of Health System and Consortium.
- All respondents at medical schools labeled 'Medical School' in the report (70 respondents). This cohort includes sponsoring institutions with the institution type of Medical School.
- All respondents at other types of institutions labeled 'Other' in the report (59 respondents). This cohort includes sponsoring institutions with the institution types of Ambulatory Care/Community Health Center, Ambulatory Care/Other, Ambulatory Surgery Center, End-of-Life Care Facility (Hospice), Governmental Public Health Agency, Long-Term Care Facility, Medical Examiner’s Office, Military Treatment Facility, Non-Medical School Educational Foundation/Organization, Poison Control Center, Prison/Jail/Other Carceral Facility, School (Primary/Secondary/College/University), School of Public Health, Sports Venue, VA Healthcare System Facility, Blood Collection and Processing Center, Reference Laboratory, and Other.

Selected Findings

The unweighted mean program year 1 stipend for all responding institutions is $66,712 (as of July 1, 2024). The mean difference for program year 1 unweighted stipends between stipends as of July 1, 2023, and stipends as of July 1, 2024, is $2,912. The weighted mean program year 1 stipend for all regions is $68,053 (as of July 1, 2024).

Of the 290 institutions that submitted stipends data and responded to the question, the majority of the institutions (95.9%) reported that they pay the same base stipends to residents and fellows at each level across all specialties.

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The tables are organized into three sections. Section 1, Resident/Fellow Stipends, presents information on resident and fellow stipends. Section 2, Resident/Fellow Health Benefits, presents information on resident and fellow health benefits. Section 3, Resident/Fellow Non-Health Benefits, presents information on resident and fellow non-health benefits and policies.

Throughout the report, there are four categories of institution type: General Hospitals & Specialty Hospitals, Health Systems & Consortiums, Medical Schools, and Other. As described in the Methodology section, these categories are based on the sponsoring institution's self-reported institution type.

All sponsoring institutions in the report are nonprofit organizations, based on the information reported to AAMC in the 2024 Survey of Resident/Fellow Stipends and Benefits.

Section 1 Resident/Fellow Stipends

Tables 1-12b present stipend data reported by region and institution type. These tables include mean stipend data and values at the 25th, 50th (median), and 75th percentiles. With the exception of Table 2, which presents data adjusted by the Consumer Price Index (CPI-U, for all urban consumers), the stipend data are not adjusted for regional wage or cost-of-living differences.

Stipend tables 4a-4d, 5a-5d, 6a-6d, 7a-7d, 8a-8d, and 9a-9d provide breakouts by institution size. Institution size is determined by the median number of residents and the median number of programs for each sponsoring institution. Cohorts were created for sponsoring institutions falling at or above these medians and below these medians. Sponsoring institutions are included in breakouts by institution size if the sponsoring institution reported the number of ACGME-accredited programs and/or reported the number of residents/fellows at the sponsoring institution to the survey.

Section 2 Resident/Fellow Health Benefits

Tables 13-17 display the health benefits offered to residents and fellows as of July 1, 2024. These tables include the percentage of responding institutions offering resident/fellow health benefits for all institutions combined and by institution type.

Section 3 Resident/Fellow Non-Health Benefits

Tables 18-39 present non-health benefits offered to residents and fellows. These benefits include housing, parking, meals, leave, retirement, seminar attendance, life insurance, disability insurance, child care services, and financial and career counseling services. In addition, some tables report data on wellness benefits, mental health services, access to urgent care, tools for self-screening of well-being, access to lactation facilities, and testing policies for drug and/or alcohol abuse.

Resident/Fellow Stipends by Region and Institution Type Flat File

The RSS Data tab of this report contains a flat, analytic file of the aggregated stipend data presented in Section 1 Resident/Fellow Stipends Table 1 and Tables 4 through Table 9. Compensation statistics for stipends are provided only when at least five institutions are represented. For weighted average stipends, compensation statistics are provided when at least five institutions are represented and at least five residents/fellows are reported. In addition, resident counts and weighted means are suppressed for the breakout of institution type. Resident counts and weighted means for all institutions by region, which are displayed in Tables 4-4d, can be found in the flat, analytic file. Likewise, institution counts and unweighted means for all institutions and by institution type, which are found in Tables 5 through 9, can be found in the flat, analytic file.

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Thank you to all the sponsoring institutions who responded to the 2024 Survey of Resident/Fellow Stipends and Benefits and helped make this report possible.

If you have any thoughts or questions, please contact survey staff at residentstipends@aamc.org.

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The AAMC Survey of Resident/Fellow Stipends and Benefits Report uses the following chart to classify states by region:

Northeast	Central	Southern	Western
Connecticut	Illinois	Alabama	Alaska
Delaware	Indiana	Arkansas	Arizona
District of Columbia	Iowa	Florida	California
Maine	Kansas	Georgia	Colorado
Maryland	Michigan	Kentucky	Hawaii
Massachusetts	Minnesota	Louisiana	Idaho
New Hampshire	Missouri	Mississippi	Montana
New Jersey	Nebraska	North Carolina	Nevada
New York	North Dakota	Oklahoma	New Mexico
Pennsylvania	Ohio	Puerto Rico*	Oregon
Rhode Island	South Dakota	South Carolina	Utah
Vermont	Wisconsin	Tennessee	Washington
		Texas	Wyoming
		Virginia	
		West Virginia	

*Puerto Rico is classified in the Southern region. However, Puerto Rican institutions are not included in regional breakdowns. If institutions in Puerto Rico respond to the survey, they are included only in the calculation of All Regions.

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TABLE 1 Resident/Fellow Unweighted Stipends Nationwide

Survey of Resident/Fellow Stipends and Benefits Report 2024

Table 1 presents summary data on national resident/fellow stipends for each of eight program years. The program year one unweighted mean stipend as of July 1, 2024 for all responding institutions is $66,712. Unweighted means are means where each institution has the same weight, regardless of the size of its training program. This approach prevents larger institutions from skewing the mean.

	Year of Training	Institution Count	Mean Unweighted Stipend	25th Percentile	Median	75th Percentile
Stipends as of July 1, 2024	Program Year 1	335	$66,712	$61,101	$65,100	$70,101
	Program Year 2	334	$68,901	$63,484	$67,582	$72,672
	Program Year 3	333	$71,776	$66,056	$70,304	$76,167
	Program Year 4	263	$75,665	$69,077	$73,903	$80,299
	Program Year 5	235	$79,170	$72,322	$77,405	$84,095
	Program Year 6	204	$81,649	$74,969	$79,944	$86,503
	Program Year 7	173	$85,925	$78,304	$83,986	$91,451
	Program Year 8	122	$90,562	$83,796	$88,624	$95,787

Information from the 2024 survey is as of July 1, 2024.

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TABLE 2 Resident/Fellow First-Year Stipends Nationwide, Mean Unweighted Stipends and Mean Inflation-Adjusted Stipends

Survey of Resident/Fellow Stipends and Benefits Report 2024

Table 2 displays mean first program year stipends for each year from 1968-1969 to stipends as of July 1, 2024. Since a different group of institutions responds each year, changes in stipends from year-to-year may reflect characteristics of different cohorts of institutions responding to the survey each year, in addition to actual stipend changes.

Table 2 also displays unweighted and adjusted stipends by the U.S. Bureau of Labor Statistics Consumer Price Index for "All Urban Consumers (CPI-U). All Items" from 1968-1969 to stipends as of July 1, 2024. Stipend data are shown in 2024 dollars and adjusted to constant 1969 dollars. Between July 1, 2023 and July 1, 2024, stipends paid by respondents in the 2024 survey were 4.6%, or $2,912, higher than stipends paid by 2023 survey respondents. CPI-U-adjusted stipends increased by $111 (from $7,256 to $7,368). The CPI-U-adjusted mean first program year stipend as of July 1, 2024 is $7,368, which represents a 18.8% real increase over the $6,200 mean first program year stipend that residents were paid in 1968-1969.

Survey Year	Mean Unweighted Stipend	Percent Change from Prior Survey Year	Dollar Change from Prior Survey Year	CPI-U	Mean Inflation-Adjusted Stipend
2024	$66,712	4.6%	$2,912	314.2	$7,368
2023	$63,800	4.7%	$2,858	305.1	$7,256
2022	$60,942	2.8%	$1,664	296.3	$7,137
2021	$59,279	0.6%	$358	271.7	$7,571
2020	$58,921	3.0%	$1,730	257.8	$7,931
2019-2020	$57,191	1.9%	$1,065	256.1	$7,749
2018-2019	$56,126	3.7%	$1,999	252.0	$7,728
2016-2017	$54,127	4.9%	$2,541	241.0	$7,793
2014-2015	$51,586	1.6%	$821	238.3	$7,512
2013-2014	$50,765	1.0%	$491	233.5	$7,544
2012-2013	$50,274	1.8%	$880	229.5	$7,601
2011-2012	$49,394	1.9%	$934	225.7	$7,594
2010-2011	$48,460	2.1%	$1,002	218.0	$7,714
2009-2010	$47,458	2.6%	$1,213	215.7	$7,635
2008-2009	$46,245	3.4%	$1,498	218.8	$7,334
2007-2008	$44,747	3.4%	$1,481	208.4	$7,451
2006-2007	$43,266	2.8%	$1,196	202.9	$7,399
2005-2006	$42,070	3.1%	$1,282	194.5	$7,506
2004-2005	$40,788	2.5%	$979	189.7	$7,461
2003-2004	$39,809	4.1%	$1,562	183.7	$7,520
2002-2003	$38,238	2.3%	$855	179.9	$7,376
2001-2002	$37,383	4.6%	$1,655	178.0	$7,288
2000-2001	$35,728	2.1%	$743	172.4	$7,191
1999-2000	$34,985	2.6%	$881	166.2	$7,304
1998-1999	$34,104	2.1%	$717	163.0	$7,260
1997-1998	$33,387	1.8%	$598	160.3	$7,227
1996-1997	$32,789	3.6%	$1,139	156.7	$7,261
1995-1996	$31,650	2.9%	$897	152.5	$7,202

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TABLE 2

Resident/Fellow First-Year Stipends Nationwide, Mean Unweighted Stipends and Mean Inflation-Adjusted Stipends

Survey of Resident/Fellow Stipends and Benefits Report 2024

1994-1995	$30,753	3.8%	$1,121	148.0	$7,210
1993-1994	$29,632	3.5%	$1,014	144.4	$7,121
1992-1993	$28,618	5.2%	$1,407	140.2	$7,083
1991-1992	$27,211	5.2%	$1,353	136.0	$6,943
1990-1991	$25,858	4.9%	$1,209	129.9	$6,907
1989-1990	$24,649	3.9%	$920	124.1	$6,892
1988-1989	$23,729	4.5%	$1,013	118.0	$6,978
1987-1988	$22,716	3.3%	$722	113.5	$6,945
1986-1987	$21,994	2.5%	$538	109.5	$6,970
1985-1986	$21,456	3.1%	$642	107.6	$6,919
1984-1985	$20,814	4.5%	$895	103.7	$6,965
1983-1984	$19,919	5.1%	$958	99.5	$6,947
1982-1983	$18,961	7.5%	$1,320	97.0	$6,783
1981-1982	$17,641	9.0%	$1,453	90.6	$6,757
1980-1981	$16,188	9.0%	$1,335	82.7	$6,792
1979-1980	$14,853	6.4%	$888	72.3	$7,129
1978-1979	$13,965	5.9%	$779	65.2	$7,432
1977-1978	$13,186	4.4%	$558	60.7	$7,538
1976-1977	$12,628	8.1%	$943	56.8	$7,715
1975-1976	$11,685	9.3%	$993	53.6	$7,565
1974-1975	$10,692	5.7%	$578	49.0	$7,572
1973-1974	$10,114	4.3%	$416	44.2	$7,940
1972-1973	$9,698	5.4%	$500	41.7	$8,070
1971-1972	$9,198	13.3%	$1,083	40.6	$7,861
1970-1971	$8,115	10.8%	$790	38.8	$7,258
1969-1970	$7,325	18.1%	$1,125	36.6	$6,945
1968-1969	$6,200	-	-	34.7	$6,200

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TABLE 3a Resident/Fellow Unweighted Stipends Nationwide, Dollar Change and Percent Change

Survey of Resident/Fellow Stipends and Benefits Report 2024

Table 3a displays the percent and dollar changes in mean unweighted stipends as of July 1, 2023 and as of July 1, 2024 calculated for respondents reporting in both years. Dollar and percent increases are reported only for institutions that responded to both the 2023 and 2024 AAMC Resident/Fellow Surveys (240 institutions at the first program year, declining to 95 institutions at the eighth year). The mean increase between first-year unweighted stipends as of July 1, 2023 and as of July 1, 2024 is $3,067. The percent increase over the first-year unweighted stipends as of July 1, 2023 and as of July 1, 2024 is 4.8%.

	Year of Training	Institution Count	Mean Unweighted Stipend	25th Percentile	Median	75th Percentile
Dollar Change	Program Year 1	240	$3,067	$1,612	$2,430	$3,958
	Program Year 2	243	$3,116	$1,723	$2,519	$4,005
	Program Year 3	241	$3,227	$1,802	$2,631	$4,188
	Program Year 4	200	$3,628	$2,000	$2,978	$4,544
	Program Year 5	182	$3,780	$2,118	$3,208	$4,707
	Program Year 6	163	$3,890	$2,134	$3,222	$4,840
	Program Year 7	137	$4,138	$2,302	$3,414	$5,422
	Program Year 8	95	$4,509	$2,500	$3,890	$5,931
Percent Change	Program Year 1	240	4.8%	2.5%	4.0%	6.0%
	Program Year 2	243	4.7%	2.6%	4.0%	6.0%
	Program Year 3	241	4.6%	2.6%	4.0%	6.0%
	Program Year 4	200	5.0%	3.0%	4.0%	6.1%
	Program Year 5	182	4.9%	3.0%	4.0%	6.1%
	Program Year 6	163	5.0%	3.0%	4.1%	6.1%
	Program Year 7	137	5.1%	3.0%	4.0%	6.5%
	Program Year 8	95	5.2%	3.0%	4.5%	6.6%

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TABLE 3b Resident/Fellow Dollar Change and Percent Change in Unweighted Stipends Nationwide, Received by Academic Cohorts of Residents Advancing One Year

Table 3b displays the unweighted stipend increases for a cohort of institutions (ranging from 242 to 101 institutions depending on program year) that responded in both survey year 2023 and survey year 2024. The total increase for any cohort typically includes a step increase (the increase in payment received when entering the next program year) and a base increase (the overall average increase associated with increases in the cost of living for every level). The mean increase from the first program year in survey year 2023 to the second year in survey year 2024 was $5,637, or 8.8%.

	Year of Training	Institution Count	Mean Unweighted Stipend	25th Percentile	Median	75th Percentile
Dollar Change	PY 1 to PY 2	242	$5,637	$3,616	$4,923	$6,597
	PY 2 to PY 3	243	$5,953	$3,937	$5,149	$7,029
	PY 3 to PY 4	204	$6,480	$4,500	$5,889	$7,672
	PY 4 to PY 5	184	$6,821	$4,819	$6,218	$8,130
	PY 5 to PY 6	165	$6,637	$4,597	$6,078	$7,960
	PY 6 to PY 7	140	$7,532	$5,090	$6,786	$8,602
	PY 7 to PY 8	101	$7,785	$5,524	$7,092	$9,889
Percent Change	PY 1 to PY 2	242	8.8%	5.8%	7.8%	10.2%
	PY 2 to PY 3	243	8.9%	6.2%	8.0%	10.2%
	PY 3 to PY 4	204	9.3%	6.9%	8.6%	10.8%
	PY 4 to PY 5	184	9.4%	7.0%	8.6%	10.8%
	PY 5 to PY 6	165	8.8%	6.3%	8.2%	10.3%
	PY 6 to PY 7	140	9.6%	6.7%	8.5%	11.2%
	PY 7 to PY 8	101	9.4%	6.8%	8.8%	11.6%

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TABLE 4 Resident/Fellow Weighted Mean Stipends, by Region

Survey of Resident/Fellow Stipends and Benefits Report 2024

Table 4 displays the number of residents and fellows at each institution and the weighted mean stipends for each program year. The mean is weighted by the number of residents and fellows. The weighted mean stipend for all regions at the first program year is $68,053. The All Region category comprises all participating institutions. A comparison of the unweighted mean stipend for the first program year in table 1 and weighted mean stipend for the first program year for all regions in table 4 shows a difference of $1,340 between weighted and unweighted mean stipends.

	Year of Training	Aggregate Residents	Weighted Mean Stipend
All Region	Program Year 1	26,199	$68,053
	Program Year 2	25,572	$71,013
	Program Year 3	24,722	$74,054
	Program Year 4	17,722	$78,198
	Program Year 5	12,548	$82,514
	Program Year 6	7,085	$85,933
	Program Year 7	2,372	$90,292
	Program Year 8	566	$94,221
Northeast	Program Year 1	7,404	$72,536
	Program Year 2	7,372	$75,688
	Program Year 3	7,184	$79,459
	Program Year 4	5,116	$83,254
	Program Year 5	3,557	$87,844
	Program Year 6	2,002	$92,207
	Program Year 7	685	$97,538
	Program Year 8	189	$103,736
Southern	Program Year 1	7,845	$62,704
	Program Year 2	7,455	$65,169
	Program Year 3	7,157	$67,491
	Program Year 4	5,342	$71,136
	Program Year 5	3,714	$74,992
	Program Year 6	2,199	$78,002
	Program Year 7	695	$81,512
	Program Year 8	167	$84,272
Central	Program Year 1	6,722	$65,444
	Program Year 2	6,558	$67,980
	Program Year 3	6,298	$70,440
	Program Year 4	4,286	$74,174
	Program Year 5	3,045	$77,930
	Program Year 6	1,672	$81,016
	Program Year 7	616	$84,357
	Program Year 8	160	$88,686
Western	Program Year 1	4,127	$75,063
	Program Year 2	4,115	$78,479
	Program Year 3	4,021	$82,152
	Program Year 4	2,949	$88,271
	Program Year 5	2,213	$93,064
	Program Year 6	1,203	$96,978
	Program Year 7	374	$103,188
	Program Year 8	50	$109,194

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TABLE 4 Resident/Fellow Weighted Mean Stipends, by Region

Survey of Resident/Fellow Stipends and Benefits Report 2024

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4a Resident/Fellow Weighted Mean Stipends, by Region, for Institutions with a total amount of ACGME-accredited programs greater than or equal to the median

Table 4a displays the number of residents and fellows and the weighted mean stipends for each program year for sponsoring institutions that were at or above the 50th percentile for number of ACGME-accredited programs. The 50th percentile for number of ACGME-accredited programs across responding sponsoring institutions in all regions is 10.0 ACGME-accredited programs. The mean is weighted by the number of residents and fellows. The table is also broken out by region.

	Year of Training	Aggregate Residents	Weighted Mean Stipend
All Region	Program Year 1	22,950	$68,489
	Program Year 2	22,771	$71,444
	Program Year 3	22,072	$74,471
	Program Year 4	17,040	$78,358
	Program Year 5	12,283	$82,609
	Program Year 6	6,923	$86,161
	Program Year 7	2,328	$90,611
	Program Year 8	545	$95,177
Northeast	Program Year 1	6,643	$72,709
	Program Year 2	6,692	$75,792
	Program Year 3	6,538	$79,483
	Program Year 4	4,968	$83,133
	Program Year 5	3,504	$87,733
	Program Year 6	1,980	$92,195
	Program Year 7	683	$97,552
	Program Year 8	189	$103,736
Southern	Program Year 1	6,820	$63,114
	Program Year 2	6,590	$65,636
	Program Year 3	6,352	$67,974
	Program Year 4	5,124	$71,365
	Program Year 5	3,641	$75,079
	Program Year 6	2,117	$78,288
	Program Year 7	660	$82,148
	Program Year 8	146	$86,409
Central	Program Year 1	6,096	$65,695
	Program Year 2	5,979	$68,285
	Program Year 3	5,733	$70,766
	Program Year 4	4,119	$74,344
	Program Year 5	2,975	$78,053
	Program Year 6	1,647	$81,091
	Program Year 7	613	$84,395
	Program Year 8	160	$88,686
Western	Program Year 1	3,363	$76,207
	Program Year 2	3,482	$79,588
	Program Year 3	3,427	$83,225
	Program Year 4	2,813	$88,611
	Program Year 5	2,150	$93,396
	Program Year 6	1,172	$97,396
	Program Year 7	370	$103,271
	Program Year 8	50	$109,194

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TABLE 4 Resident/Fellow Weighted Mean Stipends, by Region

Survey of Resident/Fellow Stipends and Benefits Report 2024

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4b Resident/Fellow Weighted Mean Stipends, by Region, for Institutions with a total amount of ACGME-accredited programs less than the median

Table 4b displays the number of residents and fellows and the weighted mean stipends for each program year for sponsoring institutions that were below the 50th percentile for number of ACGME-accredited programs. The 50th percentile for number of ACGME-accredited programs across responding sponsoring institutions in all regions is 10.0 ACGME-accredited programs. The mean is weighted by the number of residents and fellows. The table is also broken out by region.

	Year of Training	Aggregate Residents	Weighted Mean Stipend
All Region	Program Year 1	3,047	$65,450
	Program Year 2	2,605	$68,108
	Program Year 3	2,449	$71,316
	Program Year 4	574	$76,084
	Program Year 5	225	$80,072
	Program Year 6	102	$80,208
	Program Year 7	10	$86,979
	Program Year 8	0	
Northeast	Program Year 1	761	$71,031
	Program Year 2	680	$74,663
	Program Year 3	646	$79,209
	Program Year 4	148	$87,338
	Program Year 5	53	$95,180
	Program Year 6	22	$93,279
	Program Year 7	2	
	Program Year 8	0	
Southern	Program Year 1	823	$60,533
	Program Year 2	669	$62,182
	Program Year 3	604	$64,351
	Program Year 4	110	$67,335
	Program Year 5	33	$75,291
	Program Year 6	22	$73,842
	Program Year 7	1	
	Program Year 8	0	
Central	Program Year 1	626	$63,002
	Program Year 2	579	$64,824
	Program Year 3	565	$67,131
	Program Year 4	167	$69,970
	Program Year 5	70	$72,668
	Program Year 6	25	$76,065
	Program Year 7	3	
	Program Year 8	0	
Western	Program Year 1	764	$70,024
	Program Year 2	633	$72,375
	Program Year 3	594	$75,961
	Program Year 4	136	$81,238
	Program Year 5	63	$81,721
	Program Year 6	31	$81,169
	Program Year 7	4	
	Program Year 8	0	

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TABLE 4 Resident/Fellow Weighted Mean Stipends, by Region

Survey of Resident/Fellow Stipends and Benefits Report 2024

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4c Resident/Fellow Weighted Mean Stipends, by Region, for Institutions with a number of residents/fellows greater than or equal to the median

Table 4c displays the number of residents and fellows and the weighted mean stipends for each program year for sponsoring institutions that were at or above the 50th percentile for number of residents/fellows. The 50th percentile of number of residents/fellows across responding institutions in all regions is 140.0 residents/fellows. The mean is weighted by the number of residents and fellows. The table is also broken out by region.

	Year of Training	Aggregate Residents	Weighted Mean Stipend
All Region	Program Year 1	23,330	$68,448
	Program Year 2	23,221	$71,363
	Program Year 3	22,568	$74,376
	Program Year 4	17,157	$78,317
	Program Year 5	12,298	$82,623
	Program Year 6	6,962	$86,078
	Program Year 7	2,354	$90,323
	Program Year 8	561	$94,291
Northeast	Program Year 1	6,738	$72,926
	Program Year 2	6,792	$76,056
	Program Year 3	6,644	$79,819
	Program Year 4	4,980	$83,324
	Program Year 5	3,506	$87,887
	Program Year 6	1,984	$92,279
	Program Year 7	682	$97,535
	Program Year 8	186	$104,020
Southern	Program Year 1	7,091	$62,934
	Program Year 2	6,929	$65,351
	Program Year 3	6,717	$67,636
	Program Year 4	5,237	$71,175
	Program Year 5	3,656	$74,992
	Program Year 6	2,169	$78,041
	Program Year 7	692	$81,508
	Program Year 8	165	$84,242
Central	Program Year 1	6,208	$65,584
	Program Year 2	6,074	$68,169
	Program Year 3	5,825	$70,652
	Program Year 4	4,142	$74,301
	Program Year 5	2,997	$78,014
	Program Year 6	1,643	$81,106
	Program Year 7	612	$84,406
	Program Year 8	160	$88,686
Western	Program Year 1	3,293	$76,558
	Program Year 2	3,426	$79,884
	Program Year 3	3,382	$83,482
	Program Year 4	2,798	$88,718
	Program Year 5	2,139	$93,498
	Program Year 6	1,166	$97,484
	Program Year 7	368	$103,371
	Program Year 8	50	$109,194

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TABLE 4 Resident/Fellow Weighted Mean Stipends, by Region

Survey of Resident/Fellow Stipends and Benefits Report 2024

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4d Resident/Fellow Weighted Mean Stipends, by Region, for Institutions with a number of residents/fellows less than the median

Table 4d displays the number of residents and fellows and the weighted mean stipends for each program year for sponsoring institutions that were below the 50th percentile for number of residents/fellows. The 50th percentile of number of residents/fellows across responding institutions in all regions is 140.0 residents/fellows. The mean is weighted by the number of residents and fellows. The table is also broken out by region.

	Year of Training	Aggregate Residents	Weighted Mean Stipend
All Region	Program Year 1	2,869	$64,838
	Program Year 2	2,351	$67,553
	Program Year 3	2,154	$70,681
	Program Year 4	565	$74,566
	Program Year 5	250	$77,134
	Program Year 6	123	$77,745
	Program Year 7	18	$86,212
	Program Year 8	5	
Northeast	Program Year 1	666	$68,591
	Program Year 2	580	$71,377
	Program Year 3	540	$75,022
	Program Year 4	136	$80,692
	Program Year 5	51	$84,940
	Program Year 6	18	$84,256
	Program Year 7	3	
	Program Year 8	3	
Southern	Program Year 1	754	$60,542
	Program Year 2	526	$62,762
	Program Year 3	440	$65,263
	Program Year 4	105	$69,170
	Program Year 5	58	$75,035
	Program Year 6	30	$75,193
	Program Year 7	3	
	Program Year 8	2	
Central	Program Year 1	514	$63,752
	Program Year 2	484	$65,604
	Program Year 3	473	$67,824
	Program Year 4	144	$70,522
	Program Year 5	48	$72,675
	Program Year 6	29	$75,882
	Program Year 7	4	
	Program Year 8	0	
Western	Program Year 1	834	$69,158
	Program Year 2	689	$71,493
	Program Year 3	639	$75,114
	Program Year 4	151	$79,989
	Program Year 5	74	$80,521
	Program Year 6	37	$81,034
	Program Year 7	6	
	Program Year 8	0	

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TABLE 5 Resident/Fellow Unweighted Stipends for All Regions, by Institution Type

Survey of Resident/Fellow Stipends and Benefits Report 2024

Table 5 displays unweighted stipends for sponsoring institutions in all U.S. regions. Unweighted stipends were reported for 335 institutions for the first program year.

	Year of Training	Institution Count	Mean Unweighted Stipend	25th Percentile	Median	75th Percentile
Total	Program Year 1	335	$66,712	$61,101	$65,100	$70,101
	Program Year 2	334	$68,901	$63,484	$67,582	$72,672
	Program Year 3	333	$71,776	$66,056	$70,304	$76,167
	Program Year 4	263	$75,665	$69,077	$73,903	$80,299
	Program Year 5	235	$79,170	$72,322	$77,405	$84,095
	Program Year 6	204	$81,649	$74,969	$79,944	$86,503
	Program Year 7	173	$85,925	$78,304	$83,986	$91,451
	Program Year 8	122	$90,562	$83,796	$88,624	$95,787
General Hospital & Specialty Hospital	Program Year 1	115	$67,373	$61,893	$66,706	$71,759
	Program Year 2	118	$70,176	$64,235	$69,760	$74,333
	Program Year 3	118	$73,399	$66,416	$72,673	$78,007
	Program Year 4	88	$77,745	$71,774	$76,925	$82,871
	Program Year 5	77	$81,735	$75,049	$80,327	$87,630
	Program Year 6	63	$83,922	$77,574	$82,194	$90,082
	Program Year 7	48	$88,889	$82,385	$86,414	$94,864
	Program Year 8	35	$94,015	$87,364	$94,241	$101,040
Health System & Consortium	Program Year 1	93	$65,859	$61,711	$65,100	$68,626
	Program Year 2	93	$68,273	$63,871	$67,500	$71,258
	Program Year 3	93	$70,875	$66,298	$69,500	$74,082
	Program Year 4	78	$74,271	$68,824	$72,580	$77,602
	Program Year 5	68	$77,657	$73,054	$75,681	$80,897
	Program Year 6	59	$79,880	$74,979	$77,836	$83,757
	Program Year 7	51	$84,300	$78,012	$83,191	$87,915
	Program Year 8	37	$88,171	$82,211	$86,819	$91,832
Medical School	Program Year 1	70	$65,036	$60,837	$63,949	$67,553
	Program Year 2	70	$67,437	$63,070	$66,116	$70,321
	Program Year 3	70	$69,891	$65,290	$68,392	$72,692
	Program Year 4	67	$73,659	$68,162	$71,205	$77,037
	Program Year 5	64	$76,840	$70,476	$74,511	$80,115
	Program Year 6	62	$79,898	$73,068	$77,433	$83,257
	Program Year 7	55	$83,698	$76,367	$81,200	$88,496
	Program Year 8	37	$88,562	$83,134	$85,918	$92,664
Other	Program Year 1	57	$68,830	$60,500	$65,920	$70,387
	Program Year 2	53	$69,098	$62,000	$68,557	$73,000
	Program Year 3	52	$72,241	$64,875	$70,459	$77,128
	Program Year 4	30	$77,668	$69,640	$75,958	$83,182
	Program Year 5	26	$81,269	$72,720	$79,885	$85,742
	Program Year 6	20	$85,135	$75,459	$82,729	$89,354
	Program Year 7	19	$89,249	$78,176	$87,310	$94,557
	Program Year 8	13	$93,762	$87,000	$92,310	$96,402

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TABLE 5 Resident/Fellow Unweighted Stipends for All Regions, by Institution Type

Survey of Resident/Fellow Stipends and Benefits Report 2024

5a Resident/Fellow Unweighted Stipends for All Regions, by Institution Type, for Institutions with a total amount of ACGME-accredited programs greater than or equal to the median

Table 5a displays unweighted stipends for sponsoring institutions in all U.S. regions that were at or above the 50th percentile for number of ACGME-accredited programs. The 50th percentile for General Hospitals & Specialty Hospitals is 5.0; for Health Systems & Consortiums is 12.0; for Medical Schools is 45.0; for Other institutions is 2.0; and, for Total respondents is 10.0. Unweighted stipends were reported for 169 institutions for the first program year.

	Year of Training	Institution Count	Mean Unweighted Stipend	25th Percentile	Median	75th Percentile
Total	Program Year 1	169	$67,591	$62,546	$65,817	$70,660
	Program Year 2	170	$70,153	$64,424	$68,416	$73,173
	Program Year 3	170	$73,048	$66,810	$71,053	$77,021
	Program Year 4	169	$76,220	$69,606	$73,903	$80,567
	Program Year 5	169	$79,422	$72,941	$77,217	$84,050
	Program Year 6	163	$82,262	$75,299	$80,163	$87,274
	Program Year 7	149	$86,090	$78,409	$83,821	$91,451
	Program Year 8	111	$90,829	$83,759	$88,624	$96,000
General Hospital & Specialty Hospital	Program Year 1	61	$69,059	$64,020	$68,447	$74,006
	Program Year 2	63	$71,778	$66,236	$70,792	$76,458
	Program Year 3	63	$75,167	$68,863	$73,676	$79,891
	Program Year 4	61	$78,296	$71,870	$77,433	$83,323
	Program Year 5	61	$81,509	$74,786	$79,674	$87,185
	Program Year 6	54	$84,656	$77,707	$82,666	$90,521
	Program Year 7	42	$89,373	$82,689	$86,519	$96,104
	Program Year 8	31	$94,530	$87,364	$94,981	$101,289
Health System & Consortium	Program Year 1	48	$66,599	$61,463	$65,661	$68,920
	Program Year 2	48	$69,081	$64,178	$67,985	$71,510
	Program Year 3	48	$71,665	$66,647	$70,526	$74,456
	Program Year 4	48	$74,745	$69,299	$72,928	$77,764
	Program Year 5	48	$77,948	$72,929	$75,663	$81,331
	Program Year 6	46	$80,468	$74,961	$77,797	$84,328
	Program Year 7	44	$84,254	$77,609	$82,203	$87,745
	Program Year 8	32	$88,562	$82,743	$86,787	$92,099
Medical School	Program Year 1	36	$68,191	$63,547	$66,579	$70,367
	Program Year 2	36	$70,814	$65,629	$69,210	$73,252
	Program Year 3	36	$73,591	$67,992	$71,981	$76,795
	Program Year 4	36	$76,765	$70,201	$74,889	$79,993
	Program Year 5	36	$80,036	$73,105	$78,541	$83,545
	Program Year 6	36	$82,927	$75,674	$81,087	$87,199
	Program Year 7	36	$86,283	$79,305	$83,691	$90,421
	Program Year 8	30	$90,587	$83,814	$87,298	$93,231
Other	Program Year 1	34	$66,894	$61,027	$66,099	$69,468
	Program Year 2	34	$69,209	$62,460	$68,654	$72,479
	Program Year 3	33	$72,146	$65,000	$70,614	$75,500
	Program Year 4	26	$75,927	$67,652	$74,447	$81,803
	Program Year 5	24	$80,290	$72,606	$79,305	$84,901
	Program Year 6	20	$85,135	$75,459	$82,729	$89,354
	Program Year 7	19	$89,249	$78,176	$87,310	$94,557
	Program Year 8	13	$93,762	$87,000	$92,310	$96,402

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TABLE 5 Resident/Fellow Unweighted Stipends for All Regions, by Institution Type

Survey of Resident/Fellow Stipends and Benefits Report 2024

5b Resident/Fellow Unweighted Stipends for All Regions, by Institution Type, for Institutions with a total amount of ACGME-accredited programs less than the median

Table 5b displays unweighted stipends for sponsoring institutions in all U.S. regions that were below the 50th percentile for number of ACGME-accredited programs. The 50th percentile for General Hospitals & Specialty Hospitals is 5.0; for Health Systems & Consortiums is 12.0; for Medical Schools is 45.0; for Other institutions is 2.0; and, for Total respondents is 10.0. Unweighted stipends were reported for 164 institutions for the first program year.

	Year of Training	Institution Count	Mean Unweighted Stipend	25th Percentile	Median	75th Percentile
Total	Program Year 1	164	$65,829	$60,198	$64,010	$69,717
	Program Year 2	162	$67,613	$62,229	$66,953	$71,891
	Program Year 3	161	$70,464	$64,750	$69,376	$75,014
	Program Year 4	93	$74,779	$68,505	$73,416	$80,139
	Program Year 5	65	$78,704	$70,775	$77,807	$84,391
	Program Year 6	40	$79,455	$72,619	$78,068	$84,582
	Program Year 7	23	$85,577	$77,832	$84,873	$90,968
	Program Year 8	10	$89,717	$88,269	$89,002	$94,135
General Hospital & Specialty Hospital	Program Year 1	53	$65,347	$60,000	$64,000	$70,350
	Program Year 2	54	$68,235	$62,131	$67,708	$72,410
	Program Year 3	54	$71,270	$64,330	$70,536	$77,317
	Program Year 4	27	$76,501	$70,450	$76,585	$82,324
	Program Year 5	16	$82,598	$77,182	$81,762	$88,632
	Program Year 6	9	$79,518	$73,000	$81,307	$86,000
	Program Year 7	6	$85,497	$82,467	$85,827	$89,195
	Program Year 8	4				
Health System & Consortium	Program Year 1	45	$65,069	$61,838	$64,488	$67,040
	Program Year 2	45	$67,411	$63,871	$66,851	$69,452
	Program Year 3	45	$70,033	$66,298	$69,220	$72,495
	Program Year 4	30	$73,512	$68,441	$72,419	$75,434
	Program Year 5	20	$76,957	$73,481	$75,681	$79,103
	Program Year 6	13	$77,802	$75,647	$78,296	$80,625
	Program Year 7	7	$84,591	$81,884	$83,986	$88,726
	Program Year 8	5	$85,672	$82,211	$88,150	$88,884
Medical School	Program Year 1	33	$61,816	$60,500	$62,546	$63,978
	Program Year 2	33	$63,990	$61,884	$64,286	$66,137
	Program Year 3	33	$66,105	$64,000	$66,303	$68,394
	Program Year 4	30	$70,250	$66,672	$69,226	$71,756
	Program Year 5	27	$72,947	$69,442	$71,354	$74,804
	Program Year 6	25	$75,956	$71,723	$74,044	$77,806
	Program Year 7	18	$79,322	$74,897	$76,367	$80,287
	Program Year 8	6	$81,630	$80,156	$82,491	$84,571
Other	Program Year 1	23	$71,692	$60,250	$65,920	$72,799
	Program Year 2	19	$68,900	$61,877	$67,600	$73,605
	Program Year 3	19	$72,408	$64,750	$70,304	$77,532
	Program Year 4	4				
	Program Year 5	2				
	Program Year 6	0				
	Program Year 7	0				
	Program Year 8	0				

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TABLE 5

Resident/Fellow Unweighted Stipends for All Regions, by Institution Type

Survey of Resident/Fellow Stipends and Benefits Report 2024

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TABLE 5 Resident/Fellow Unweighted Stipends for All Regions, by Institution Type

Survey of Resident/Fellow Stipends and Benefits Report 2024

5c Resident/Fellow Unweighted Stipends for All Regions, by Institution Type, for Institutions with a number of residents/fellows greater than or equal to the median

Table 5c displays unweighted stipends for sponsoring institutions in all U.S. regions that were at or above the 50th percentile for number of residents/fellows. The 50th percentile for General Hospitals & Specialty Hospitals is 82.0; for Health Systems & Consortiums is 186.0; for Medical Schools is 582.5; for Other institutions is 32.0; and, for Total respondents is 140.0. Unweighted stipends were reported for 166 institutions for the first program year.

	Year of Training	Institution Count	Mean Unweighted Stipend	25th Percentile	Median	75th Percentile
Total	Program Year 1	166	$67,420	$62,070	$66,220	$70,592
	Program Year 2	167	$70,014	$64,251	$68,871	$73,160
	Program Year 3	167	$72,896	$66,384	$71,181	$76,900
	Program Year 4	167	$75,980	$69,299	$74,118	$80,476
	Program Year 5	164	$79,408	$72,941	$77,658	$84,072
	Program Year 6	156	$82,257	$75,241	$80,458	$87,442
	Program Year 7	144	$85,875	$78,383	$83,822	$91,484
	Program Year 8	108	$90,639	$83,673	$88,547	$95,923
General Hospital & Specialty Hospital	Program Year 1	57	$69,434	$64,032	$68,926	$75,778
	Program Year 2	58	$72,188	$66,603	$71,263	$78,973
	Program Year 3	58	$75,696	$69,280	$74,911	$82,077
	Program Year 4	57	$78,570	$71,979	$78,000	$84,816
	Program Year 5	56	$82,105	$75,773	$81,213	$88,306
	Program Year 6	50	$85,370	$78,967	$84,578	$91,694
	Program Year 7	39	$89,930	$83,011	$89,245	$96,767
	Program Year 8	31	$94,363	$87,364	$94,981	$101,130
Health System & Consortium	Program Year 1	47	$66,718	$62,081	$65,718	$69,112
	Program Year 2	47	$69,205	$64,368	$68,307	$71,566
	Program Year 3	47	$71,811	$67,200	$70,519	$74,546
	Program Year 4	47	$74,900	$70,128	$72,839	$77,912
	Program Year 5	46	$78,238	$73,503	$75,771	$81,388
	Program Year 6	45	$80,672	$75,016	$77,836	$84,332
	Program Year 7	42	$83,957	$77,794	$81,896	$87,493
	Program Year 8	32	$88,418	$82,154	$85,774	$92,099
Medical School	Program Year 1	35	$68,241	$63,175	$66,530	$70,558
	Program Year 2	35	$70,871	$65,237	$69,431	$73,368
	Program Year 3	35	$73,626	$67,595	$71,980	$76,933
	Program Year 4	35	$76,796	$69,901	$74,888	$80,124
	Program Year 5	35	$80,052	$73,051	$78,540	$83,714
	Program Year 6	35	$82,931	$75,626	$81,086	$87,285
	Program Year 7	35	$86,229	$79,122	$83,560	$90,459
	Program Year 8	29	$90,431	$83,759	$87,693	$93,276
Other	Program Year 1	28	$66,120	$60,741	$65,248	$69,861
	Program Year 2	28	$68,611	$61,386	$67,986	$72,792
	Program Year 3	28	$71,537	$65,711	$70,396	$76,003
	Program Year 4	24	$74,773	$68,661	$74,447	$81,726
	Program Year 5	21	$77,923	$72,641	$78,800	$84,320
	Program Year 6	17	$82,163	$75,487	$82,680	$88,133
	Program Year 7	17	$85,580	$78,104	$86,980	$92,383
	Program Year 8	12	$91,971	$86,679	$91,729	$94,604

Information from the 2024 survey is as of July 1, 2024.

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TABLE 5

Resident/Fellow Unweighted Stipends for All Regions, by Institution Type

Survey of Resident/Fellow Stipends and Benefits Report 2024

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TABLE 5 Resident/Fellow Unweighted Stipends for All Regions, by Institution Type

Survey of Resident/Fellow Stipends and Benefits Report 2024

5d Resident/Fellow Unweighted Stipends for All Regions, by Institution Type, for Institutions with a number of residents/fellows less than the median

Table 5d displays unweighted stipends for sponsoring institutions in all U.S. regions that were below the 50th percentile for number of residents/fellows. The 50th percentile for General Hospitals & Specialty Hospitals is 82.0; for Health Systems & Consortiums is 186.0; for Medical Schools is 582.5; for Other institutions is 32.0; and, for Total respondents is 140.0. Unweighted stipends were reported for 161 institutions for the first program year.

	Year of Training	Institution Count	Mean Unweighted Stipend	25th Percentile	Median	75th Percentile
Total	Program Year 1	161	$65,589	$60,500	$64,052	$69,209
	Program Year 2	159	$67,333	$62,375	$66,910	$71,168
	Program Year 3	159	$70,112	$65,000	$68,959	$74,125
	Program Year 4	93	$74,450	$68,505	$73,223	$80,000
	Program Year 5	68	$77,780	$70,944	$76,549	$83,331
	Program Year 6	46	$78,490	$72,735	$77,611	$83,671
	Program Year 7	27	$84,536	$76,641	$83,986	$89,174
	Program Year 8	14	$89,971	$87,152	$88,844	$94,135
General Hospital & Specialty Hospital	Program Year 1	54	$64,666	$60,000	$63,689	$69,085
	Program Year 2	56	$67,569	$62,210	$66,459	$71,401
	Program Year 3	56	$70,437	$64,610	$68,602	$75,182
	Program Year 4	29	$75,989	$70,500	$74,189	$79,477
	Program Year 5	19	$80,561	$73,802	$78,949	$83,785
	Program Year 6	12	$78,059	$75,312	$77,455	$82,714
	Program Year 7	8	$84,325	$80,453	$83,269	$87,743
	Program Year 8	4				
Health System & Consortium	Program Year 1	46	$64,981	$61,743	$64,244	$67,007
	Program Year 2	46	$67,321	$63,581	$66,808	$69,403
	Program Year 3	46	$69,920	$66,089	$68,698	$72,358
	Program Year 4	31	$73,317	$68,159	$72,176	$75,126
	Program Year 5	22	$76,441	$72,843	$75,572	$78,264
	Program Year 6	14	$77,337	$72,960	$77,350	$80,467
	Program Year 7	9	$85,902	$83,283	$83,986	$91,936
	Program Year 8	5	$86,594	$86,819	$88,150	$88,884
Medical School	Program Year 1	35	$61,831	$60,155	$62,546	$63,989
	Program Year 2	35	$64,003	$61,798	$64,286	$66,286
	Program Year 3	35	$66,156	$63,950	$66,303	$68,407
	Program Year 4	32	$70,228	$66,550	$69,226	$72,204
	Program Year 5	29	$72,963	$69,383	$71,354	$75,402
	Program Year 6	27	$75,966	$71,629	$74,044	$78,403
	Program Year 7	20	$79,269	$74,363	$76,367	$81,333
	Program Year 8	8	$81,787	$79,254	$82,491	$85,357
Other	Program Year 1	25	$70,924	$60,500	$65,920	$72,301
	Program Year 2	21	$68,401	$62,500	$67,600	$73,000
	Program Year 3	21	$71,411	$65,000	$70,304	$77,000
	Program Year 4	5	$81,507	$77,179	$85,000	$85,338
	Program Year 5	4				
	Program Year 6	2				
	Program Year 7	1				
	Program Year 8	1				

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TABLE 5 Resident/Fellow Unweighted Stipends for All Regions, by Institution Type

Survey of Resident/Fellow Stipends and Benefits Report 2024

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TABLE 6 Resident/Fellow Unweighted Stipends for Northeast Region, by Institution Type

Survey of Resident/Fellow Stipends and Benefits Report 2024

Table 6 displays unweighted stipends for sponsoring institutions in the Northeast region. Unweighted stipends were reported for 86 institutions for the first program year.

	Year of Training	Institution Count	Mean Unweighted Stipend	25th Percentile	Median	75th Percentile
Total	Program Year 1	86	$70,773	$65,781	$70,000	$75,771
	Program Year 2	85	$73,633	$68,590	$72,675	$77,541
	Program Year 3	85	$77,307	$72,003	$76,447	$82,500
	Program Year 4	67	$82,463	$77,047	$80,901	$87,083
	Program Year 5	61	$85,752	$79,747	$84,320	$89,500
	Program Year 6	54	$88,282	$82,467	$87,285	$92,256
	Program Year 7	49	$91,472	$84,796	$90,536	$98,000
	Program Year 8	39	$95,097	$88,310	$95,583	$101,192
General Hospital & Specialty Hospital	Program Year 1	42	$70,249	$65,775	$70,000	$76,378
	Program Year 2	42	$73,477	$68,835	$72,521	$79,387
	Program Year 3	42	$77,482	$72,349	$76,902	$84,005
	Program Year 4	33	$83,661	$78,000	$81,927	$88,702
	Program Year 5	30	$87,762	$82,177	$86,172	$94,628
	Program Year 6	25	$90,624	$85,376	$89,848	$98,675
	Program Year 7	20	$94,075	$88,133	$93,589	$103,341
	Program Year 8	16	$97,457	$92,060	$96,462	$106,148
Health System & Consortium	Program Year 1	23	$69,470	$65,625	$68,036	$71,423
	Program Year 2	23	$72,371	$68,196	$71,238	$73,673
	Program Year 3	23	$75,443	$71,157	$74,082	$76,930
	Program Year 4	18	$79,366	$73,348	$77,482	$80,988
	Program Year 5	17	$82,915	$77,101	$81,416	$84,844
	Program Year 6	15	$84,434	$79,145	$84,316	$88,097
	Program Year 7	15	$87,308	$82,245	$87,251	$91,845
	Program Year 8	10	$91,756	$88,647	$91,186	$96,059
Medical School	Program Year 1	9	$71,703	$66,628	$70,176	$71,923
	Program Year 2	9	$74,268	$68,988	$73,135	$74,799
	Program Year 3	9	$77,586	$72,495	$76,656	$77,792
	Program Year 4	9	$80,696	$75,418	$79,863	$80,904
	Program Year 5	9	$83,861	$78,906	$83,377	$84,139
	Program Year 6	9	$86,452	$81,954	$87,112	$87,505
	Program Year 7	9	$89,375	$84,376	$90,382	$91,005
	Program Year 8	9	$92,023	$86,903	$93,095	$94,646
Other	Program Year 1	12	$74,412	$68,693	$70,524	$76,831
	Program Year 2	11	$76,352	$73,093	$73,607	$78,997
	Program Year 3	11	$80,306	$77,256	$77,775	$84,986
	Program Year 4	7	$87,053	$81,990	$84,598	$89,179
	Program Year 5	5	$86,735	$84,481	$86,162	$88,598
	Program Year 6	5	$91,408	$88,133	$90,480	$92,383
	Program Year 7	5	$97,324	$92,574	$96,540	$99,123
	Program Year 8	4				

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TABLE 6 Resident/Fellow Unweighted Stipends for Northeast Region, by Institution Type

Survey of Resident/Fellow Stipends and Benefits Report 2024

6a Resident/Fellow Unweighted Stipends for Northeast Region, by Institution Type, for Institutions with a total amount of ACGME-accredited programs greater than or equal to the median

Table 6a displays unweighted stipends for sponsoring institutions in the Northeast Region that were at or above the 50th percentile for number of ACGME-accredited programs. The 50th percentile for General Hospitals & Specialty Hospitals is 5.0; for Health Systems & Consortiums is 12.0; for Medical Schools is 45.0; for Other institutions is 2.0; and, for Total respondents is 10.0. Unweighted stipends were reported for 45 institutions for the first program year.

	Year of Training	Institution Count	Mean Unweighted Stipend	25th Percentile	Median	75th Percentile
Total	Program Year 1	45	$72,123	$67,851	$70,660	$77,500
	Program Year 2	45	$75,189	$70,502	$73,473	$80,452
	Program Year 3	45	$78,864	$73,666	$77,412	$84,970
	Program Year 4	45	$82,207	$77,051	$80,904	$87,772
	Program Year 5	45	$85,536	$79,730	$84,320	$90,115
	Program Year 6	44	$88,219	$83,048	$87,482	$93,187
	Program Year 7	41	$91,688	$85,120	$90,536	$99,123
	Program Year 8	35	$95,854	$89,304	$95,583	$103,804
General Hospital & Specialty Hospital	Program Year 1	26	$72,533	$67,658	$72,413	$78,317
	Program Year 2	26	$75,982	$70,072	$75,356	$81,499
	Program Year 3	26	$80,443	$73,779	$78,938	$85,885
	Program Year 4	25	$84,724	$78,000	$83,323	$90,470
	Program Year 5	25	$88,290	$81,902	$86,569	$95,324
	Program Year 6	23	$90,849	$84,361	$89,848	$100,423
	Program Year 7	18	$94,269	$85,908	$93,589	$104,254
	Program Year 8	15	$97,513	$89,879	$96,308	$106,189
Health System & Consortium	Program Year 1	12	$70,359	$67,607	$68,997	$71,215
	Program Year 2	12	$73,061	$70,305	$71,493	$73,352
	Program Year 3	12	$75,793	$73,122	$74,163	$76,688
	Program Year 4	12	$79,055	$75,778	$77,482	$80,707
	Program Year 5	12	$82,168	$78,854	$80,775	$84,552
	Program Year 6	12	$85,227	$81,920	$84,324	$88,019
	Program Year 7	11	$87,901	$83,655	$87,251	$90,513
	Program Year 8	7	$94,328	$90,339	$91,832	$98,105
Medical School	Program Year 1	8	$72,619	$67,315	$70,558	$74,802
	Program Year 2	8	$75,247	$69,821	$73,368	$77,549
	Program Year 3	8	$78,852	$73,373	$76,933	$81,255
	Program Year 4	8	$82,242	$77,040	$80,124	$84,554
	Program Year 5	8	$85,402	$79,711	$83,714	$87,492
	Program Year 6	8	$88,317	$82,121	$87,285	$90,414
	Program Year 7	8	$91,605	$84,934	$90,459	$93,966
	Program Year 8	8	$94,584	$88,078	$93,186	$97,625
Other	Program Year 1	6	$71,601	$69,176	$70,524	$74,256
	Program Year 2	6	$75,032	$73,257	$73,540	$76,558
	Program Year 3	6	$78,720	$77,536	$77,691	$79,173
	Program Year 4	5	$83,121	$81,841	$82,139	$84,598
	Program Year 5	5	$86,735	$84,481	$86,162	$88,598
	Program Year 6	5	$91,408	$88,133	$90,480	$92,383
	Program Year 7	5	$97,324	$92,574	$96,540	$99,123
	Program Year 8	4				

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TABLE 6 Resident/Fellow Unweighted Stipends for Northeast Region, by Institution Type

Survey of Resident/Fellow Stipends and Benefits Report 2024

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6b Resident/Fellow Unweighted Stipends for Northeast Region, by Institution Type, for Institutions with a total amount of ACGME-accredited programs less than the median

Table 6b displays unweighted stipends for sponsoring institutions in the Northeast Region that were below the 50th percentile for number of ACGME-accredited programs. The 50th percentile for General Hospitals & Specialty Hospitals is 5.0; for Health Systems & Consortiums is 12.0; for Medical Schools is 45.0; for Other institutions is 2.0; and, for Total respondents is 10.0. Unweighted stipends were reported for 41 institutions for the first program year.

	Year of Training	Institution Count	Mean Unweighted Stipend	25th Percentile	Median	75th Percentile
Total	Program Year 1	41	$69,293	$64,796	$68,078	$71,965
	Program Year 2	40	$71,883	$67,892	$71,016	$75,225
	Program Year 3	40	$75,554	$70,619	$74,395	$79,018
	Program Year 4	22	$82,988	$77,141	$80,299	$86,349
	Program Year 5	16	$86,357	$80,043	$83,965	$88,910
	Program Year 6	10	$88,559	$82,234	$86,242	$90,918
	Program Year 7	8	$90,365	$84,560	$90,968	$93,736
	Program Year 8	4				
General Hospital & Specialty Hospital	Program Year 1	16	$66,536	$63,126	$67,891	$71,143
	Program Year 2	16	$69,405	$65,793	$71,370	$74,490
	Program Year 3	16	$72,670	$68,230	$74,507	$78,054
	Program Year 4	8	$80,340	$78,396	$80,702	$83,594
	Program Year 5	5	$85,124	$83,000	$85,424	$88,539
	Program Year 6	2				
	Program Year 7	2				
	Program Year 8	1				
Health System & Consortium	Program Year 1	11	$68,499	$64,262	$65,647	$72,087
	Program Year 2	11	$71,618	$67,892	$68,465	$74,894
	Program Year 3	11	$75,061	$70,607	$71,947	$78,729
	Program Year 4	6	$79,987	$73,064	$77,285	$84,384
	Program Year 5	5	$84,709	$77,101	$83,262	$88,910
	Program Year 6	3				
	Program Year 7	4				
	Program Year 8	3				
Medical School	Program Year 1	1				
	Program Year 2	1				
	Program Year 3	1				
	Program Year 4	1				
	Program Year 5	1				
	Program Year 6	1				
	Program Year 7	1				
	Program Year 8	1				
Other	Program Year 1	6	$77,223	$66,561	$74,849	$86,329
	Program Year 2	5	$77,936	$73,000	$76,762	$84,916
	Program Year 3	5	$82,210	$77,000	$84,886	$88,313
	Program Year 4	2				
	Program Year 5	0				
	Program Year 6	0				
	Program Year 7	0				
	Program Year 8	0				

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TABLE 6 Resident/Fellow Unweighted Stipends for Northeast Region, by Institution Type

Survey of Resident/Fellow Stipends and Benefits Report 2024

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6c Resident/Fellow Unweighted Stipends for Northeast Region, by Institution Type, for Institutions with a number of residents/fellows greater than or equal to the median

Table 6c displays unweighted stipends for sponsoring institutions in the Northeast Region that were at or above the 50th percentile for number of residents/fellows. The 50th percentile for General Hospitals & Specialty Hospitals is 82.0; for Health Systems & Consortiums is 186.0; for Medical Schools is 582.5; for Other institutions is 32.0; and, for Total respondents is 140.0. Unweighted stipends were reported for 44 institutions for the first program year.

	Year of Training	Institution Count	Mean Unweighted Stipend	25th Percentile	Median	75th Percentile
Total	Program Year 1	44	$72,526	$67,990	$70,800	$78,072
	Program Year 2	44	$75,728	$71,054	$73,537	$81,226
	Program Year 3	44	$79,654	$73,978	$77,462	$85,453
	Program Year 4	44	$82,995	$77,312	$81,016	$89,243
	Program Year 5	44	$86,381	$79,917	$84,387	$94,153
	Program Year 6	43	$89,141	$83,536	$87,505	$96,401
	Program Year 7	40	$92,236	$86,283	$90,771	$99,182
	Program Year 8	33	$96,003	$90,139	$95,583	$101,500
General Hospital & Specialty Hospital	Program Year 1	24	$72,993	$68,440	$73,795	$78,072
	Program Year 2	24	$76,280	$71,128	$76,458	$81,226
	Program Year 3	24	$80,838	$74,649	$79,891	$85,544
	Program Year 4	24	$84,250	$78,095	$83,511	$89,416
	Program Year 5	24	$87,813	$82,726	$87,100	$94,981
	Program Year 6	23	$91,206	$85,425	$90,082	$100,423
	Program Year 7	18	$94,817	$89,434	$94,388	$104,254
	Program Year 8	16	$97,457	$92,060	$96,462	$106,148
Health System & Consortium	Program Year 1	12	$70,359	$67,607	$68,997	$71,215
	Program Year 2	12	$73,061	$70,305	$71,493	$73,352
	Program Year 3	12	$75,793	$73,122	$74,163	$76,688
	Program Year 4	12	$79,055	$75,778	$77,482	$80,707
	Program Year 5	12	$82,168	$78,854	$80,775	$84,552
	Program Year 6	12	$85,227	$81,920	$84,324	$88,019
	Program Year 7	11	$87,901	$83,655	$87,251	$90,513
	Program Year 8	7	$94,328	$90,339	$91,832	$98,105
Medical School	Program Year 1	7	$73,474	$68,860	$70,940	$77,681
	Program Year 2	7	$76,141	$71,617	$73,601	$80,300
	Program Year 3	7	$79,760	$75,161	$77,210	$84,717
	Program Year 4	7	$83,217	$78,722	$80,384	$88,203
	Program Year 5	7	$86,330	$81,678	$84,050	$90,845
	Program Year 6	7	$89,226	$84,644	$87,458	$93,323
	Program Year 7	7	$92,638	$87,751	$90,536	$96,928
	Program Year 8	7	$95,681	$90,782	$93,276	$100,603
Other	Program Year 1	5	$74,783	$70,387	$70,660	$75,876
	Program Year 2	5	$78,643	$73,473	$73,607	$80,452
	Program Year 3	5	$82,866	$77,606	$77,775	$85,086
	Program Year 4	5	$86,203	$81,841	$82,139	$84,598
	Program Year 5	4				
	Program Year 6	4				
	Program Year 7	4				
	Program Year 8	3				

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TABLE 6 Resident/Fellow Unweighted Stipends for Northeast Region, by Institution Type

Survey of Resident/Fellow Stipends and Benefits Report 2024

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6d Resident/Fellow Unweighted Stipends for Northeast Region, by Institution Type, for Institutions with a number of residents/fellows less than the median

Table 6d displays unweighted stipends for sponsoring institutions in the Northeast Region that were below the 50th percentile for number of residents/fellows. The 50th percentile for General Hospitals & Specialty Hospitals is 82.0; for Health Systems & Consortiums is 186.0; for Medical Schools is 582.5; for Other institutions is 32.0; and, for Total respondents is 140.0. Unweighted stipends were reported for 39 institutions for the first program year.

	Year of Training	Institution Count	Mean Unweighted Stipend	25th Percentile	Median	75th Percentile
Total	Program Year 1	39	$68,925	$64,015	$67,704	$72,551
	Program Year 2	38	$71,332	$66,784	$70,766	$76,250
	Program Year 3	38	$74,742	$68,876	$74,045	$79,315
	Program Year 4	21	$81,614	$76,585	$80,226	$86,217
	Program Year 5	15	$84,332	$79,945	$83,538	$88,911
	Program Year 6	10	$85,228	$81,305	$86,242	$90,918
	Program Year 7	8	$88,487	$81,264	$90,968	$93,736
	Program Year 8	6	$90,113	$77,168	$91,880	$96,364
General Hospital & Specialty Hospital	Program Year 1	16	$66,257	$61,504	$66,852	$70,573
	Program Year 2	16	$69,439	$64,703	$70,370	$73,101
	Program Year 3	16	$72,670	$66,750	$73,816	$77,818
	Program Year 4	7	$82,778	$77,793	$79,477	$84,469
	Program Year 5	4				
	Program Year 6	1				
	Program Year 7	1				
	Program Year 8	0				
Health System & Consortium	Program Year 1	11	$68,499	$64,262	$65,647	$72,087
	Program Year 2	11	$71,618	$67,892	$68,465	$74,894
	Program Year 3	11	$75,061	$70,607	$71,947	$78,729
	Program Year 4	6	$79,987	$73,064	$77,285	$84,384
	Program Year 5	5	$84,709	$77,101	$83,262	$88,910
	Program Year 6	3				
	Program Year 7	4				
	Program Year 8	3				
Medical School	Program Year 1	2				
	Program Year 2	2				
	Program Year 3	2				
	Program Year 4	2				
	Program Year 5	2				
	Program Year 6	2				
	Program Year 7	2				
	Program Year 8	2				
Other	Program Year 1	6	$75,042	$66,561	$72,728	$78,637
	Program Year 2	5	$74,944	$73,000	$76,762	$77,541
	Program Year 3	5	$78,868	$77,000	$79,639	$84,886
	Program Year 4	2				
	Program Year 5	1				
	Program Year 6	1				
	Program Year 7	1				
	Program Year 8	1				

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TABLE 7 Resident/Fellow Unweighted Stipends for Southern Region, by Institution Type

Survey of Resident/Fellow Stipends and Benefits Report 2024

Table 7 displays unweighted stipends for sponsoring institutions in the Southern region. Unweighted stipends were reported for 100 institutions for the first program year.

	Year of Training	Institution Count	Mean Unweighted Stipend	25th Percentile	Median	75th Percentile
Total	Program Year 1	100	$62,198	$58,799	$61,141	$64,150
	Program Year 2	98	$63,743	$60,625	$63,553	$66,733
	Program Year 3	97	$65,944	$62,735	$66,056	$69,220
	Program Year 4	75	$69,233	$65,861	$69,299	$72,601
	Program Year 5	68	$73,409	$69,981	$72,941	$76,757
	Program Year 6	62	$75,893	$72,547	$75,611	$79,867
	Program Year 7	51	$79,882	$76,099	$79,918	$83,645
	Program Year 8	35	$84,205	$81,512	$83,979	$87,464
General Hospital & Specialty Hospital	Program Year 1	23	$61,922	$58,613	$61,093	$64,342
	Program Year 2	23	$64,429	$61,184	$64,375	$67,699
	Program Year 3	23	$66,692	$62,912	$66,306	$70,374
	Program Year 4	17	$70,390	$65,268	$71,716	$74,433
	Program Year 5	14	$74,609	$72,098	$75,904	$78,157
	Program Year 6	14	$77,286	$74,853	$78,726	$81,002
	Program Year 7	10	$82,774	$81,425	$83,893	$85,041
	Program Year 8	8	$86,078	$85,803	$87,364	$89,130
Health System & Consortium	Program Year 1	30	$61,366	$58,849	$60,851	$63,949
	Program Year 2	30	$63,525	$60,500	$62,951	$66,666
	Program Year 3	30	$65,771	$62,569	$65,293	$69,014
	Program Year 4	24	$69,262	$66,393	$68,455	$72,380
	Program Year 5	21	$72,661	$69,981	$72,238	$75,620
	Program Year 6	18	$75,973	$72,418	$74,979	$78,445
	Program Year 7	14	$81,600	$76,125	$79,282	$84,206
	Program Year 8	10	$85,199	$81,737	$84,996	$87,557
Medical School	Program Year 1	29	$61,867	$59,277	$61,935	$64,443
	Program Year 2	29	$64,129	$61,711	$64,151	$66,357
	Program Year 3	29	$66,293	$64,168	$66,221	$68,742
	Program Year 4	26	$69,067	$66,365	$69,299	$71,880
	Program Year 5	25	$72,318	$69,666	$72,370	$75,402
	Program Year 6	24	$74,910	$72,114	$75,476	$78,036
	Program Year 7	22	$77,680	$75,868	$78,521	$81,035
	Program Year 8	14	$82,179	$81,129	$83,587	$84,217
Other	Program Year 1	18	$64,473	$59,039	$60,500	$63,818
	Program Year 2	16	$62,467	$60,694	$61,627	$65,482
	Program Year 3	15	$64,467	$61,515	$65,000	$67,474
	Program Year 4	8	$67,226	$64,952	$68,303	$69,968
	Program Year 5	8	$76,684	$71,860	$72,798	$75,179
	Program Year 6	6	$76,341	$74,718	$75,430	$75,552
	Program Year 7	5	$78,982	$77,504	$78,104	$78,248
	Program Year 8	3				

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TABLE 7 Resident/Fellow Unweighted Stipends for Southern Region, by Institution Type

Survey of Resident/Fellow Stipends and Benefits Report 2024

7a Resident/Fellow Unweighted Stipends for Southern Region, by Institution Type, for Institutions with a total amount of ACGME-accredited programs greater than or equal to the median

Table 7a displays unweighted stipends for sponsoring institutions in the Southern Region that were at or above the 50th percentile for number of ACGME-accredited programs. The 50th percentile for General Hospitals & Specialty Hospitals is 5.0; for Health Systems & Consortiums is 12.0; for Medical Schools is 45.0; for Other institutions is 2.0; and, for Total respondents is 10.0. Unweighted stipends were reported for 53 institutions for the first program year.

	Year of Training	Institution Count	Mean Unweighted Stipend	25th Percentile	Median	75th Percentile
Total	Program Year 1	53	$62,688	$59,786	$63,162	$65,528
	Program Year 2	54	$65,067	$62,148	$65,276	$68,179
	Program Year 3	54	$67,402	$64,490	$67,318	$70,909
	Program Year 4	53	$70,406	$67,121	$70,284	$74,387
	Program Year 5	53	$73,499	$70,238	$72,955	$77,427
	Program Year 6	52	$76,356	$73,068	$75,721	$80,458
	Program Year 7	48	$80,100	$76,340	$80,056	$83,557
	Program Year 8	33	$84,486	$81,579	$83,979	$87,279
General Hospital & Specialty Hospital	Program Year 1	12	$64,898	$63,144	$64,342	$67,695
	Program Year 2	13	$67,302	$65,291	$67,174	$69,996
	Program Year 3	13	$69,733	$66,726	$69,712	$72,720
	Program Year 4	13	$72,795	$70,720	$74,386	$75,683
	Program Year 5	13	$75,579	$73,736	$77,082	$78,332
	Program Year 6	13	$78,385	$76,083	$79,790	$81,074
	Program Year 7	10	$82,774	$81,425	$83,893	$85,041
	Program Year 8	8	$86,078	$85,803	$87,364	$89,130
Health System & Consortium	Program Year 1	13	$62,255	$58,798	$60,508	$64,917
	Program Year 2	13	$64,564	$61,039	$62,600	$67,662
	Program Year 3	13	$66,990	$63,126	$65,100	$70,532
	Program Year 4	13	$70,180	$66,485	$68,200	$73,528
	Program Year 5	13	$73,224	$69,981	$71,000	$76,648
	Program Year 6	13	$76,101	$72,280	$73,900	$79,893
	Program Year 7	13	$81,729	$76,034	$78,645	$84,514
	Program Year 8	9	$85,531	$81,579	$86,819	$87,649
Medical School	Program Year 1	15	$62,537	$60,139	$61,174	$66,060
	Program Year 2	15	$64,904	$62,484	$63,686	$68,738
	Program Year 3	15	$67,121	$64,693	$66,221	$70,932
	Program Year 4	15	$69,973	$67,320	$69,299	$73,798
	Program Year 5	15	$73,239	$70,476	$72,941	$77,397
	Program Year 6	15	$75,943	$73,068	$75,721	$79,592
	Program Year 7	15	$79,451	$76,365	$80,193	$81,837
	Program Year 8	11	$83,282	$82,116	$83,759	$85,107
Other	Program Year 1	11	$61,560	$59,583	$61,108	$64,434
	Program Year 2	11	$63,429	$61,086	$63,840	$66,562
	Program Year 3	10	$64,922	$61,572	$65,735	$67,505
	Program Year 4	8	$67,226	$64,952	$68,303	$69,968
	Program Year 5	7	$72,496	$71,220	$72,641	$73,047
	Program Year 6	6	$76,341	$74,718	$75,430	$75,552
	Program Year 7	5	$78,982	$77,504	$78,104	$78,248
	Program Year 8	3				

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TABLE 7 Resident/Fellow Unweighted Stipends for Southern Region, by Institution Type

Survey of Resident/Fellow Stipends and Benefits Report 2024

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7b Resident/Fellow Unweighted Stipends for Southern Region, by Institution Type, for Institutions with a total amount of ACGME-accredited programs less than the median

Table 7b displays unweighted stipends for sponsoring institutions in the Southern Region that were below the 50th percentile for number of ACGME-accredited programs. The 50th percentile for General Hospitals & Specialty Hospitals is 5.0; for Health Systems & Consortiums is 12.0; for Medical Schools is 45.0; for Other institutions is 2.0; and, for Total respondents is 10.0. Unweighted stipends were reported for 46 institutions for the first program year.

	Year of Training	Institution Count	Mean Unweighted Stipend	25th Percentile	Median	75th Percentile
Total	Program Year 1	46	$61,731	$58,417	$60,154	$62,703
	Program Year 2	43	$62,176	$60,265	$62,000	$64,920
	Program Year 3	42	$64,171	$62,008	$64,240	$66,932
	Program Year 4	21	$66,514	$63,500	$66,975	$70,071
	Program Year 5	14	$73,536	$69,949	$72,619	$75,293
	Program Year 6	9	$73,938	$72,320	$74,500	$76,877
	Program Year 7	2				
	Program Year 8	1				
General Hospital & Specialty Hospital	Program Year 1	11	$58,676	$56,138	$58,427	$61,019
	Program Year 2	10	$60,695	$58,115	$61,054	$63,087
	Program Year 3	10	$62,737	$60,162	$62,565	$65,624
	Program Year 4	4				
	Program Year 5	1				
	Program Year 6	1				
	Program Year 7	0				
	Program Year 8	0				
Health System & Consortium	Program Year 1	17	$60,685	$59,000	$62,267	$63,796
	Program Year 2	17	$62,729	$60,500	$64,344	$66,110
	Program Year 3	17	$64,839	$62,500	$66,551	$68,394
	Program Year 4	11	$68,177	$65,050	$69,940	$72,259
	Program Year 5	8	$71,747	$70,848	$75,148	$75,457
	Program Year 6	5	$75,638	$75,647	$77,624	$78,296
	Program Year 7	1				
	Program Year 8	1				
Medical School	Program Year 1	13	$61,414	$59,277	$61,966	$63,725
	Program Year 2	13	$63,581	$61,711	$64,286	$65,687
	Program Year 3	13	$65,696	$64,168	$66,221	$68,394
	Program Year 4	10	$68,200	$66,648	$69,685	$70,975
	Program Year 5	9	$71,389	$69,666	$72,370	$74,205
	Program Year 6	8	$73,658	$72,114	$75,090	$77,406
	Program Year 7	6	$74,630	$75,554	$76,356	$78,028
	Program Year 8	2				
Other	Program Year 1	7	$69,050	$58,300	$59,155	$60,612
	Program Year 2	5	$60,350	$59,775	$61,224	$61,253
	Program Year 3	5	$63,558	$62,030	$63,353	$65,000
	Program Year 4	0				
	Program Year 5	1				
	Program Year 6	0				
	Program Year 7	0				
	Program Year 8	0				

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TABLE 7 Resident/Fellow Unweighted Stipends for Southern Region, by Institution Type

Survey of Resident/Fellow Stipends and Benefits Report 2024

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7c Resident/Fellow Unweighted Stipends for Southern Region, by Institution Type, for Institutions with a number of residents/fellows greater than or equal to the median

Table 7c displays unweighted stipends for sponsoring institutions in the Southern Region that were at or above the 50th percentile for number of residents/fellows. The 50th percentile for General Hospitals & Specialty Hospitals is 82.0; for Health Systems & Consortiums is 186.0; for Medical Schools is 582.5; for Other institutions is 32.0; and, for Total respondents is 140.0. Unweighted stipends were reported for 53 institutions for the first program year.

	Year of Training	Institution Count	Mean Unweighted Stipend	25th Percentile	Median	75th Percentile
Total	Program Year 1	53	$62,525	$59,000	$61,553	$65,528
	Program Year 2	54	$64,889	$61,173	$64,503	$68,179
	Program Year 3	54	$67,198	$63,344	$66,847	$70,794
	Program Year 4	54	$70,143	$66,611	$69,674	$74,387
	Program Year 5	52	$73,479	$70,025	$72,948	$77,478
	Program Year 6	51	$76,116	$72,642	$75,574	$80,458
	Program Year 7	48	$79,648	$75,995	$78,701	$83,557
	Program Year 8	33	$83,958	$81,444	$83,759	$87,279
General Hospital & Specialty Hospital	Program Year 1	10	$63,858	$60,417	$64,332	$66,789
	Program Year 2	11	$66,396	$62,821	$67,174	$69,483
	Program Year 3	11	$68,886	$65,196	$69,712	$72,207
	Program Year 4	11	$71,760	$67,870	$74,386	$75,058
	Program Year 5	10	$75,337	$72,345	$77,255	$78,157
	Program Year 6	10	$78,177	$75,248	$80,170	$81,002
	Program Year 7	8	$82,518	$82,569	$83,893	$84,580
	Program Year 8	7	$85,559	$85,455	$87,037	$88,375
Health System & Consortium	Program Year 1	14	$62,337	$58,565	$60,851	$65,339
	Program Year 2	14	$64,595	$60,555	$62,951	$67,522
	Program Year 3	14	$67,019	$62,862	$65,293	$69,926
	Program Year 4	14	$70,251	$66,611	$68,455	$72,457
	Program Year 5	13	$73,552	$69,981	$71,760	$75,620
	Program Year 6	13	$76,414	$72,830	$74,942	$78,494
	Program Year 7	12	$79,926	$75,914	$77,773	$83,522
	Program Year 8	9	$85,019	$81,579	$83,173	$87,649
Medical School	Program Year 1	15	$62,548	$60,139	$61,174	$66,060
	Program Year 2	15	$64,916	$62,484	$63,686	$68,738
	Program Year 3	15	$67,130	$64,693	$66,221	$70,932
	Program Year 4	15	$69,957	$67,320	$69,299	$73,798
	Program Year 5	15	$73,199	$70,476	$72,941	$77,397
	Program Year 6	15	$75,889	$73,068	$75,721	$79,592
	Program Year 7	15	$79,198	$76,365	$80,193	$81,837
	Program Year 8	11	$82,537	$82,116	$83,759	$85,107
Other	Program Year 1	9	$61,149	$59,166	$61,224	$64,009
	Program Year 2	9	$63,022	$61,171	$63,840	$65,774
	Program Year 3	9	$65,848	$63,288	$67,412	$69,408
	Program Year 4	7	$67,258	$64,302	$69,606	$70,193
	Program Year 5	6	$72,496	$70,615	$72,798	$73,092
	Program Year 6	5	$76,709	$75,373	$75,487	$75,574
	Program Year 7	5	$78,982	$77,504	$78,104	$78,248
	Program Year 8	3				

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TABLE 7 Resident/Fellow Unweighted Stipends for Southern Region, by Institution Type

Survey of Resident/Fellow Stipends and Benefits Report 2024

7d Resident/Fellow Unweighted Stipends for Southern Region, by Institution Type, for Institutions with a number of residents/fellows less than the median

Table 7d displays unweighted stipends for sponsoring institutions in the Southern Region that were below the 50th percentile for number of residents/fellows. The 50th percentile for General Hospitals & Specialty Hospitals is 82.0; for Health Systems & Consortiums is 186.0; for Medical Schools is 582.5; for Other institutions is 32.0; and, for Total respondents is 140.0. Unweighted stipends were reported for 45 institutions for the first program year.

	Year of Training	Institution Count	Mean Unweighted Stipend	25th Percentile	Median	75th Percentile
Total	Program Year 1	45	$61,854	$58,427	$60,944	$62,739
	Program Year 2	42	$62,323	$60,228	$62,157	$64,960
	Program Year 3	42	$64,521	$62,033	$65,000	$67,062
	Program Year 4	21	$66,892	$63,000	$67,000	$70,720
	Program Year 5	16	$73,181	$68,780	$72,619	$75,074
	Program Year 6	11	$74,860	$73,382	$75,647	$77,587
	Program Year 7	3				
	Program Year 8	2				
General Hospital & Specialty Hospital	Program Year 1	13	$60,434	$56,275	$60,944	$63,000
	Program Year 2	12	$62,626	$58,346	$62,755	$65,073
	Program Year 3	12	$64,680	$60,485	$65,146	$66,795
	Program Year 4	6	$67,879	$62,500	$67,360	$71,467
	Program Year 5	4				
	Program Year 6	4				
	Program Year 7	2				
	Program Year 8	1				
Health System & Consortium	Program Year 1	16	$60,516	$59,000	$61,325	$63,321
	Program Year 2	16	$62,588	$60,500	$63,372	$65,793
	Program Year 3	16	$64,680	$62,375	$65,521	$68,273
	Program Year 4	10	$67,877	$64,275	$68,531	$72,117
	Program Year 5	8	$71,214	$68,826	$73,851	$75,487
	Program Year 6	5	$74,826	$72,162	$75,647	$78,296
	Program Year 7	2				
	Program Year 8	1				
Medical School	Program Year 1	14	$61,136	$58,823	$61,951	$63,584
	Program Year 2	14	$63,286	$61,313	$64,219	$65,557
	Program Year 3	14	$65,396	$63,676	$66,120	$68,101
	Program Year 4	11	$67,854	$65,269	$69,299	$70,745
	Program Year 5	10	$70,995	$69,266	$71,573	$73,889
	Program Year 6	9	$73,276	$71,097	$74,459	$77,272
	Program Year 7	7	$74,427	$74,283	$76,164	$77,535
	Program Year 8	3				
Other	Program Year 1	7	$69,661	$59,078	$60,000	$60,500
	Program Year 2	5	$61,406	$61,000	$61,253	$62,000
	Program Year 3	5	$63,277	$62,030	$63,353	$65,000
	Program Year 4	1				
	Program Year 5	2				
	Program Year 6	1				
	Program Year 7	0				
	Program Year 8	0				

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TABLE 8 Resident/Fellow Unweighted Stipends for Central Region, by Institution Type

Survey of Resident/Fellow Stipends and Benefits Report 2024

Table 8 displays unweighted stipends for sponsoring institutions in the Central region. Unweighted stipends were reported for 77 institutions for the first program year.

	Year of Training	Institution Count	Mean Unweighted Stipend	25th Percentile	Median	75th Percentile
Total	Program Year 1	77	$64,572	$61,836	$64,020	$66,690
	Program Year 2	79	$66,339	$63,595	$66,515	$69,126
	Program Year 3	79	$68,618	$66,298	$68,437	$71,321
	Program Year 4	68	$71,604	$68,505	$71,378	$74,136
	Program Year 5	60	$74,400	$70,631	$74,381	$77,781
	Program Year 6	54	$77,442	$73,623	$77,461	$81,026
	Program Year 7	46	$80,680	$76,901	$80,833	$84,144
	Program Year 8	30	$86,664	$83,334	$85,749	$90,154
General Hospital & Specialty Hospital	Program Year 1	23	$64,038	$61,893	$64,000	$66,254
	Program Year 2	25	$66,332	$63,484	$66,412	$69,134
	Program Year 3	25	$68,687	$66,298	$68,829	$71,853
	Program Year 4	18	$72,292	$68,629	$73,151	$75,082
	Program Year 5	15	$74,565	$70,636	$75,307	$77,876
	Program Year 6	12	$78,211	$76,129	$78,266	$81,152
	Program Year 7	10	$80,741	$76,750	$81,312	$83,867
	Program Year 8	4				
Health System & Consortium	Program Year 1	28	$64,604	$62,444	$64,861	$66,502
	Program Year 2	28	$66,809	$64,391	$66,857	$68,609
	Program Year 3	28	$69,033	$66,842	$68,824	$70,766
	Program Year 4	26	$71,629	$69,629	$71,160	$73,324
	Program Year 5	22	$74,914	$73,496	$74,381	$76,554
	Program Year 6	21	$77,438	$75,354	$77,184	$79,414
	Program Year 7	18	$80,875	$77,814	$80,707	$83,565
	Program Year 8	14	$85,243	$82,236	$83,922	$88,038
Medical School	Program Year 1	18	$63,449	$60,885	$63,302	$64,821
	Program Year 2	18	$65,559	$62,614	$65,092	$67,378
	Program Year 3	18	$67,741	$64,461	$67,201	$69,969
	Program Year 4	18	$70,535	$66,964	$70,251	$72,940
	Program Year 5	17	$73,143	$69,500	$73,000	$76,000
	Program Year 6	16	$76,089	$72,510	$75,266	$79,085
	Program Year 7	13	$79,430	$75,600	$78,036	$82,468
	Program Year 8	8	$85,874	$83,708	$85,840	$88,431
Other	Program Year 1	8	$68,522	$58,374	$66,897	$70,529
	Program Year 2	8	$66,473	$60,235	$68,541	$70,005
	Program Year 3	8	$68,927	$62,040	$70,889	$73,188
	Program Year 4	6	$72,643	$66,440	$74,447	$76,108
	Program Year 5	6	$75,660	$69,257	$77,536	$79,558
	Program Year 6	5	$79,941	$79,306	$81,100	$82,680
	Program Year 7	5	$83,105	$82,351	$84,800	$87,310
	Program Year 8	4				

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TABLE 8 Resident/Fellow Unweighted Stipends for Central Region, by Institution Type

Survey of Resident/Fellow Stipends and Benefits Report 2024

8a Resident/Fellow Unweighted Stipends for Central Region, by Institution Type, for Institutions with a total amount of ACGME-accredited programs greater than or equal to the median

Table 8a displays unweighted stipends for sponsoring institutions in the Central Region that were at or above the 50th percentile for number of ACGME-accredited programs. The 50th percentile for General Hospitals & Specialty Hospitals is 5.0; for Health Systems & Consortiums is 12.0; for Medical Schools is 45.0; for Other institutions is 2.0; and, for Total respondents is 10.0. Unweighted stipends were reported for 44 institutions for the first program year.

	Year of Training	Institution Count	Mean Unweighted Stipend	25th Percentile	Median	75th Percentile
Total	Program Year 1	44	$64,753	$62,593	$65,085	$67,030
	Program Year 2	44	$67,078	$64,309	$67,255	$69,935
	Program Year 3	44	$69,388	$66,344	$69,496	$72,785
	Program Year 4	44	$72,069	$69,257	$71,633	$75,418
	Program Year 5	44	$75,058	$72,727	$74,619	$78,249
	Program Year 6	42	$77,773	$75,061	$77,747	$81,026
	Program Year 7	38	$81,099	$77,711	$81,312	$84,649
	Program Year 8	28	$86,609	$83,107	$85,733	$90,503
General Hospital & Specialty Hospital	Program Year 1	12	$64,199	$61,950	$64,454	$66,315
	Program Year 2	12	$66,366	$63,484	$66,986	$68,869
	Program Year 3	12	$68,807	$66,298	$68,863	$71,418
	Program Year 4	12	$71,507	$68,505	$72,064	$74,434
	Program Year 5	12	$74,303	$70,636	$75,180	$77,781
	Program Year 6	9	$78,223	$77,172	$78,692	$80,805
	Program Year 7	7	$80,566	$77,832	$80,958	$83,538
	Program Year 8	2				
Health System & Consortium	Program Year 1	19	$64,740	$63,368	$65,100	$66,565
	Program Year 2	19	$67,101	$65,465	$67,177	$68,778
	Program Year 3	19	$69,352	$67,981	$69,492	$70,905
	Program Year 4	19	$71,943	$70,936	$71,465	$73,365
	Program Year 5	19	$75,043	$73,549	$74,437	$76,171
	Program Year 6	18	$77,636	$75,566	$77,184	$79,031
	Program Year 7	17	$80,692	$77,615	$80,707	$82,303
	Program Year 8	14	$85,243	$82,236	$83,922	$88,038
Medical School	Program Year 1	6	$66,788	$65,112	$66,705	$68,460
	Program Year 2	6	$69,453	$67,530	$69,124	$71,814
	Program Year 3	6	$71,966	$69,971	$71,647	$74,544
	Program Year 4	6	$75,087	$72,894	$74,514	$78,104
	Program Year 5	6	$78,170	$75,575	$77,599	$81,683
	Program Year 6	6	$80,937	$78,137	$80,263	$84,662
	Program Year 7	6	$83,920	$81,866	$83,014	$87,373
	Program Year 8	6	$87,059	$85,794	$86,812	$89,908
Other	Program Year 1	6	$65,446	$60,697	$66,897	$69,025
	Program Year 2	6	$67,830	$62,855	$69,591	$70,615
	Program Year 3	6	$70,352	$64,659	$72,087	$74,163
	Program Year 4	6	$72,643	$66,440	$74,447	$76,108
	Program Year 5	6	$75,660	$69,257	$77,536	$79,558
	Program Year 6	5	$79,941	$79,306	$81,100	$82,680
	Program Year 7	5	$83,105	$82,351	$84,800	$87,310
	Program Year 8	4				

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TABLE 8 Resident/Fellow Unweighted Stipends for Central Region, by Institution Type

Survey of Resident/Fellow Stipends and Benefits Report 2024

8b Resident/Fellow Unweighted Stipends for Central Region, by Institution Type, for Institutions with a total amount of ACGME-accredited programs less than the median

Table 8b displays unweighted stipends for sponsoring institutions in the Central Region that were below the 50th percentile for number of ACGME-accredited programs. The 50th percentile for General Hospitals & Specialty Hospitals is 5.0; for Health Systems & Consortiums is 12.0; for Medical Schools is 45.0; for Other institutions is 2.0; and, for Total respondents is 10.0. Unweighted stipends were reported for 33 institutions for the first program year.

	Year of Training	Institution Count	Mean Unweighted Stipend	25th Percentile	Median	75th Percentile
Total	Program Year 1	33	$64,331	$61,711	$63,290	$65,094
	Program Year 2	35	$65,411	$63,484	$64,860	$67,580
	Program Year 3	35	$67,651	$66,298	$67,000	$70,280
	Program Year 4	24	$70,752	$68,505	$70,727	$73,571
	Program Year 5	16	$72,588	$70,466	$70,818	$75,308
	Program Year 6	12	$76,281	$72,619	$76,788	$78,699
	Program Year 7	8	$78,688	$74,937	$77,832	$82,245
	Program Year 8	2				
General Hospital & Specialty Hospital	Program Year 1	11	$63,863	$60,918	$63,290	$65,892
	Program Year 2	13	$66,300	$64,188	$65,500	$69,134
	Program Year 3	13	$68,576	$66,412	$67,019	$71,853
	Program Year 4	6	$73,861	$73,079	$74,113	$75,736
	Program Year 5	3				
	Program Year 6	3				
	Program Year 7	3				
	Program Year 8	2				
Health System & Consortium	Program Year 1	9	$64,316	$61,950	$64,000	$65,188
	Program Year 2	9	$66,194	$64,189	$66,000	$66,764
	Program Year 3	9	$68,359	$66,435	$68,000	$68,437
	Program Year 4	7	$70,776	$68,463	$70,490	$72,190
	Program Year 5	3				
	Program Year 6	3				
	Program Year 7	1				
	Program Year 8	0				
Medical School	Program Year 1	12	$61,780	$60,561	$62,018	$63,302
	Program Year 2	12	$63,612	$62,046	$63,968	$64,796
	Program Year 3	12	$65,628	$63,975	$65,771	$66,851
	Program Year 4	12	$68,259	$66,409	$68,166	$70,280
	Program Year 5	11	$70,401	$68,442	$70,096	$71,808
	Program Year 6	10	$73,180	$71,067	$72,661	$74,568
	Program Year 7	7	$75,581	$73,650	$75,600	$77,093
	Program Year 8	2				
Other	Program Year 1	2				
	Program Year 2	2				
	Program Year 3	2				
	Program Year 4	0				
	Program Year 5	0				
	Program Year 6	0				
	Program Year 7	0				
	Program Year 8	0				

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TABLE 8 Resident/Fellow Unweighted Stipends for Central Region, by Institution Type

Survey of Resident/Fellow Stipends and Benefits Report 2024

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8c Resident/Fellow Unweighted Stipends for Central Region, by Institution Type, for Institutions with a number of residents/fellows greater than or equal to the median

Table 8c displays unweighted stipends for sponsoring institutions in the Central Region that were at or above the 50th percentile for number of residents/fellows. The 50th percentile for General Hospitals & Specialty Hospitals is 82.0; for Health Systems & Consortiums is 186.0; for Medical Schools is 582.5; for Other institutions is 32.0; and, for Total respondents is 140.0. Unweighted stipends were reported for 46 institutions for the first program year.

	Year of Training	Institution Count	Mean Unweighted Stipend	25th Percentile	Median	75th Percentile
Total	Program Year 1	46	$64,513	$62,099	$64,899	$66,949
	Program Year 2	46	$66,812	$64,241	$67,177	$69,645
	Program Year 3	46	$69,136	$65,980	$69,492	$72,394
	Program Year 4	46	$71,811	$68,629	$71,629	$75,065
	Program Year 5	45	$74,877	$71,907	$74,800	$78,065
	Program Year 6	42	$77,833	$75,061	$77,797	$81,026
	Program Year 7	37	$81,193	$78,000	$81,665	$84,800
	Program Year 8	28	$86,609	$83,107	$85,733	$90,503
General Hospital & Specialty Hospital	Program Year 1	10	$64,156	$61,950	$64,548	$66,472
	Program Year 2	10	$66,605	$63,484	$67,045	$70,149
	Program Year 3	10	$69,125	$66,298	$69,648	$72,587
	Program Year 4	10	$71,847	$68,505	$72,668	$75,065
	Program Year 5	10	$74,727	$70,636	$75,532	$77,970
	Program Year 6	8	$78,553	$76,515	$79,428	$81,549
	Program Year 7	7	$81,535	$78,313	$82,880	$85,488
	Program Year 8	3				
Health System & Consortium	Program Year 1	17	$65,038	$64,126	$65,188	$66,690
	Program Year 2	17	$67,451	$66,515	$67,332	$69,117
	Program Year 3	17	$69,733	$68,405	$69,492	$71,181
	Program Year 4	17	$72,252	$70,958	$71,465	$73,681
	Program Year 5	17	$75,235	$73,729	$74,437	$76,937
	Program Year 6	17	$77,770	$76,200	$77,184	$79,414
	Program Year 7	16	$80,884	$78,204	$80,707	$83,369
	Program Year 8	14	$85,243	$82,236	$83,922	$88,038
Medical School	Program Year 1	6	$66,788	$65,112	$66,705	$68,460
	Program Year 2	6	$69,453	$67,530	$69,124	$71,814
	Program Year 3	6	$71,966	$69,971	$71,647	$74,544
	Program Year 4	6	$75,087	$72,894	$74,514	$78,104
	Program Year 5	6	$78,170	$75,575	$77,599	$81,683
	Program Year 6	6	$80,937	$78,137	$80,263	$84,662
	Program Year 7	6	$83,920	$81,866	$83,014	$87,373
	Program Year 8	6	$87,059	$85,794	$86,812	$89,908
Other	Program Year 1	6	$65,446	$60,697	$66,897	$69,025
	Program Year 2	6	$67,830	$62,855	$69,591	$70,615
	Program Year 3	6	$70,352	$64,659	$72,087	$74,163
	Program Year 4	6	$72,643	$66,440	$74,447	$76,108
	Program Year 5	6	$75,660	$69,257	$77,536	$79,558
	Program Year 6	5	$79,941	$79,306	$81,100	$82,680
	Program Year 7	5	$83,105	$82,351	$84,800	$87,310
	Program Year 8	4				

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TABLE 8 Resident/Fellow Unweighted Stipends for Central Region, by Institution Type

Survey of Resident/Fellow Stipends and Benefits Report 2024

8d Resident/Fellow Unweighted Stipends for Central Region, by Institution Type, for Institutions with a number of residents/fellows less than the median

Table 8d displays unweighted stipends for sponsoring institutions in the Central Region that were below the 50th percentile for number of residents/fellows. The 50th percentile for General Hospitals & Specialty Hospitals is 82.0; for Health Systems & Consortiums is 186.0; for Medical Schools is 582.5; for Other institutions is 32.0; and, for Total respondents is 140.0. Unweighted stipends were reported for 31 institutions for the first program year.

	Year of Training	Institution Count	Mean Unweighted Stipend	25th Percentile	Median	75th Percentile
Total	Program Year 1	31	$64,659	$61,774	$63,654	$65,141
	Program Year 2	33	$65,680	$63,484	$65,500	$67,600
	Program Year 3	33	$67,897	$66,298	$67,019	$70,304
	Program Year 4	22	$71,172	$68,505	$70,996	$73,881
	Program Year 5	15	$72,968	$70,626	$71,000	$75,309
	Program Year 6	12	$76,074	$72,619	$75,879	$78,622
	Program Year 7	9	$78,569	$75,000	$77,615	$81,665
	Program Year 8	2				
General Hospital & Specialty Hospital	Program Year 1	13	$63,947	$61,836	$63,290	$65,094
	Program Year 2	15	$66,149	$63,836	$65,500	$68,704
	Program Year 3	15	$68,395	$66,355	$67,019	$71,537
	Program Year 4	8	$72,848	$71,501	$73,398	$74,568
	Program Year 5	5	$74,241	$71,000	$75,307	$75,311
	Program Year 6	4				
	Program Year 7	3				
	Program Year 8	1				
Health System & Consortium	Program Year 1	11	$63,932	$61,894	$64,000	$65,094
	Program Year 2	11	$65,819	$64,030	$66,000	$66,857
	Program Year 3	11	$67,951	$66,367	$68,000	$68,698
	Program Year 4	9	$70,452	$68,420	$70,490	$71,028
	Program Year 5	5	$73,823	$73,159	$73,656	$73,729
	Program Year 6	4				
	Program Year 7	2				
	Program Year 8	0				
Medical School	Program Year 1	12	$61,780	$60,561	$62,018	$63,302
	Program Year 2	12	$63,612	$62,046	$63,968	$64,796
	Program Year 3	12	$65,628	$63,975	$65,771	$66,851
	Program Year 4	12	$68,259	$66,409	$68,166	$70,280
	Program Year 5	11	$70,401	$68,442	$70,096	$71,808
	Program Year 6	10	$73,180	$71,067	$72,661	$74,568
	Program Year 7	7	$75,581	$73,650	$75,600	$77,093
	Program Year 8	2				
Other	Program Year 1	2				
	Program Year 2	2				
	Program Year 3	2				
	Program Year 4	0				
	Program Year 5	0				
	Program Year 6	0				
	Program Year 7	0				
	Program Year 8	0				

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TABLE 9 Resident/Fellow Unweighted Stipends for Western Region, by Institution Type

Survey of Resident/Fellow Stipends and Benefits Report 2024

Table 9 displays unweighted stipends for sponsoring institutions in the Western region. Unweighted stipends were reported for 69 institutions for the first program year.

	Year of Training	Institution Count	Mean Unweighted Stipend	25th Percentile	Median	75th Percentile
Total	Program Year 1	69	$71,622	$64,858	$71,064	$74,009
	Program Year 2	69	$74,331	$67,415	$73,055	$77,142
	Program Year 3	69	$77,858	$70,367	$76,459	$80,869
	Program Year 4	50	$82,538	$74,055	$80,607	$87,002
	Program Year 5	44	$86,524	$77,807	$84,637	$93,869
	Program Year 6	32	$90,204	$81,153	$90,367	$97,390
	Program Year 7	26	$97,002	$86,811	$97,105	$103,586
	Program Year 8	18	$99,596	$88,823	$98,173	$108,367
General Hospital & Specialty Hospital	Program Year 1	26	$71,665	$65,097	$71,630	$74,539
	Program Year 2	27	$74,657	$69,531	$73,500	$77,436
	Program Year 3	27	$78,393	$73,087	$77,000	$82,334
	Program Year 4	19	$81,173	$75,411	$80,543	$85,393
	Program Year 5	17	$85,634	$79,475	$86,000	$90,709
	Program Year 6	11	$87,057	$80,909	$90,067	$92,426
	Program Year 7	8	$93,752	$88,613	$94,650	$97,576
	Program Year 8	7	$97,443	$91,892	$96,948	$101,289
Health System & Consortium	Program Year 1	12	$73,100	$69,274	$71,834	$76,586
	Program Year 2	12	$75,706	$71,428	$73,494	$79,326
	Program Year 3	12	$79,181	$73,720	$76,848	$83,085
	Program Year 4	10	$83,990	$77,842	$83,399	$87,998
	Program Year 5	8	$87,137	$79,112	$82,733	$94,312
	Program Year 6	5	$90,542	$80,689	$81,706	$97,317
	Program Year 7	4				
	Program Year 8	3				
Medical School	Program Year 1	13	$72,151	$64,061	$72,301	$75,530
	Program Year 2	13	$74,924	$66,910	$74,209	$77,378
	Program Year 3	13	$77,938	$70,367	$78,064	$80,869
	Program Year 4	13	$81,810	$73,903	$84,123	$87,002
	Program Year 5	13	$85,508	$77,807	$89,049	$90,672
	Program Year 6	13	$89,259	$81,307	$93,567	$97,609
	Program Year 7	11	$96,134	$86,610	$98,513	$103,101
	Program Year 8	6	$101,851	$91,317	$102,794	$111,018
Other	Program Year 1	18	$70,192	$64,894	$67,046	$71,406
	Program Year 2	17	$72,388	$67,000	$69,010	$72,661
	Program Year 3	17	$76,015	$70,000	$72,485	$75,500
	Program Year 4	8	$85,147	$74,894	$77,832	$87,367
	Program Year 5	6	$90,432	$79,979	$80,928	$93,884
	Program Year 6	3				
	Program Year 7	3				
	Program Year 8	2				

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TABLE 9 Resident/Fellow Unweighted Stipends for Western Region, by Institution Type

Survey of Resident/Fellow Stipends and Benefits Report 2024

9a Resident/Fellow Unweighted Stipends for Western Region, by Institution Type, for Institutions with a total amount of ACGME-accredited programs greater than or equal to the median

Table 9a displays unweighted stipends for sponsoring institutions in the Western Region that were at or above the 50th percentile for number of ACGME-accredited programs. The 50th percentile for General Hospitals & Specialty Hospitals is 5.0; for Health Systems & Consortiums is 12.0; for Medical Schools is 45.0; for Other institutions is 2.0; and, for Total respondents is 10.0. Unweighted stipends were reported for 26 institutions for the first program year.

	Year of Training	Institution Count	Mean Unweighted Stipend	25th Percentile	Median	75th Percentile
Total	Program Year 1	26	$74,905	$64,829	$73,653	$81,635
	Program Year 2	26	$77,572	$67,654	$76,493	$84,211
	Program Year 3	26	$81,307	$70,897	$79,745	$87,787
	Program Year 4	26	$85,137	$74,331	$84,396	$91,435
	Program Year 5	26	$88,690	$78,224	$88,225	$95,397
	Program Year 6	24	$92,418	$81,307	$93,330	$98,972
	Program Year 7	21	$98,380	$86,980	$98,513	$104,350
	Program Year 8	15	$100,934	$89,922	$99,397	$109,631
General Hospital & Specialty Hospital	Program Year 1	10	$74,044	$70,285	$71,630	$77,355
	Program Year 2	11	$76,033	$72,355	$73,500	$79,196
	Program Year 3	11	$79,329	$76,033	$76,707	$82,306
	Program Year 4	10	$81,294	$78,692	$80,772	$83,424
	Program Year 5	10	$84,866	$80,289	$85,285	$87,347
	Program Year 6	8	$89,446	$85,705	$90,367	$93,339
	Program Year 7	7	$95,020	$91,843	$95,471	$97,932
	Program Year 8	6	$98,913	$95,473	$99,074	$101,334
Health System & Consortium	Program Year 1	4				
	Program Year 2	4				
	Program Year 3	4				
	Program Year 4	4				
	Program Year 5	4				
	Program Year 6	3				
	Program Year 7	3				
	Program Year 8	2				
Medical School	Program Year 1	7	$76,452	$68,679	$74,009	$84,544
	Program Year 2	7	$79,577	$71,678	$77,378	$88,537
	Program Year 3	7	$82,834	$75,580	$80,869	$91,591
	Program Year 4	7	$86,496	$79,311	$87,002	$94,779
	Program Year 5	7	$90,069	$83,428	$90,473	$98,215
	Program Year 6	7	$93,437	$87,437	$93,622	$101,465
	Program Year 7	7	$96,864	$90,932	$98,513	$104,478
	Program Year 8	5	$104,496	$99,397	$106,190	$112,627
Other	Program Year 1	10	$71,672	$64,894	$66,099	$69,759
	Program Year 2	10	$73,772	$67,104	$68,714	$71,996
	Program Year 3	10	$77,465	$70,044	$71,307	$74,746
	Program Year 4	6	$86,500	$73,453	$77,050	$90,472
	Program Year 5	5	$92,511	$79,960	$81,822	$97,904
	Program Year 6	3				
	Program Year 7	3				
	Program Year 8	2				

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TABLE 9 Resident/Fellow Unweighted Stipends for Western Region, by Institution Type

Survey of Resident/Fellow Stipends and Benefits Report 2024

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9b Resident/Fellow Unweighted Stipends for Western Region, by Institution Type, for Institutions with a total amount of ACGME-accredited programs less than the median

Table 9b displays unweighted stipends for sponsoring institutions in the Western Region that were below the 50th percentile for number of ACGME-accredited programs. The 50th percentile for General Hospitals & Specialty Hospitals is 5.0; for Health Systems & Consortiums is 12.0; for Medical Schools is 45.0; for Other institutions is 2.0; and, for Total respondents is 10.0. Unweighted stipends were reported for 42 institutions for the first program year.

	Year of Training	Institution Count	Mean Unweighted Stipend	25th Percentile	Median	75th Percentile
Total	Program Year 1	42	$69,580	$64,894	$69,455	$72,166
	Program Year 2	42	$72,332	$67,701	$71,885	$74,703
	Program Year 3	42	$75,744	$70,429	$74,963	$78,852
	Program Year 4	24	$79,722	$74,359	$79,670	$84,862
	Program Year 5	18	$83,397	$78,364	$82,132	$87,671
	Program Year 6	8	$83,561	$79,028	$83,406	$90,490
	Program Year 7	5	$91,211	$85,515	$88,347	$95,471
	Program Year 8	3				
General Hospital & Specialty Hospital	Program Year 1	15	$70,057	$62,576	$69,805	$72,442
	Program Year 2	15	$73,691	$67,969	$72,290	$76,895
	Program Year 3	15	$77,799	$71,496	$77,982	$82,334
	Program Year 4	9	$81,038	$73,903	$80,139	$85,969
	Program Year 5	7	$86,731	$79,079	$88,228	$94,641
	Program Year 6	3				
	Program Year 7	1				
	Program Year 8	1				
Health System & Consortium	Program Year 1	8	$70,517	$67,754	$69,844	$72,060
	Program Year 2	8	$72,944	$69,589	$72,586	$74,180
	Program Year 3	8	$76,040	$72,602	$75,415	$77,848
	Program Year 4	6	$80,009	$75,514	$79,597	$84,762
	Program Year 5	4				
	Program Year 6	2				
	Program Year 7	1				
	Program Year 8	1				
Medical School	Program Year 1	6	$67,133	$62,870	$67,911	$72,166
	Program Year 2	6	$69,496	$64,950	$70,111	$73,985
	Program Year 3	6	$72,225	$67,381	$73,280	$77,596
	Program Year 4	6	$76,344	$70,341	$76,552	$82,892
	Program Year 5	6	$80,187	$72,967	$80,124	$88,125
	Program Year 6	6	$84,384	$75,860	$83,406	$93,465
	Program Year 7	4				
	Program Year 8	1				
Other	Program Year 1	8	$68,342	$65,440	$68,371	$71,895
	Program Year 2	7	$70,411	$68,005	$70,160	$72,989
	Program Year 3	7	$73,944	$71,526	$74,160	$76,245
	Program Year 4	2				
	Program Year 5	1				
	Program Year 6	0				
	Program Year 7	0				
	Program Year 8	0				

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TABLE 9 Resident/Fellow Unweighted Stipends for Western Region, by Institution Type

Survey of Resident/Fellow Stipends and Benefits Report 2024

9c Resident/Fellow Unweighted Stipends for Western Region, by Institution Type, for Institutions with a number of residents/fellows greater than or equal to the median

Table 9c displays unweighted stipends for sponsoring institutions in the Western Region that were at or above the 50th percentile for number of residents/fellows. The 50th percentile for General Hospitals & Specialty Hospitals is 82.0; for Health Systems & Consortiums is 186.0; for Medical Schools is 582.5; for Other institutions is 32.0; and, for Total respondents is 140.0. Unweighted stipends were reported for 23 institutions for the first program year.

	Year of Training	Institution Count	Mean Unweighted Stipend	25th Percentile	Median	75th Percentile
Total	Program Year 1	23	$74,747	$70,185	$74,009	$80,444
	Program Year 2	23	$77,521	$72,267	$76,540	$83,103
	Program Year 3	23	$80,863	$75,546	$80,793	$87,202
	Program Year 4	23	$84,603	$77,958	$84,718	$91,310
	Program Year 5	23	$88,336	$79,821	$89,049	$95,264
	Program Year 6	20	$92,408	$82,509	$93,595	$98,972
	Program Year 7	19	$97,328	$88,419	$98,513	$104,257
	Program Year 8	14	$101,801	$92,026	$100,388	$109,900
General Hospital & Specialty Hospital	Program Year 1	12	$74,056	$70,804	$72,109	$76,349
	Program Year 2	12	$76,748	$72,595	$74,277	$81,197
	Program Year 3	12	$80,174	$76,246	$78,511	$84,425
	Program Year 4	11	$82,554	$79,084	$81,476	$85,974
	Program Year 5	11	$86,159	$81,103	$87,185	$89,469
	Program Year 6	8	$89,657	$85,705	$91,213	$93,339
	Program Year 7	6	$94,945	$90,850	$95,524	$98,289
	Program Year 8	5	$98,456	$94,981	$96,948	$101,379
Health System & Consortium	Program Year 1	4				
	Program Year 2	4				
	Program Year 3	4				
	Program Year 4	4				
	Program Year 5	4				
	Program Year 6	3				
	Program Year 7	3				
	Program Year 8	2				
Medical School	Program Year 1	7	$76,452	$68,679	$74,009	$84,544
	Program Year 2	7	$79,577	$71,678	$77,378	$88,537
	Program Year 3	7	$82,834	$75,580	$80,869	$91,591
	Program Year 4	7	$86,496	$79,311	$87,002	$94,779
	Program Year 5	7	$90,069	$83,428	$90,473	$98,215
	Program Year 6	7	$93,437	$87,437	$93,622	$101,465
	Program Year 7	7	$96,864	$90,932	$98,513	$104,478
	Program Year 8	5	$104,496	$99,397	$106,190	$112,627
Other	Program Year 1	7	$68,031	$64,149	$65,637	$68,453
	Program Year 2	7	$70,459	$66,728	$68,557	$70,766
	Program Year 3	7	$73,067	$69,079	$70,614	$73,993
	Program Year 4	5	$78,209	$72,732	$75,615	$78,485
	Program Year 5	4				
	Program Year 6	2				
	Program Year 7	2				
	Program Year 8	2				

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TABLE 9 Resident/Fellow Unweighted Stipends for Western Region, by Institution Type

Survey of Resident/Fellow Stipends and Benefits Report 2024

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9d Resident/Fellow Unweighted Stipends for Western Region, by Institution Type, for Institutions with a number of residents/fellows less than the median

Table 9d displays unweighted stipends for sponsoring institutions in the Western Region that were below the 50th percentile for number of residents/fellows. The 50th percentile for General Hospitals & Specialty Hospitals is 82.0; for Health Systems & Consortiums is 186.0; for Medical Schools is 582.5; for Other institutions is 32.0; and, for Total respondents is 140.0. Unweighted stipends were reported for 43 institutions for the first program year.

	Year of Training	Institution Count	Mean Unweighted Stipend	25th Percentile	Median	75th Percentile
Total	Program Year 1	43	$68,732	$64,275	$68,036	$71,760
	Program Year 2	43	$71,457	$67,053	$70,160	$74,209
	Program Year 3	43	$74,799	$70,103	$74,000	$78,064
	Program Year 4	26	$78,964	$73,289	$78,862	$84,643
	Program Year 5	20	$82,369	$77,025	$80,556	$86,557
	Program Year 6	11	$82,407	$78,740	$80,689	$87,786
	Program Year 7	6	$90,156	$85,040	$86,931	$93,690
	Program Year 8	4				
General Hospital & Specialty Hospital	Program Year 1	12	$67,907	$60,818	$67,964	$71,760
	Program Year 2	13	$71,468	$66,910	$71,201	$75,348
	Program Year 3	13	$75,360	$70,367	$75,687	$79,115
	Program Year 4	8	$79,274	$73,052	$78,529	$81,900
	Program Year 5	6	$84,673	$78,443	$82,460	$91,535
	Program Year 6	3				
	Program Year 7	2				
	Program Year 8	2				
Health System & Consortium	Program Year 1	8	$70,517	$67,754	$69,844	$72,060
	Program Year 2	8	$72,944	$69,589	$72,586	$74,180
	Program Year 3	8	$76,040	$72,602	$75,415	$77,848
	Program Year 4	6	$80,009	$75,514	$79,597	$84,762
	Program Year 5	4				
	Program Year 6	2				
	Program Year 7	1				
	Program Year 8	1				
Medical School	Program Year 1	6	$67,133	$62,870	$67,911	$72,166
	Program Year 2	6	$69,496	$64,950	$70,111	$73,985
	Program Year 3	6	$72,225	$67,381	$73,280	$77,596
	Program Year 4	6	$76,344	$70,341	$76,552	$82,892
	Program Year 5	6	$80,187	$72,967	$80,124	$88,125
	Program Year 6	6	$84,384	$75,860	$83,406	$93,465
	Program Year 7	4				
	Program Year 8	1				
Other	Program Year 1	10	$67,973	$65,230	$67,766	$71,122
	Program Year 2	9	$69,986	$67,000	$70,000	$71,769
	Program Year 3	9	$73,289	$70,000	$73,052	$74,425
	Program Year 4	2				
	Program Year 5	1				
	Program Year 6	0				
	Program Year 7	0				
	Program Year 8	0				

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TABLE 10 Percent of Respondents which Provide Higher Stipends to Chief and/or Other Residents/Fellows

Survey of Resident/Fellow Stipends and Benefits Report 2024

Table 10 displays the percentage of institutions whose base stipends are the same across specialties, that provide higher stipends to chief residencies, and that provide higher stipends to residents/fellows other than chief residencies as of July 1, 2024. For 10a below, there are 51 institutions not included in the table because they indicated the response option "N/A: Sponsoring institution has only one specialty."

		Institution Count	Percent Responded Yes	Percent Responded No
10a.	Percent of institutions whose base stipends are the same across all specialties	290	95.9%	4.1%
10b.	Percent of institutions that provide higher stipends to chief residencies	338	68.6%	31.4%
10c.	Percent of institutions that provide higher stipends to residents/fellows other than chief residencies	338	13.9%	86.1%

10b.1 How Chief Resident Stipends are Determined

Table 10b.1 displays how chief resident stipends are determined for institutions that provide higher stipends to chief residents as of July 1, 2024. Institutions that responded "Yes" in table 10 line b were eligible to answer this question.

	Institution Count	Percent
Formula	18	7.8%
Set amount	151	65.1%
Varies by department	47	20.3%
Other	16	6.9%
Total	232	100.0%

10b.2 Additional Set Amount Provided to Chief Residents when Higher Chief Resident Stipends Determined by Set Amount

Table 10b.2 displays aggregate statistics for the additional set dollar amount chief residents are provided when chief residents receive higher stipends and the amount is determined by a set amount. Institutions that responded "Yes" in table 10 line b (chief residents are provided higher stipends) and responded "Set Amount" in table 10b.1 (higher chief resident stipends determined by a set amount) were eligible to answer this question.

	Institution Count	Mean	25th Percentile	Median	75th Percentile
Additional set dollar amount	146	$4,345	$1,500	$2,407	$3,850

10c.1 Which Type of Residents/Fellows are paid Higher Stipends

Table 10c.1 displays types of residents/fellows other than chief residencies that are paid higher stipends as of July 1, 2024. Institutions that responded "Yes" in table 10 line c were eligible to answer this question. Of eligible to answer institutions, 47 respondents (11 General Hospitals & Specialty Hospitals, 17 Health Systems & Consortiums, 12 Medical Schools, and 7 Other) answered the question. Respondents could select more than one answer.

	Institution Count	Percent
Resident/fellow faculty	14	29.8%
Residents/fellows with an H-1B visa	7	14.9%
Residency association officers	3	6.4%
Trainees with prior GME experience	4	8.5%
Other	26	55.3%

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TABLE 11 When was the Last Time Stipends were Adjusted

Survey of Resident/Fellow Stipends and Benefits Report 2024

Table 11 displays the last time stipends were adjusted at each institution.

	Institution Count	Percent
As of July 1, 2024	243	71.5%
Last year	62	18.2%
Two years ago	15	4.4%
Three years ago	6	1.8%
Other	14	4.1%
Total	340	100.0%

11a Tools used to Decide the Stipend Adjustment Amount

Table 11a provides a summary of what tools were used to decide on the stipend adjustment amount. Of responding institutions, 341 respondents (119 General Hospitals & Specialty Hospitals, 93 Health Systems & Consortiums, 70 Medical Schools, and 59 Other) answered the question. Of those respondents, 239 selected more than one approach to adjusting stipends.

	Institution Count	Percent
GME office recommendation	195	57.2%
Review of market data other than AAMC	125	36.7%
AAMC Resident/Fellow Stipends and Benefits Report	215	63.0%
Union agreement	35	10.3%
Cost-of-living adjustment	152	44.6%
Other	56	16.4%

11b Entities or Individuals with Ultimate Approval Authority over Stipend Adjustments

Table 11b provides a summary of which entities or individuals have ultimate approval authority over stipend adjustments. Of responding institutions, 341 respondents (119 General Hospitals & Specialty Hospitals, 93 Health Systems & Consortiums, 70 Medical Schools, and 59 Other) answered the question. Of those respondents, 217 selected more than one entity or individual with ultimate approval authority over stipend adjustments.

	Institution Count	Percent
Board of regents or trustees	81	23.8%
CEO or President	145	42.5%
CFO/Finance/Human Resources	130	38.1%
GME office	83	24.3%
Graduate Medical Education Committee	153	44.9%
Hospital/Health System	88	25.8%
Union	27	7.9%
Other	44	12.9%

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TABLE 12 Whether Residents/Fellows are Unionized

Survey of Resident/Fellow Stipends and Benefits Report 2024

Table 12 provides a summary of whether the residents/fellows at the sponsoring institution are unionized.

	Institution Count	Percent
Yes	45	13.2%
No	296	86.8%
Total	341	100.0%

12a Number of Years Residents/Fellows have been Unionized

Table 12a displays the number of years residents/fellows at the sponsoring institution have been unionized. Institutions that responded "Yes" in table 12 were eligible to answer this question. This table includes records which reported zero years.

	Institution Count	Median Years	Mean Years
Number of Years	42	8	12

12b Type of Resident/Fellow Union

Table 12b provides a summary of the type of resident/fellow union at the sponsoring institution. Institutions that responded "Yes" in table 12 were eligible to answer this question.

	Institution Count	Percent
Affiliated with larger union	39	88.6%
Independent union	4	9.1%
Other	1	2.3%
Total	44	100.0%

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TABLE 13 Number of Respondents Offering Residents/Fellows Premium Medical Coverage, by Institution Type

Survey of Resident/Fellow Stipends and Benefits Report 2024

Table 13 displays the responding institution count for what portion of the premium for medical coverage is offered to residents and fellows by institutions.

	Year of Training	All Institutions (n=338)	General Hospital & Specialty Hospital (n=119)	Health System & Consortium (n=91)	Medical School (n=70)	Other (n=58)
Individual coverage	Fully paid	100	32	22	29	17
	Cost shared	215	77	64	38	36
	Fully paid with option for more coverage	16	6	4	1	5
	No portion paid	4	2	1	1	0
	Not offered	1	1	0	0	0
	Not answered	2	1	0	1	0
Resident/fellow plus spouse	Fully paid	56	16	12	18	10
	Cost shared	255	91	71	48	45
	Fully paid with option for more coverage	10	5	2	1	2
	No portion paid	10	3	5	1	1
	Not offered	2	1	1	0	0
	Not answered	5	3	0	2	0
Resident/fellow plus domestic partner	Fully paid	39	11	8	14	6
	Cost shared	197	70	55	34	38
	Fully paid with option for more coverage	8	5	1	1	1
	No portion paid	9	3	3	1	2
	Not offered	64	20	20	17	7
	Not answered	21	10	4	3	4
Resident/fellow plus children	Fully paid	56	16	12	18	10
	Cost shared	253	89	71	48	45
	Fully paid with option for more coverage	10	5	2	1	2
	No portion paid	10	3	5	1	1
	Not offered	2	1	1	0	0
	Not answered	7	5	0	2	0
Resident/fellow plus spouse and children	Fully paid	57	17	12	18	10
	Cost shared	256	91	71	49	45
	Fully paid with option for more coverage	11	6	2	1	2
	No portion paid	10	3	5	1	1
	Not offered	1	1	0	0	0
	Not answered	3	1	1	1	0
Resident/fellow plus domestic partner and children	Fully paid	38	11	7	14	6
	Cost shared	199	70	55	36	38
	Fully paid with option for more coverage	9	6	1	1	1
	No portion paid	9	3	3	1	2
	Not offered	60	19	19	15	7
	Not answered	23	10	6	3	4

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TABLE 14 Number of Respondents Including Selected Benefits in Medical Coverage, by Institution Type

Table 14 displays the responding institution count for which selected benefits are included in the institutions' medical coverage for residents and fellows.

		All Institutions (n=338)	General Hospital & Specialty Hospital (n=119)	Health System & Consortium (n=91)	Medical School (n=70)	Other (n=58)
Vision care	Included in group medical insurance	108	36	31	24	17
	Separate plan offered	228	82	60	45	41
	Not offered	2	1	0	1	0
	Not answered	0	0	0	0	0
Prescription drugs	Included in group medical insurance	316	108	86	68	54
	Separate plan offered	21	10	5	2	4
	Not offered	1	1	0	0	0
	Not answered	0	0	0	0	0
Behavioral and mental health care	Included in group medical insurance	318	111	86	65	56
	Separate plan offered	14	6	4	3	1
	Not offered	4	2	1	0	1
	Not answered	2	0	0	2	0
Substance abuse treatment	Included in group medical insurance	296	104	79	60	53
	Separate plan offered	18	4	5	6	3
	Not offered	14	6	5	1	2
	Not answered	10	5	2	3	0
Dental care	Included in group medical insurance	82	29	23	17	13
	Separate plan offered	250	87	68	52	43
	Not offered	1	1	0	0	0
	Not answered	5	2	0	1	2
Integrative medicine	Included in group medical insurance	130	43	34	28	25
	Separate plan offered	21	10	6	4	1
	Not offered	172	60	48	34	30
	Not answered	15	6	3	4	2
Gym memberships	Included in group medical insurance	46	15	14	5	12
	Separate plan offered	101	42	24	22	13
	Not offered	174	55	50	41	28
	Not answered	17	7	3	2	5
Preventive care	Included in group medical insurance	271	96	74	57	44
	Separate plan offered	29	11	8	5	5
	Not offered	30	9	7	6	8
	Not answered	8	3	2	2	1

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TABLE 15 Percent of Respondents Requiring Copayments and/or Deductibles in Medical Coverage Contract

Table 15 displays the number and percentage of institutions that require copayments, coinsurance, or deductibles for inpatient, ambulatory, and other services in the residents/fellows medical coverage contract as of July 1, 2024.

	Institution Count	Percent Responded Yes	Percent Responded No
Inpatient Services	336	91.7%	8.3%
Ambulatory Services	336	91.7%	8.3%
Behavioral and mental health care	334	90.4%	9.6%
Other services	300	90.3%	9.7%

TABLE 16 Whether Dollar or Service Limits Are Placed on Benefits for Certain Health Care Services

Table 16 displays the number and percentage of institutions that place dollar or service limits on health care benefits as of July 1, 2024.

	Institution Count	Percent Responded Yes	Percent Responded No
All respondents	328	43.9%	56.1%

16a Which Benefits Have Dollar or Service Limits

Table 16a displays the types of health care services that have dollar or service limits on health care benefits as of July 1, 2024. Institutions that responded "Yes" in table 16 (144 institutions) were eligible to answer this question. Respondents could select more than one answer.

	Institution Count	Percent
Bariatric surgery	49	34.0%
Chiropractic care	80	55.6%
Integrative medicine	47	32.6%
Dental care	95	66.0%
Infertility treatments	80	55.6%
Occupational/Physical therapy	73	50.7%
Orthodontics	97	67.4%
Vision care	96	66.7%
Other	11	7.6%

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TABLE 17 Describe Services Provided by your Institution's Employee Assistance Program (EAP) to Residents/Fellows

Table 17 provides a summary of the services provided by employee assistance programs to residents/fellows. Of responding institutions, 332 respondents (117 General Hospitals & Specialty Hospitals, 90 Health Systems & Consortiums, 70 Medical Schools, and 55 Other) answered the question. Of those respondents, 316 indicated more than one service provided by their institution's Employee Assistance Program.

	Institution Count	Percent
Clinical Services/Mental Health: Individual assessment and short-term counseling up to 3 in person sessions	309	93.1%
Clinical Services/Mental Health: Clinical staff to serve same-day appointments / crisis care	263	79.2%
Clinical Services/Mental Health: Assessment, referral, and follow-up support as needed	300	90.4%
Clinical Services: Substance abuse professional services	242	72.9%
Child care and parenting information	202	60.8%
Elder care resources	175	52.7%
Legal care: Unlimited phone consultations	80	24.1%
Legal care: Attorney referral, free 1/2 hour face-to-face consultation and/or discount on services	155	46.7%
Financial counsel: Unlimited phone consult	152	45.8%
Ergonomics: General ergonomics awareness session and personal evaluation	140	42.2%
N/A, no EAP or EAP is not available to residents/fellows	1	0.3%

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TABLE 18 Whether Institution Offers a Flexible or "Cafeteria Style" Benefits Plan to Residents/Fellows

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Table 18 displays the number and percentage of institutions that offer a flexible benefits plan to residents/fellows as of July 1, 2024.

	Institution Count	Percent Responded Yes	Percent Responded No
All respondents	323	71.2%	28.8%

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TABLE 19 Life Insurance and Disability Insurance Premiums, All Respondents

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Table 19 displays the number and percentage of institutions that offer life insurance, long-term disability insurance, and short-term disability insurance premiums to residents/fellows as of July 1, 2024. Institution refers to the sponsoring institution, GME office, or clinical/residency program department.

		Institution Count	Percent
Life insurance premium coverage	Fully paid	207	62.2%
	Cost shared	83	24.9%
	Available, but not paid by institution	38	11.4%
	Not offered	5	1.5%
	Total	333	100.0%
Long-term disability insurance premium coverage	Fully paid	171	51.5%
	Cost shared	90	27.1%
	Available, but not paid by institution	60	18.1%
	Not offered	11	3.3%
	Total	332	100.0%
Short-term disability insurance premium coverage	Fully paid	138	41.9%
	Cost shared	94	28.6%
	Available, but not paid by institution	69	21.0%
	Not offered	28	8.5%
	Total	329	100.0%

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TABLE 20 Portion of Respondents by Level of Coverage for Selected Resident/Fellow Benefits, by Institution Type

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Table 20 displays the responding institution count for the level of coverage for selected resident and fellow benefits offered by institutions, which can refer to the sponsoring institution, GME office, or clinical/residency program department.

		All Institutions (n=334)	General Hospital & Specialty Hospital (n=116)	Health System & Consortium (n=92)	Medical School (n=70)	Other (n=56)
Housing costs	Fully paid by institution	4	0	0	2	2
	Cost shared	35	17	9	6	3
	Available but not paid	26	11	7	6	2
	Not offered	260	87	72	54	47
	Not answered	9	1	4	2	2
Parking	Fully paid by institution	234	87	68	43	36
	Cost shared	33	13	7	8	5
	Available but not paid	40	11	13	10	6
	Not offered	22	4	3	7	8
	Not answered	5	1	1	2	1
Meals when working	Fully paid by institution	115	50	37	14	14
	Cost shared	119	45	30	31	13
	Available but not paid	48	10	14	10	14
	Not offered	46	10	10	11	15
	Not answered	6	1	1	4	0
Meals when on call	Fully paid by institution	195	75	59	36	25
	Cost shared	100	36	24	26	14
	Available but not paid	17	2	4	4	7
	Not offered	22	3	5	4	10
	Not answered	0	0	0	0	0
Scrubs or lab coats	Fully paid by institution	293	106	82	59	46
	Cost shared	24	8	8	4	4
	Available but not paid	10	1	1	5	3
	Not offered	7	1	1	2	3
	Not answered	0	0	0	0	0
Cell phones	Fully paid by institution	50	17	17	6	10
	Cost shared	55	20	13	13	9
	Available but not paid	16	9	1	4	2
	Not offered	202	67	55	45	35
	Not answered	11	3	6	2	0
Moving expenses	Fully paid by institution	23	8	9	2	4
	Cost shared	54	16	16	13	9
	Available but not paid	14	3	4	4	3
	Not offered	238	88	63	48	39
	Not answered	5	1	0	3	1
USMLE preparation	Fully paid by institution	75	31	22	10	12
	Cost shared	89	30	26	17	16
	Available but not paid	34	10	10	9	5
	Not offered	127	41	31	32	23
	Not answered	9	4	3	2	0
USMLE test	Fully paid by institution	129	51	40	17	21
	Cost shared	56	22	16	10	8
	Available but not paid	27	5	7	11	4
	Not offered	111	33	27	28	23
	Not answered	11	5	2	4	0
State licensing fees	Fully paid by institution	202	76	55	38	33
	Cost shared	31	14	8	6	3
	Available but not paid	18	4	8	5	1
	Not offered	81	22	21	20	18
	Not answered	2	0	0	1	1
Specialty board fees	Fully paid by institution	84	28	27	7	22
	Cost shared	60	27	16	9	8
	Available but not paid	32	9	11	10	2
	Not offered	151	50	37	40	24
	Not answered	7	2	1	4	0
Gym access/membership	Fully paid by institution	90	34	28	15	13
	Cost shared	64	22	17	13	12
	Available but not paid	83	25	22	25	11
	Not offered	88	33	23	14	18
	Not answered	9	2	2	3	2

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TABLE 21 Whether Institutions Provide Funds or Tools to Residents/Fellows, All Respondents

Table 21 displays the institution count and percentage institution paid or not paid for whether the institution provides various tools, or funds for tools, to residents/fellows as of July 1, 2024. Institution refers to the sponsoring institution, GME office, or clinical/residency program department.

	Institution Count	Percent Institution Paid	Percent Not Paid
Books	326	75.8%	24.2%
Conference travel	328	86.9%	13.1%
Computers	325	62.2%	37.8%
Professional society dues	327	71.9%	28.1%
Preparation of posters	330	79.7%	20.3%
Generic "education allowance"	330	81.2%	18.8%
Research support	332	81.0%	19.0%
Statistical support	327	77.7%	22.3%
Medical editing support for writing grants and manuscripts	328	60.7%	39.3%
Library access	330	97.0%	3.0%

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TABLE 22 Whether Institutions Offer a Retirement Plan to Residents/Fellows

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Table 22 displays the number and percentage of institutions that offer a retirement plan to residents/fellows as of July 1, 2024.

	Institution Count	Percent Responded Yes	Percent Responded No
All respondents	333	80.5%	19.5%

22a Whether Institutions Offer a Defined-Benefit Retirement Plan to Residents/Fellows

Table 22a displays the number which responded and percentage of the 268 institutions that answered “Yes” in table 22 (offering a retirement plan to resident/fellows) when responding to whether they provide a defined-benefit retirement plan to residents/fellows as of July 1, 2024.

	Institution Count	Percent Responded Yes	Percent Responded No
Institutions responding “Yes” in Table 22	265	61.1%	38.9%

22b Percent of Stipends Matched as Employer Retirement Contributions

Table 22b provides a summary of the maximum retirement matching contributions made to residents/fellows, regardless of matching formulas. Institutions that responded "Yes" in table 22 were eligible to answer this question.

	Institution Count	Percent
0%	54	23.5%
0.01-1.99%	3	1.3%
2.00-2.99%	17	7.4%
3.00-3.99%	71	30.9%
4.00-4.99%	31	13.5%
5.00-5.99%	22	9.6%
6.00-6.99%	18	7.8%
7.00%+	14	6.1%
Total	230	100.0%

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TABLE 22 Whether Institutions Offer a Retirement Plan to Residents/Fellows

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22c Vesting Period for Retirement Matching Contributions to be Fully Vested

Table 22c provides a summary of the vesting period for retirement matching contributions made to residents/fellows. Institutions that responded "Yes" in table 22 were eligible to answer this question.

	Institution Count	Percent
Immediately	52	20.5%
After a year	40	15.7%
After two years	10	3.9%
After more than two years	57	22.4%
Other	35	13.8%
Institution does not offer matching retirement contributions	60	23.6%
Total	254	100.0%

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TABLE 23 Fully Paid Leave for Medical, Parental, or Caregiver Leave, All Respondents

Survey of Resident/Fellow Stipends and Benefits Report 2024

Table 23 displays the institution count, median, and mean amount of days of fully paid leave for medical, parental, or caregiver leave for residents/fellows as of July 1, 2024. This table excludes records which reported zero days.

	Institution Count	Median Days	Mean Days
Medical, parental, or caregiver leave	296	42	44

TABLE 24 Whether Residents/Fellows Receive the Same Number of Days of Paid Leave, Regardless of Program Year

Table 24 displays the number and percentage of institutions that provide the same number of days of paid leave during a year to residents/fellows, regardless of program year, as of July 1, 2024.

	Institution Count	Percent Responded Yes	Percent Responded No
All respondents	334	89.5%	10.5%

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TABLE 25

Annual Vacation and Other Paid Leave for Residents

Table 25 displays the annual vacation and other paid leave available to residents as of July 1, 2024. This table includes respondents that reported at least one paid leave day. The survey question stated: "On average, how many days of paid leave do residents receive during a year? Please round to the whole number of days. The days of leave reported in each category should be mutually exclusive. For example, if your institution does not distinguish between types of paid leave and provides a general paid time off category, please report the amount of days in the General PTO option and do not also report the days in other categories." No restrictions were placed on the values respondents could enter in the response options.

		Institution Count	Percent
Annual Vacation	0 to 10	15	6.0%
	11 to 15	70	28.2%
	16 to 21	112	45.2%
	22 to 28	42	16.9%
	29 or more	9	3.6%
	Total	248	100.0%
Sick Days	0 to 10	120	53.6%
	11 to 15	82	36.6%
	16 to 21	9	4.0%
	22 to 28	1	0.4%
	29 or more	12	5.4%
	Total	224	100.0%
Holidays	0 to 10	180	88.2%
	11 to 15	21	10.3%
	16 to 21	2	1.0%
	22 to 28	1	0.5%
	29 or more	0	0.0%
	Total	204	100.0%
Personal days	0 to 10	160	98.8%
	11 to 15	1	0.6%
	16 to 21	0	0.0%
	22 to 28	0	0.0%
	29 or more	1	0.6%
	Total	162	100.0%
General PTO	0 to 10	91	49.7%
	11 to 15	5	2.7%
	16 to 21	55	30.1%
	22 to 28	22	12.0%
	29 or more	10	5.5%
	Total	183	100.0%
Other days	0 to 10	136	92.5%
	11 to 15	1	0.7%
	16 to 21	0	0.0%
	22 to 28	1	0.7%
	29 or more	9	6.1%
	Total	147	100.0%
Total paid time, including sick days	0 to 10	0	0.0%
	11 to 15	4	1.2%
	16 to 21	50	15.2%
	22 to 28	73	22.3%
	29 or more	201	61.3%
	Total	328	100.0%

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TABLE 26 Time Allotted to Residents/Fellows to Attend Seminar

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Table 26 displays the days first- and second-year residents are allotted to attend educational seminars as of July 1, 2024. Of the 341 institutions responding to the survey, 234 reported that they could not report this because the number of days varies by department. Additionally, 19 reported that they could not report this because the number of days were unlimited.

		Institution Count	Percent
First year	0	11	16.4%
	1 to 5	49	73.1%
	6 to 9	5	7.5%
	10 or more	2	3.0%
	Total	67	100.0%
Second year	0	0	0.0%
	1 to 5	62	88.6%
	6 to 9	5	7.1%
	10 or more	3	4.3%
	Total	70	100.0%

TABLE 27 Time for Seminars in Addition to Paid Leave and Contributing to Meeting Costs

Table 27 displays the number and percentage of institutions that allow time off to attend seminars in addition to vacation leave and contributes to meeting costs.

	Institution Count	Percent Responded Yes	Percent Responded No
27a. Whether time off to attend seminars is in addition to vacation leave	328	86.9%	13.1%
27b. Whether the institution or program contributes to meeting costs	328	74.7%	25.3%

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TABLE 28 Contribution Type and Maximum Benefit to Meeting Costs, All Respondents

Table 28 displays the number of institutions that pay for registration fee, per diem, and other meeting cost fees as well as the median maximum amount contributed for meeting costs as of July 1, 2024. Only institutions responding “Yes” in table 27 line b were eligible to answer this question. Respondents could select more than one answer.

	Contribution Type	Institution Count and Median Amount ($)
First year	Registration fee	149
	Per diem	115
	Unspecified	107
	Median maximum amount	$1,500
Second Year	Registration fee	163
	Per diem	126
	Unspecified	118
	Median maximum amount	$1,500

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TABLE 29 Whether Institutions Provide Child Care for Children of Residents/Fellows, All Respondents

Survey of Resident/Fellow Stipends and Benefits Report 2024

Table 29 displays the number and percentage of institutions that provide child care, and the portion offered, for children of residents/fellows as of July 1, 2024.

		Institution Count	Percent
On-site care	Fully paid	4	1.2%
	Cost shared	18	5.5%
	Available, but not paid by institution	50	15.2%
	Not offered	256	78.0%
	Total	328	100.0%
Off-site care	Fully paid	1	0.3%
	Cost shared	20	6.1%
	Available, but not paid by institution	62	18.9%
	Not offered	245	74.7%
	Total	328	100.0%
Sick child care	Fully paid	6	1.9%
	Cost shared	25	7.7%
	Available, but not paid by institution	30	9.3%
	Not offered	263	81.2%
	Total	324	100.0%
Urgent or back-up care	Fully paid	7	2.2%
	Cost shared	32	10.0%
	Available, but not paid by institution	31	9.7%
	Not offered	251	78.2%
	Total	321	100.0%

TABLE 30 Whether Institutions that do not Provide Child Care Assist Resident/Fellows with Locating Child Care

Table 30 displays the number and percentage of institutions that assist residents/fellows with locating child care if the institution does not provide child care.

	Institution Count	Percent Responded Yes	Percent Responded No
Whether institutions that do not provide child care assist residents/fellows with locating child care	291	42.3%	57.7%

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TABLE 31 Additional Benefits Covered by Institutions

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Table 31 displays the number and percentage of institutions that offer financial counseling and educational debt management services or offer career counseling or placement services.

	Institution Count	Percent Responded Yes	Percent Responded No
31a. Whether institutions offer financial counseling and educational debt management services to resident/fellows	334	80.2%	19.8%
31b. Whether institutions offer career counseling or placement services to residents/fellows	332	52.4%	47.6%

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TABLE 32 Whether Institutions Provide Resident/Fellow Wellness Benefits and How Wellness Benefits are Paid For, All Respondents

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Table 32 displays the number and percentage of institutions that provide wellness benefits, and the portion offered, for residents/fellows as of July 1, 2024. The following table is based on 331 respondents (116 General Hospitals & Specialty Hospitals, 91 Health Systems & Consortiums, 68 Medical Schools, and 56 Other) that provided data for at least one wellness benefit. Respondents could select more than one answer.

		Institution Count	Percent
Access to confidential mental health assessment, counseling, and treatment	Paid by institution	238	71.9%
	Paid by department	6	1.8%
	Paid by program	11	3.3%
	Paid by insurance plan	151	45.6%
	Other payment	2	0.6%
	Not offered	0	0.0%
Access to urgent and emergency care, 24 hours a day, 7 days a week	Paid by institution	150	45.3%
	Paid by department	1	0.3%
	Paid by program	3	0.9%
	Paid by insurance plan	203	61.3%
	Other payment	3	0.9%
	Not offered	1	0.3%
Tools for self-screening of well-being (e.g., screening for burn-out, depression, suicide, resilience, wellness and related constructs)	Paid by institution	255	77.0%
	Paid by department	16	4.8%
	Paid by program	34	10.3%
	Paid by insurance plan	61	18.4%
	Other payment	5	1.5%
	Not offered	7	2.1%
Access to lactation facilities	Paid by institution	302	91.2%
	Paid by department	12	3.6%
	Paid by program	16	4.8%
	Paid by insurance plan	12	3.6%
	Other payment	4	1.2%
	Not offered	1	0.3%

TABLE 33 Describe your Institution's Access to Confidential Mental Health Assessment, Counseling, and Treatment Services to Residents/Fellows

Table 33 provides a summary of confidential mental health assessment, counseling, and treatment services offered to residents/fellows. Of responding institutions, 333 respondents (117 General Hospitals & Specialty Hospitals, 92 Health Systems & Consortiums, 67 Medical Schools, and 57 Other) answered the question. Of those respondents, 304 indicated more than one service provided by their institution.

	Institution Count	Percent
Counselors/providers made available off-site	172	51.7%
Counselors/providers made available on-site	185	55.6%
EAP/FEAP offers services	310	93.1%
GME office coordinates care	123	36.9%
Access care through insurance plan options	280	84.1%
Dedicated/on-call provider available	82	24.6%
Wellness program provides access	188	56.5%
Other	15	4.5%

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TABLE 34 Describe your Institution's Access to Urgent and Emergent Care 24 Hours a Day, Seven Days a Week to Residents/Fellows

Table 34 provides a summary of urgent and emergent care 24 hours a day, seven days a week access for residents/fellows. Of responding institutions 333 respondents (117 General Hospitals & Specialty Hospitals, 92 Health Systems & Consortiums, 67 Medical Schools, and 57 Other) answered the question. Of those respondents, 310 indicated more than one service provided by their institution.

	Institution Count	Percent
Crisis line	178	53.5%
Crisis response center	75	22.5%
EAP/FEAP	266	79.9%
Emergency room	282	84.7%
Hospital	184	55.3%
Access to care through insurance plan options	290	87.1%
Urgent care center	165	49.5%
Other	20	6.0%

TABLE 35 Describe your Institution's Access to Tools for Self-screening of Well-being to Residents/Fellows

Table 35 provides a summary of self-screening well-being tools offered to residents/fellows. Of responding institutions, 332 respondents (117 General Hospitals & Specialty Hospitals, 91 Health Systems & Consortiums, 67 Medical Schools, and 57 Other) answered the question. Of those respondents, 297 indicated more than one service provided by their institution.

	Institution Count	Percent
Access to crises hotline/other resources	224	67.5%
Links to online tools emailed to residents/fellows regularly	192	57.8%
Online screening tools available on demand	216	65.1%
Provided through FEAP/EAP resources	253	76.2%
Provided through insurance	174	52.4%
Well-being survey (administered at least annually)	221	66.6%
These are provided at department level, not the institution-level	11	3.3%
Other	17	5.1%

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TABLE 36

Describe your Institution's Access to Lactation Facilities

Table 36 provides a summary of institution lactation facility access for residents/fellows. Of responding institutions, 333 respondents (117 General Hospitals & Specialty Hospitals, 92 Health Systems & Consortiums, 67 Medical Schools, and 57 Other) answered the question. Of those respondents, 169 indicated more than one service provided by their institution.

	Institution Count	Percent
Lactation rooms on site for staff available for resident/fellow use	301	90.4%
Lactation rooms on site reserved for residents/fellows	101	30.3%
Private rooms (although not dedicated lactation rooms) that can be used for lactation purposes available for residents/fellows	141	42.3%
No lactation rooms on site	1	0.3%
Other	2	0.6%

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TABLE 37 Whether Institutions Require Various Drug and/or Alcohol Testing for Residents/Fellows, All Respondents

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Table 37 displays the number and percentage of institutions that require different types of drug and/or alcohol testing for residents/fellows as of July 1, 2024.

	Institution Count	Percent Responded Yes	Percent Responded No
Pre-appointment Testing	326	79.4%	20.6%
Random testing	301	18.3%	81.7%
Testing when probable cause is present	322	93.5%	6.5%
Repeat testing in the absence of probable cause	295	16.3%	83.7%

TABLE 38 Whether Drug and/or Alcohol Rehabilitation Services Covered under Resident/Fellow Health Benefits

Table 38 displays the number and percentage of institutions that provide drug and alcohol rehabilitation services in health benefits.

	Institution Count	Percent Responded Yes	Percent Responded No
Whether drug and/or alcohol rehabilitation services covered under resident/fellow health benefits	325	92.9%	7.1%

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TABLE 39 Accommodations Provided to Residents/Fellows under the Americans with Disabilities Act (ADA) Within the Past Year

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Table 39 provides a summary of accommodations provided by institutions under the Americans with Disabilities Act within the past year. Of responding institutions, 325 respondents answered the question. Respondents could select more than one answer.

	Institution Count	Percent
Revised schedule	175	53.8%
Sign language interpreter	40	12.3%
Testing accommodations	151	46.5%
Transcribed or recorded lectures	62	19.1%
Transcription software	63	19.4%
Wheelchair access	85	26.2%
None requested	111	34.2%

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RSS 2024

Resident/Fellow Stipends by Region and Institution Type Flat File

Survey of Resident/Fellow Stipends and Benefits Report 2024

Institution Type	Region	Program Year	Institutions	Institution Count	Mean Unweighted Stipend	Resident/ Fellow Count	Mean Weighted Stipend	25th	Median	75th
Total	All Regions	Program Year 1	All Institutions	335	$66,712	26,199	$68,053	$61,101	$65,100	$70,101
Total	All Regions	Program Year 2	All Institutions	334	$68,901	25,572	$71,013	$63,484	$67,582	$72,672
Total	All Regions	Program Year 3	All Institutions	333	$71,776	24,722	$74,054	$66,056	$70,304	$76,167
Total	All Regions	Program Year 4	All Institutions	263	$75,665	17,722	$78,198	$69,077	$73,903	$80,299
Total	All Regions	Program Year 5	All Institutions	235	$79,170	12,548	$82,514	$72,322	$77,405	$84,095
Total	All Regions	Program Year 6	All Institutions	204	$81,649	7,085	$85,933	$74,969	$79,944	$86,503
Total	All Regions	Program Year 7	All Institutions	173	$85,925	2,372	$90,292	$78,304	$83,986	$91,451
Total	All Regions	Program Year 8	All Institutions	122	$90,562	566	$94,221	$83,796	$88,624	$95,787
General Hospital & Specialty Hospital	All Regions	Program Year 1	All Institutions	115	$67,373			$61,893	$66,706	$71,759
General Hospital & Specialty Hospital	All Regions	Program Year 2	All Institutions	118	$70,176			$64,235	$69,760	$74,333
General Hospital & Specialty Hospital	All Regions	Program Year 3	All Institutions	118	$73,399			$66,416	$72,673	$78,007
General Hospital & Specialty Hospital	All Regions	Program Year 4	All Institutions	88	$77,745			$71,774	$76,925	$82,871
General Hospital & Specialty Hospital	All Regions	Program Year 5	All Institutions	77	$81,735			$75,049	$80,327	$87,630
General Hospital & Specialty Hospital	All Regions	Program Year 6	All Institutions	63	$83,922			$77,574	$82,194	$90,082
General Hospital & Specialty Hospital	All Regions	Program Year 7	All Institutions	48	$88,889			$82,385	$86,414	$94,864
General Hospital & Specialty Hospital	All Regions	Program Year 8	All Institutions	35	$94,015			$87,364	$94,241	$101,040
Health System & Consortium	All Regions	Program Year 1	All Institutions	93	$65,859			$61,711	$65,100	$68,626
Health System & Consortium	All Regions	Program Year 2	All Institutions	93	$68,273			$63,871	$67,500	$71,258
Health System & Consortium	All Regions	Program Year 3	All Institutions	93	$70,875			$66,298	$69,500	$74,082
Health System & Consortium	All Regions	Program Year 4	All Institutions	78	$74,271			$68,824	$72,580	$77,602
Health System & Consortium	All Regions	Program Year 5	All Institutions	68	$77,657			$73,054	$75,681	$80,897
Health System & Consortium	All Regions	Program Year 6	All Institutions	59	$79,880			$74,979	$77,836	$83,757
Health System & Consortium	All Regions	Program Year 7	All Institutions	51	$84,300			$78,012	$83,191	$87,915
Health System & Consortium	All Regions	Program Year 8	All Institutions	37	$88,171			$82,211	$86,819	$91,832
Medical School	All Regions	Program Year 1	All Institutions	70	$65,036			$60,837	$63,949	$67,553
Medical School	All Regions	Program Year 2	All Institutions	70	$67,437			$63,070	$66,116	$70,321
Medical School	All Regions	Program Year 3	All Institutions	70	$69,891			$65,290	$68,392	$72,692
Medical School	All Regions	Program Year 4	All Institutions	67	$73,659			$68,162	$71,205	$77,037
Medical School	All Regions	Program Year 5	All Institutions	64	$76,840			$70,476	$74,511	$80,115
Medical School	All Regions	Program Year 6	All Institutions	62	$79,898			$73,068	$77,433	$83,257
Medical School	All Regions	Program Year 7	All Institutions	55	$83,698			$76,367	$81,200	$88,496
Medical School	All Regions	Program Year 8	All Institutions	37	$88,562			$83,134	$85,918	$92,664
Other	All Regions	Program Year 1	All Institutions	57	$68,830			$60,500	$65,920	$70,387
Other	All Regions	Program Year 2	All Institutions	53	$69,098			$62,000	$68,557	$73,000
Other	All Regions	Program Year 3	All Institutions	52	$72,241			$64,875	$70,459	$77,128
Other	All Regions	Program Year 4	All Institutions	30	$77,668			$69,640	$75,958	$83,182
Other	All Regions	Program Year 5	All Institutions	26	$81,269			$72,720	$79,885	$85,742
Other	All Regions	Program Year 6	All Institutions	20	$85,135			$75,459	$82,729	$89,354
Other	All Regions	Program Year 7	All Institutions	19	$89,249			$78,176	$87,310	$94,557
Other	All Regions	Program Year 8	All Institutions	13	$93,762			$87,000	$92,310	$96,402
Total	All Regions	Program Year 1	Institutions with Number of ACGME-Accredited Programs At or Above the Median (10)	169	$67,591	22,950	$68,489	$62,546	$65,817	$70,660
Total	All Regions	Program Year 2	Institutions with Number of ACGME-Accredited Programs At or Above the Median (10)	170	$70,153	22,771	$71,444	$64,424	$68,416	$73,173
Total	All Regions	Program Year 3	Institutions with Number of ACGME-Accredited Programs At or Above the Median (10)	170	$73,048	22,072	$74,471	$66,810	$71,053	$77,021
Total	All Regions	Program Year 4	Institutions with Number of ACGME-Accredited Programs At or Above the Median (10)	169	$76,220	17,040	$78,358	$69,606	$73,903	$80,567
Total	All Regions	Program Year 5	Institutions with Number of ACGME-Accredited Programs At or Above the Median (10)	169	$79,422	12,283	$82,609	$72,941	$77,217	$84,050
Total	All Regions	Program Year 6	Institutions with Number of ACGME-Accredited Programs At or Above the Median (10)	163	$82,262	6,923	$86,161	$75,299	$80,163	$87,274
Total	All Regions	Program Year 7	Institutions with Number of ACGME-Accredited Programs At or Above the Median (10)	149	$86,090	2,328	$90,611	$78,409	$83,821	$91,451
Total	All Regions	Program Year 8	Institutions with Number of ACGME-Accredited Programs At or Above the Median (10)	111	$90,829	545	$95,177	$83,759	$88,624	$96,000
General Hospital & Specialty Hospital	All Regions	Program Year 1	Institutions with Number of ACGME-Accredited Programs At or Above the Median (5)	61	$69,059			$64,020	$68,447	$74,006
General Hospital & Specialty Hospital	All Regions	Program Year 2	Institutions with Number of ACGME-Accredited Programs At or Above the Median (5)	63	$71,778			$66,236	$70,792	$76,458
General Hospital & Specialty Hospital	All Regions	Program Year 3	Institutions with Number of ACGME-Accredited Programs At or Above the Median (5)	63	$75,167			$68,863	$73,676	$79,891
General Hospital & Specialty Hospital	All Regions	Program Year 4	Institutions with Number of ACGME-Accredited Programs At or Above the Median (5)	61	$78,296			$71,870	$77,433	$83,323
General Hospital & Specialty Hospital	All Regions	Program Year 5	Institutions with Number of ACGME-Accredited Programs At or Above the Median (5)	61	$81,509			$74,786	$79,674	$87,185
General Hospital & Specialty Hospital	All Regions	Program Year 6	Institutions with Number of ACGME-Accredited Programs At or Above the Median (5)	54	$84,656			$77,707	$82,666	$90,521
General Hospital & Specialty Hospital	All Regions	Program Year 7	Institutions with Number of ACGME-Accredited Programs At or Above the Median (5)	42	$89,373			$82,689	$86,519	$96,104
General Hospital & Specialty Hospital	All Regions	Program Year 8	Institutions with Number of ACGME-Accredited Programs At or Above the Median (5)	31	$94,530			$87,364	$94,981	$101,289
Health System & Consortium	All Regions	Program Year 1	Institutions with Number of ACGME-Accredited Programs At or Above the Median (12)	48	$66,599			$61,463	$65,661	$68,920
Health System & Consortium	All Regions	Program Year 2	Institutions with Number of ACGME-Accredited Programs At or Above the Median (12)	48	$69,081			$64,178	$67,985	$71,510
Health System & Consortium	All Regions	Program Year 3	Institutions with Number of ACGME-Accredited Programs At or Above the Median (12)	48	$71,665			$66,647	$70,526	$74,456
Health System & Consortium	All Regions	Program Year 4	Institutions with Number of ACGME-Accredited Programs At or Above the Median (12)	48	$74,745			$69,299	$72,928	$77,764
Health System & Consortium	All Regions	Program Year 5	Institutions with Number of ACGME-Accredited Programs At or Above the Median (12)	48	$77,948			$72,929	$75,663	$81,331
Health System & Consortium	All Regions	Program Year 6	Institutions with Number of ACGME-Accredited Programs At or Above the Median (12)	46	$80,468			$74,961	$77,797	$84,328
Health System & Consortium	All Regions	Program Year 7	Institutions with Number of ACGME-Accredited Programs At or Above the Median (12)	44	$84,254			$77,609	$82,203	$87,745
Health System & Consortium	All Regions	Program Year 8	Institutions with Number of ACGME-Accredited Programs At or Above the Median (12)	32	$88,562			$82,743	$86,787	$92,099
Medical School	All Regions	Program Year 1	Institutions with Number of ACGME-Accredited Programs At or Above the Median (45)	36	$68,191			$63,547	$66,579	$70,367
Medical School	All Regions	Program Year 2	Institutions with Number of ACGME-Accredited Programs At or Above the Median (45)	36	$70,814			$65,629	$69,210	$73,252

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Medical School	All Regions	Program Year 3	Institutions with Number of ACGME-Accredited Programs At or Above the Median (45)	36	$73,591			$67,992	$71,981	$76,795
Medical School	All Regions	Program Year 4	Institutions with Number of ACGME-Accredited Programs At or Above the Median (45)	36	$76,765			$70,201	$74,889	$79,993
Medical School	All Regions	Program Year 5	Institutions with Number of ACGME-Accredited Programs At or Above the Median (45)	36	$80,036			$73,105	$78,541	$83,545
Medical School	All Regions	Program Year 6	Institutions with Number of ACGME-Accredited Programs At or Above the Median (45)	36	$82,927			$75,674	$81,087	$87,199
Medical School	All Regions	Program Year 7	Institutions with Number of ACGME-Accredited Programs At or Above the Median (45)	36	$86,283			$79,305	$83,691	$90,421
Medical School	All Regions	Program Year 8	Institutions with Number of ACGME-Accredited Programs At or Above the Median (45)	30	$90,587			$83,814	$87,298	$93,231
Other	All Regions	Program Year 1	Institutions with Number of ACGME-Accredited Programs At or Above the Median (2)	34	$66,894			$61,027	$66,099	$69,468
Other	All Regions	Program Year 2	Institutions with Number of ACGME-Accredited Programs At or Above the Median (2)	34	$69,209			$62,460	$68,654	$72,479
Other	All Regions	Program Year 3	Institutions with Number of ACGME-Accredited Programs At or Above the Median (2)	33	$72,146			$65,000	$70,614	$75,500
Other	All Regions	Program Year 4	Institutions with Number of ACGME-Accredited Programs At or Above the Median (2)	26	$75,927			$67,652	$74,447	$81,803
Other	All Regions	Program Year 5	Institutions with Number of ACGME-Accredited Programs At or Above the Median (2)	24	$80,290			$72,606	$79,305	$84,901
Other	All Regions	Program Year 6	Institutions with Number of ACGME-Accredited Programs At or Above the Median (2)	20	$85,135			$75,459	$82,729	$89,354
Other	All Regions	Program Year 7	Institutions with Number of ACGME-Accredited Programs At or Above the Median (2)	19	$89,249			$78,176	$87,310	$94,557
Other	All Regions	Program Year 8	Institutions with Number of ACGME-Accredited Programs At or Above the Median (2)	13	$93,762			$87,000	$92,310	$96,402
Total	All Regions	Program Year 1	Institutions with Number of ACGME-Accredited Programs Below the Median (10)	164	$65,829	3,047	$65,450	$60,198	$64,010	$69,717
Total	All Regions	Program Year 2	Institutions with Number of ACGME-Accredited Programs Below the Median (10)	162	$67,613	2,605	$68,108	$62,229	$66,953	$71,891
Total	All Regions	Program Year 3	Institutions with Number of ACGME-Accredited Programs Below the Median (10)	161	$70,464	2,449	$71,316	$64,750	$69,376	$75,014
Total	All Regions	Program Year 4	Institutions with Number of ACGME-Accredited Programs Below the Median (10)	93	$74,779	574	$76,084	$68,505	$73,416	$80,139
Total	All Regions	Program Year 5	Institutions with Number of ACGME-Accredited Programs Below the Median (10)	65	$78,704	225	$80,072	$70,775	$77,807	$84,391
Total	All Regions	Program Year 6	Institutions with Number of ACGME-Accredited Programs Below the Median (10)	40	$79,455	102	$80,208	$72,619	$78,068	$84,582
Total	All Regions	Program Year 7	Institutions with Number of ACGME-Accredited Programs Below the Median (10)	23	$85,577	10	$86,979	$77,832	$84,873	$90,968
Total	All Regions	Program Year 8	Institutions with Number of ACGME-Accredited Programs Below the Median (10)	10	$89,717	0		$88,269	$89,002	$94,135
General Hospital & Specialty Hospital	All Regions	Program Year 1	Institutions with Number of ACGME-Accredited Programs Below the Median (5)	53	$65,347			$60,000	$64,000	$70,350
General Hospital & Specialty Hospital	All Regions	Program Year 2	Institutions with Number of ACGME-Accredited Programs Below the Median (5)	54	$68,235			$62,131	$67,708	$72,410
General Hospital & Specialty Hospital	All Regions	Program Year 3	Institutions with Number of ACGME-Accredited Programs Below the Median (5)	54	$71,270			$64,330	$70,536	$77,317
General Hospital & Specialty Hospital	All Regions	Program Year 4	Institutions with Number of ACGME-Accredited Programs Below the Median (5)	27	$76,501			$70,450	$76,585	$82,324
General Hospital & Specialty Hospital	All Regions	Program Year 5	Institutions with Number of ACGME-Accredited Programs Below the Median (5)	16	$82,598			$77,182	$81,762	$88,632
General Hospital & Specialty Hospital	All Regions	Program Year 6	Institutions with Number of ACGME-Accredited Programs Below the Median (5)	9	$79,518			$73,000	$81,307	$86,000
General Hospital & Specialty Hospital	All Regions	Program Year 7	Institutions with Number of ACGME-Accredited Programs Below the Median (5)	6	$85,497			$82,467	$85,827	$89,195
General Hospital & Specialty Hospital	All Regions	Program Year 8	Institutions with Number of ACGME-Accredited Programs Below the Median (5)	4						
Health System & Consortium	All Regions	Program Year 1	Institutions with Number of ACGME-Accredited Programs Below the Median (12)	45	$65,069			$61,838	$64,488	$67,040
Health System & Consortium	All Regions	Program Year 2	Institutions with Number of ACGME-Accredited Programs Below the Median (12)	45	$67,411			$63,871	$66,851	$69,452
Health System & Consortium	All Regions	Program Year 3	Institutions with Number of ACGME-Accredited Programs Below the Median (12)	45	$70,033			$66,298	$69,220	$72,495
Health System & Consortium	All Regions	Program Year 4	Institutions with Number of ACGME-Accredited Programs Below the Median (12)	30	$73,512			$68,441	$72,419	$75,434
Health System & Consortium	All Regions	Program Year 5	Institutions with Number of ACGME-Accredited Programs Below the Median (12)	20	$76,957			$73,481	$75,681	$79,103
Health System & Consortium	All Regions	Program Year 6	Institutions with Number of ACGME-Accredited Programs Below the Median (12)	13	$77,802			$75,647	$78,296	$80,625
Health System & Consortium	All Regions	Program Year 7	Institutions with Number of ACGME-Accredited Programs Below the Median (12)	7	$84,591			$81,884	$83,986	$88,726
Health System & Consortium	All Regions	Program Year 8	Institutions with Number of ACGME-Accredited Programs Below the Median (12)	5	$85,672			$82,211	$88,150	$88,884
Medical School	All Regions	Program Year 1	Institutions with Number of ACGME-Accredited Programs Below the Median (45)	33	$61,816			$60,500	$62,546	$63,978
Medical School	All Regions	Program Year 2	Institutions with Number of ACGME-Accredited Programs Below the Median (45)	33	$63,990			$61,884	$64,286	$66,137
Medical School	All Regions	Program Year 3	Institutions with Number of ACGME-Accredited Programs Below the Median (45)	33	$66,105			$64,000	$66,303	$68,394
Medical School	All Regions	Program Year 4	Institutions with Number of ACGME-Accredited Programs Below the Median (45)	30	$70,250			$66,672	$69,226	$71,756
Medical School	All Regions	Program Year 5	Institutions with Number of ACGME-Accredited Programs Below the Median (45)	27	$72,947			$69,442	$71,354	$74,804
Medical School	All Regions	Program Year 6	Institutions with Number of ACGME-Accredited Programs Below the Median (45)	25	$75,956			$71,723	$74,044	$77,806
Medical School	All Regions	Program Year 7	Institutions with Number of ACGME-Accredited Programs Below the Median (45)	18	$79,322			$74,897	$76,367	$80,287
Medical School	All Regions	Program Year 8	Institutions with Number of ACGME-Accredited Programs Below the Median (45)	6	$81,630			$80,156	$82,491	$84,571
Other	All Regions	Program Year 1	Institutions with Number of ACGME-Accredited Programs Below the Median (2)	23	$71,692			$60,250	$65,920	$72,799
Other	All Regions	Program Year 2	Institutions with Number of ACGME-Accredited Programs Below the Median (2)	19	$68,900			$61,877	$67,600	$73,605
Other	All Regions	Program Year 3	Institutions with Number of ACGME-Accredited Programs Below the Median (2)	19	$72,408			$64,750	$70,304	$77,532
Other	All Regions	Program Year 4	Institutions with Number of ACGME-Accredited Programs Below the Median (2)	4						
Other	All Regions	Program Year 5	Institutions with Number of ACGME-Accredited Programs Below the Median (2)	2						
Other	All Regions	Program Year 6	Institutions with Number of ACGME-Accredited Programs Below the Median (2)	0						
Other	All Regions	Program Year 7	Institutions with Number of ACGME-Accredited Programs Below the Median (2)	0						
Other	All Regions	Program Year 8	Institutions with Number of ACGME-Accredited Programs Below the Median (2)	0						
Total	All Regions	Program Year 1	Institutions with Number of Resident/Fellows At or Above the Median (140)	166	$67,420	23,330	$68,448	$62,070	$66,220	$70,592
Total	All Regions	Program Year 2	Institutions with Number of Resident/Fellows At or Above the Median (140)	167	$70,014	23,221	$71,363	$64,251	$68,871	$73,160
Total	All Regions	Program Year 3	Institutions with Number of Resident/Fellows At or Above the Median (140)	167	$72,896	22,568	$74,376	$66,384	$71,181	$76,900
Total	All Regions	Program Year 4	Institutions with Number of Resident/Fellows At or Above the Median (140)	167	$75,980	17,157	$78,317	$69,299	$74,118	$80,476
Total	All Regions	Program Year 5	Institutions with Number of Resident/Fellows At or Above the Median (140)	164	$79,408	12,298	$82,623	$72,941	$77,658	$84,072
Total	All Regions	Program Year 6	Institutions with Number of Resident/Fellows At or Above the Median (140)	156	$82,257	6,962	$86,078	$75,241	$80,458	$87,442
Total	All Regions	Program Year 7	Institutions with Number of Resident/Fellows At or Above the Median (140)	144	$85,875	2,354	$90,323	$78,383	$83,822	$91,484
Total	All Regions	Program Year 8	Institutions with Number of Resident/Fellows At or Above the Median (140)	108	$90,639	561	$94,291	$83,673	$88,547	$95,923
General Hospital & Specialty Hospital	All Regions	Program Year 1	Institutions with Number of Resident/Fellows At or Above the Median (82)	57	$69,434			$64,032	$68,926	$75,778
General Hospital & Specialty Hospital	All Regions	Program Year 2	Institutions with Number of Resident/Fellows At or Above the Median (82)	58	$72,188			$66,603	$71,263	$78,973
General Hospital & Specialty Hospital	All Regions	Program Year 3	Institutions with Number of Resident/Fellows At or Above the Median (82)	58	$75,696			$69,280	$74,911	$82,077
General Hospital & Specialty Hospital	All Regions	Program Year 4	Institutions with Number of Resident/Fellows At or Above the Median (82)	57	$78,570			$71,979	$78,000	$84,816
General Hospital & Specialty Hospital	All Regions	Program Year 5	Institutions with Number of Resident/Fellows At or Above the Median (82)	56	$82,105			$75,773	$81,213	$88,306
General Hospital & Specialty Hospital	All Regions	Program Year 6	Institutions with Number of Resident/Fellows At or Above the Median (82)	50	$85,370			$78,967	$84,578	$91,694
General Hospital & Specialty Hospital	All Regions	Program Year 7	Institutions with Number of Resident/Fellows At or Above the Median (82)	39	$89,930			$83,011	$89,245	$96,767
General Hospital & Specialty Hospital	All Regions	Program Year 8	Institutions with Number of Resident/Fellows At or Above the Median (82)	31	$94,363			$87,364	$94,981	$101,130
Health System & Consortium	All Regions	Program Year 1	Institutions with Number of Resident/Fellows At or Above the Median (186)	47	$66,718			$62,081	$65,718	$69,112
Health System & Consortium	All Regions	Program Year 2	Institutions with Number of Resident/Fellows At or Above the Median (186)	47	$69,205			$64,368	$68,307	$71,566

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Health System & Consortium	All Regions	Program Year 3	Institutions with Number of Resident/Fellows At or Above the Median (186)	47	$71,811			$67,200	$70,519	$74,546
Health System & Consortium	All Regions	Program Year 4	Institutions with Number of Resident/Fellows At or Above the Median (186)	47	$74,900			$70,128	$72,839	$77,912
Health System & Consortium	All Regions	Program Year 5	Institutions with Number of Resident/Fellows At or Above the Median (186)	46	$78,238			$73,503	$75,771	$81,388
Health System & Consortium	All Regions	Program Year 6	Institutions with Number of Resident/Fellows At or Above the Median (186)	45	$80,672			$75,016	$77,836	$84,332
Health System & Consortium	All Regions	Program Year 7	Institutions with Number of Resident/Fellows At or Above the Median (186)	42	$83,957			$77,794	$81,896	$87,493
Health System & Consortium	All Regions	Program Year 8	Institutions with Number of Resident/Fellows At or Above the Median (186)	32	$88,418			$82,154	$85,774	$92,099
Medical School	All Regions	Program Year 1	Institutions with Number of Resident/Fellows At or Above the Median (582.5)	35	$68,241			$63,175	$66,530	$70,558
Medical School	All Regions	Program Year 2	Institutions with Number of Resident/Fellows At or Above the Median (582.5)	35	$70,871			$65,237	$69,431	$73,368
Medical School	All Regions	Program Year 3	Institutions with Number of Resident/Fellows At or Above the Median (582.5)	35	$73,626			$67,595	$71,980	$76,933
Medical School	All Regions	Program Year 4	Institutions with Number of Resident/Fellows At or Above the Median (582.5)	35	$76,796			$69,901	$74,888	$80,124
Medical School	All Regions	Program Year 5	Institutions with Number of Resident/Fellows At or Above the Median (582.5)	35	$80,052			$73,051	$78,540	$83,714
Medical School	All Regions	Program Year 6	Institutions with Number of Resident/Fellows At or Above the Median (582.5)	35	$82,931			$75,626	$81,086	$87,285
Medical School	All Regions	Program Year 7	Institutions with Number of Resident/Fellows At or Above the Median (582.5)	35	$86,229			$79,122	$83,560	$90,459
Medical School	All Regions	Program Year 8	Institutions with Number of Resident/Fellows At or Above the Median (582.5)	29	$90,431			$83,759	$87,693	$93,276
Other	All Regions	Program Year 1	Institutions with Number of Resident/Fellows At or Above the Median (32)	28	$66,120			$60,741	$65,248	$69,861
Other	All Regions	Program Year 2	Institutions with Number of Resident/Fellows At or Above the Median (32)	28	$68,611			$61,386	$67,986	$72,792
Other	All Regions	Program Year 3	Institutions with Number of Resident/Fellows At or Above the Median (32)	28	$71,537			$65,711	$70,396	$76,003
Other	All Regions	Program Year 4	Institutions with Number of Resident/Fellows At or Above the Median (32)	24	$74,773			$68,661	$74,447	$81,726
Other	All Regions	Program Year 5	Institutions with Number of Resident/Fellows At or Above the Median (32)	21	$77,923			$72,641	$78,800	$84,320
Other	All Regions	Program Year 6	Institutions with Number of Resident/Fellows At or Above the Median (32)	17	$82,163			$75,487	$82,680	$88,133
Other	All Regions	Program Year 7	Institutions with Number of Resident/Fellows At or Above the Median (32)	17	$85,580			$78,104	$86,980	$92,383
Other	All Regions	Program Year 8	Institutions with Number of Resident/Fellows At or Above the Median (32)	12	$91,971			$86,679	$91,729	$94,604
Total	All Regions	Program Year 1	Institutions with Number of Resident/Fellows Below the Median (140)	161	$65,589	2,869	$64,838	$60,500	$64,052	$69,209
Total	All Regions	Program Year 2	Institutions with Number of Resident/Fellows Below the Median (140)	159	$67,333	2,351	$67,553	$62,375	$66,910	$71,168
Total	All Regions	Program Year 3	Institutions with Number of Resident/Fellows Below the Median (140)	159	$70,112	2,154	$70,681	$65,000	$68,959	$74,125
Total	All Regions	Program Year 4	Institutions with Number of Resident/Fellows Below the Median (140)	93	$74,450	565	$74,566	$68,505	$73,223	$80,000
Total	All Regions	Program Year 5	Institutions with Number of Resident/Fellows Below the Median (140)	68	$77,780	250	$77,134	$70,944	$76,549	$83,331
Total	All Regions	Program Year 6	Institutions with Number of Resident/Fellows Below the Median (140)	46	$78,490	123	$77,745	$72,735	$77,611	$83,671
Total	All Regions	Program Year 7	Institutions with Number of Resident/Fellows Below the Median (140)	27	$84,536	18	$86,212	$76,641	$83,986	$89,174
Total	All Regions	Program Year 8	Institutions with Number of Resident/Fellows Below the Median (140)	14	$89,971	5		$87,152	$88,844	$94,135
General Hospital & Specialty Hospital	All Regions	Program Year 1	Institutions with Number of Resident/Fellows Below the Median (82)	54	$64,666			$60,000	$63,689	$69,085
General Hospital & Specialty Hospital	All Regions	Program Year 2	Institutions with Number of Resident/Fellows Below the Median (82)	56	$67,569			$62,210	$66,459	$71,401
General Hospital & Specialty Hospital	All Regions	Program Year 3	Institutions with Number of Resident/Fellows Below the Median (82)	56	$70,437			$64,610	$68,602	$75,182
General Hospital & Specialty Hospital	All Regions	Program Year 4	Institutions with Number of Resident/Fellows Below the Median (82)	29	$75,989			$70,500	$74,189	$79,477
General Hospital & Specialty Hospital	All Regions	Program Year 5	Institutions with Number of Resident/Fellows Below the Median (82)	19	$80,561			$73,802	$78,949	$83,785
General Hospital & Specialty Hospital	All Regions	Program Year 6	Institutions with Number of Resident/Fellows Below the Median (82)	12	$78,059			$75,312	$77,455	$82,714
General Hospital & Specialty Hospital	All Regions	Program Year 7	Institutions with Number of Resident/Fellows Below the Median (82)	8	$84,325			$80,453	$83,269	$87,743
General Hospital & Specialty Hospital	All Regions	Program Year 8	Institutions with Number of Resident/Fellows Below the Median (82)	4						
Health System & Consortium	All Regions	Program Year 1	Institutions with Number of Resident/Fellows Below the Median (186)	46	$64,981			$61,743	$64,244	$67,007
Health System & Consortium	All Regions	Program Year 2	Institutions with Number of Resident/Fellows Below the Median (186)	46	$67,321			$63,581	$66,808	$69,403
Health System & Consortium	All Regions	Program Year 3	Institutions with Number of Resident/Fellows Below the Median (186)	46	$69,920			$66,089	$68,698	$72,358
Health System & Consortium	All Regions	Program Year 4	Institutions with Number of Resident/Fellows Below the Median (186)	31	$73,317			$68,159	$72,176	$75,126
Health System & Consortium	All Regions	Program Year 5	Institutions with Number of Resident/Fellows Below the Median (186)	22	$76,441			$72,843	$75,572	$78,264
Health System & Consortium	All Regions	Program Year 6	Institutions with Number of Resident/Fellows Below the Median (186)	14	$77,337			$72,960	$77,350	$80,467
Health System & Consortium	All Regions	Program Year 7	Institutions with Number of Resident/Fellows Below the Median (186)	9	$85,902			$83,283	$83,986	$91,936
Health System & Consortium	All Regions	Program Year 8	Institutions with Number of Resident/Fellows Below the Median (186)	5	$86,594			$86,819	$88,150	$88,884
Medical School	All Regions	Program Year 1	Institutions with Number of Resident/Fellows Below the Median (582.5)	35	$61,831			$60,155	$62,546	$63,989
Medical School	All Regions	Program Year 2	Institutions with Number of Resident/Fellows Below the Median (582.5)	35	$64,003			$61,798	$64,286	$66,286
Medical School	All Regions	Program Year 3	Institutions with Number of Resident/Fellows Below the Median (582.5)	35	$66,156			$63,950	$66,303	$68,407
Medical School	All Regions	Program Year 4	Institutions with Number of Resident/Fellows Below the Median (582.5)	32	$70,228			$66,550	$69,226	$72,204
Medical School	All Regions	Program Year 5	Institutions with Number of Resident/Fellows Below the Median (582.5)	29	$72,963			$69,383	$71,354	$75,402
Medical School	All Regions	Program Year 6	Institutions with Number of Resident/Fellows Below the Median (582.5)	27	$75,966			$71,629	$74,044	$78,403
Medical School	All Regions	Program Year 7	Institutions with Number of Resident/Fellows Below the Median (582.5)	20	$79,269			$74,363	$76,367	$81,333
Medical School	All Regions	Program Year 8	Institutions with Number of Resident/Fellows Below the Median (582.5)	8	$81,787			$79,254	$82,491	$85,357
Other	All Regions	Program Year 1	Institutions with Number of Resident/Fellows Below the Median (32)	25	$70,924			$60,500	$65,920	$72,301
Other	All Regions	Program Year 2	Institutions with Number of Resident/Fellows Below the Median (32)	21	$68,401			$62,500	$67,600	$73,000
Other	All Regions	Program Year 3	Institutions with Number of Resident/Fellows Below the Median (32)	21	$71,411			$65,000	$70,304	$77,000
Other	All Regions	Program Year 4	Institutions with Number of Resident/Fellows Below the Median (32)	5	$81,507			$77,179	$85,000	$85,338
Other	All Regions	Program Year 5	Institutions with Number of Resident/Fellows Below the Median (32)	4						
Other	All Regions	Program Year 6	Institutions with Number of Resident/Fellows Below the Median (32)	2						
Other	All Regions	Program Year 7	Institutions with Number of Resident/Fellows Below the Median (32)	1						
Other	All Regions	Program Year 8	Institutions with Number of Resident/Fellows Below the Median (32)	1						
Total	Northeast	Program Year 1	All Institutions	86	$70,773	7,404	$72,536	$65,781	$70,000	$75,771
Total	Northeast	Program Year 2	All Institutions	85	$73,633	7,372	$75,688	$68,590	$72,675	$77,541
Total	Northeast	Program Year 3	All Institutions	85	$77,307	7,184	$79,459	$72,003	$76,447	$82,500
Total	Northeast	Program Year 4	All Institutions	67	$82,463	5,116	$83,254	$77,047	$80,901	$87,083
Total	Northeast	Program Year 5	All Institutions	61	$85,752	3,557	$87,844	$79,747	$84,320	$89,500

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Total	Northeast	Program Year 6	All Institutions	54	$88,282	2,002	$92,207	$82,467	$87,285	$92,256
Total	Northeast	Program Year 7	All Institutions	49	$91,472	685	$97,538	$84,796	$90,536	$98,000
Total	Northeast	Program Year 8	All Institutions	39	$95,097	189	$103,736	$88,310	$95,583	$101,192
General Hospital & Specialty Hospital	Northeast	Program Year 1	All Institutions	42	$70,249			$65,775	$70,000	$76,378
General Hospital & Specialty Hospital	Northeast	Program Year 2	All Institutions	42	$73,477			$68,835	$72,521	$79,387
General Hospital & Specialty Hospital	Northeast	Program Year 3	All Institutions	42	$77,482			$72,349	$76,902	$84,005
General Hospital & Specialty Hospital	Northeast	Program Year 4	All Institutions	33	$83,661			$78,000	$81,927	$88,702
General Hospital & Specialty Hospital	Northeast	Program Year 5	All Institutions	30	$87,762			$82,177	$86,172	$94,628
General Hospital & Specialty Hospital	Northeast	Program Year 6	All Institutions	25	$90,624			$85,376	$89,848	$98,675
General Hospital & Specialty Hospital	Northeast	Program Year 7	All Institutions	20	$94,075			$88,133	$93,589	$103,341
General Hospital & Specialty Hospital	Northeast	Program Year 8	All Institutions	16	$97,457			$92,060	$96,462	$106,148
Health System & Consortium	Northeast	Program Year 1	All Institutions	23	$69,470			$65,625	$68,036	$71,423
Health System & Consortium	Northeast	Program Year 2	All Institutions	23	$72,371			$68,196	$71,238	$73,673
Health System & Consortium	Northeast	Program Year 3	All Institutions	23	$75,443			$71,157	$74,082	$76,930
Health System & Consortium	Northeast	Program Year 4	All Institutions	18	$79,366			$73,348	$77,482	$80,988
Health System & Consortium	Northeast	Program Year 5	All Institutions	17	$82,915			$77,101	$81,416	$84,844
Health System & Consortium	Northeast	Program Year 6	All Institutions	15	$84,434			$79,145	$84,316	$88,097
Health System & Consortium	Northeast	Program Year 7	All Institutions	15	$87,308			$82,245	$87,251	$91,845
Health System & Consortium	Northeast	Program Year 8	All Institutions	10	$91,756			$88,647	$91,186	$96,059
Medical School	Northeast	Program Year 1	All Institutions	9	$71,703			$66,628	$70,176	$71,923
Medical School	Northeast	Program Year 2	All Institutions	9	$74,268			$68,988	$73,135	$74,799
Medical School	Northeast	Program Year 3	All Institutions	9	$77,586			$72,495	$76,656	$77,792
Medical School	Northeast	Program Year 4	All Institutions	9	$80,696			$75,418	$79,863	$80,904
Medical School	Northeast	Program Year 5	All Institutions	9	$83,861			$78,906	$83,377	$84,139
Medical School	Northeast	Program Year 6	All Institutions	9	$86,452			$81,954	$87,112	$87,505
Medical School	Northeast	Program Year 7	All Institutions	9	$89,375			$84,376	$90,382	$91,005
Medical School	Northeast	Program Year 8	All Institutions	9	$92,023			$86,903	$93,095	$94,646
Other	Northeast	Program Year 1	All Institutions	12	$74,412			$68,693	$70,524	$76,831
Other	Northeast	Program Year 2	All Institutions	11	$76,352			$73,093	$73,607	$78,997
Other	Northeast	Program Year 3	All Institutions	11	$80,306			$77,256	$77,775	$84,986
Other	Northeast	Program Year 4	All Institutions	7	$87,053			$81,990	$84,598	$89,179
Other	Northeast	Program Year 5	All Institutions	5	$86,735			$84,481	$86,162	$88,598
Other	Northeast	Program Year 6	All Institutions	5	$91,408			$88,133	$90,480	$92,383
Other	Northeast	Program Year 7	All Institutions	5	$97,324			$92,574	$96,540	$99,123
Other	Northeast	Program Year 8	All Institutions	4						
Total	Northeast	Program Year 1	Institutions with Number of ACGME-Accredited Programs At or Above the Median (10)	45	$72,123	6,643	$72,709	$67,851	$70,660	$77,500
Total	Northeast	Program Year 2	Institutions with Number of ACGME-Accredited Programs At or Above the Median (10)	45	$75,189	6,692	$75,792	$70,502	$73,473	$80,452
Total	Northeast	Program Year 3	Institutions with Number of ACGME-Accredited Programs At or Above the Median (10)	45	$78,864	6,538	$79,483	$73,666	$77,412	$84,970
Total	Northeast	Program Year 4	Institutions with Number of ACGME-Accredited Programs At or Above the Median (10)	45	$82,207	4,968	$83,133	$77,051	$80,904	$87,772
Total	Northeast	Program Year 5	Institutions with Number of ACGME-Accredited Programs At or Above the Median (10)	45	$85,536	3,504	$87,733	$79,730	$84,320	$90,115
Total	Northeast	Program Year 6	Institutions with Number of ACGME-Accredited Programs At or Above the Median (10)	44	$88,219	1,980	$92,195	$83,048	$87,482	$93,187
Total	Northeast	Program Year 7	Institutions with Number of ACGME-Accredited Programs At or Above the Median (10)	41	$91,688	683	$97,552	$85,120	$90,536	$99,123
Total	Northeast	Program Year 8	Institutions with Number of ACGME-Accredited Programs At or Above the Median (10)	35	$95,854	189	$103,736	$89,304	$95,583	$103,804
General Hospital & Specialty Hospital	Northeast	Program Year 1	Institutions with Number of ACGME-Accredited Programs At or Above the Median (5)	26	$72,533			$67,658	$72,413	$78,317
General Hospital & Specialty Hospital	Northeast	Program Year 2	Institutions with Number of ACGME-Accredited Programs At or Above the Median (5)	26	$75,982			$70,072	$75,356	$81,499
General Hospital & Specialty Hospital	Northeast	Program Year 3	Institutions with Number of ACGME-Accredited Programs At or Above the Median (5)	26	$80,443			$73,779	$78,938	$85,885
General Hospital & Specialty Hospital	Northeast	Program Year 4	Institutions with Number of ACGME-Accredited Programs At or Above the Median (5)	25	$84,724			$78,000	$83,323	$90,470
General Hospital & Specialty Hospital	Northeast	Program Year 5	Institutions with Number of ACGME-Accredited Programs At or Above the Median (5)	25	$88,290			$81,902	$86,569	$95,324
General Hospital & Specialty Hospital	Northeast	Program Year 6	Institutions with Number of ACGME-Accredited Programs At or Above the Median (5)	23	$90,849			$84,361	$89,848	$100,423
General Hospital & Specialty Hospital	Northeast	Program Year 7	Institutions with Number of ACGME-Accredited Programs At or Above the Median (5)	18	$94,269			$85,908	$93,589	$104,254
General Hospital & Specialty Hospital	Northeast	Program Year 8	Institutions with Number of ACGME-Accredited Programs At or Above the Median (5)	15	$97,513			$89,879	$96,308	$106,189
Health System & Consortium	Northeast	Program Year 1	Institutions with Number of ACGME-Accredited Programs At or Above the Median (12)	12	$70,359			$67,607	$68,997	$71,215
Health System & Consortium	Northeast	Program Year 2	Institutions with Number of ACGME-Accredited Programs At or Above the Median (12)	12	$73,061			$70,305	$71,493	$73,352
Health System & Consortium	Northeast	Program Year 3	Institutions with Number of ACGME-Accredited Programs At or Above the Median (12)	12	$75,793			$73,122	$74,163	$76,688
Health System & Consortium	Northeast	Program Year 4	Institutions with Number of ACGME-Accredited Programs At or Above the Median (12)	12	$79,055			$75,778	$77,482	$80,707
Health System & Consortium	Northeast	Program Year 5	Institutions with Number of ACGME-Accredited Programs At or Above the Median (12)	12	$82,168			$78,854	$80,775	$84,552
Health System & Consortium	Northeast	Program Year 6	Institutions with Number of ACGME-Accredited Programs At or Above the Median (12)	12	$85,227			$81,920	$84,324	$88,019
Health System & Consortium	Northeast	Program Year 7	Institutions with Number of ACGME-Accredited Programs At or Above the Median (12)	11	$87,901			$83,655	$87,251	$90,513
Health System & Consortium	Northeast	Program Year 8	Institutions with Number of ACGME-Accredited Programs At or Above the Median (12)	7	$94,328			$90,339	$91,832	$98,105
Medical School	Northeast	Program Year 1	Institutions with Number of ACGME-Accredited Programs At or Above the Median (45)	8	$72,619			$67,315	$70,558	$74,802
Medical School	Northeast	Program Year 2	Institutions with Number of ACGME-Accredited Programs At or Above the Median (45)	8	$75,247			$69,821	$73,368	$77,549
Medical School	Northeast	Program Year 3	Institutions with Number of ACGME-Accredited Programs At or Above the Median (45)	8	$78,852			$73,373	$76,933	$81,255
Medical School	Northeast	Program Year 4	Institutions with Number of ACGME-Accredited Programs At or Above the Median (45)	8	$82,242			$77,040	$80,124	$84,554
Medical School	Northeast	Program Year 5	Institutions with Number of ACGME-Accredited Programs At or Above the Median (45)	8	$85,402			$79,711	$83,714	$87,492
Medical School	Northeast	Program Year 6	Institutions with Number of ACGME-Accredited Programs At or Above the Median (45)	8	$88,317			$82,121	$87,285	$90,414
Medical School	Northeast	Program Year 7	Institutions with Number of ACGME-Accredited Programs At or Above the Median (45)	8	$91,605			$84,934	$90,459	$93,966
Medical School	Northeast	Program Year 8	Institutions with Number of ACGME-Accredited Programs At or Above the Median (45)	8	$94,584			$88,078	$93,186	$97,625

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Other	Northeast	Program Year 1	Institutions with Number of ACGME-Accredited Programs At or Above the Median (2)	6	$71,601			$69,176	$70,524	$74,256
Other	Northeast	Program Year 2	Institutions with Number of ACGME-Accredited Programs At or Above the Median (2)	6	$75,032			$73,257	$73,540	$76,558
Other	Northeast	Program Year 3	Institutions with Number of ACGME-Accredited Programs At or Above the Median (2)	6	$78,720			$77,536	$77,691	$79,173
Other	Northeast	Program Year 4	Institutions with Number of ACGME-Accredited Programs At or Above the Median (2)	5	$83,121			$81,841	$82,139	$84,598
Other	Northeast	Program Year 5	Institutions with Number of ACGME-Accredited Programs At or Above the Median (2)	5	$86,735			$84,481	$86,162	$88,598
Other	Northeast	Program Year 6	Institutions with Number of ACGME-Accredited Programs At or Above the Median (2)	5	$91,408			$88,133	$90,480	$92,383
Other	Northeast	Program Year 7	Institutions with Number of ACGME-Accredited Programs At or Above the Median (2)	5	$97,324			$92,574	$96,540	$99,123
Other	Northeast	Program Year 8	Institutions with Number of ACGME-Accredited Programs At or Above the Median (2)	4						
Total	Northeast	Program Year 1	Institutions with Number of ACGME-Accredited Programs Below the Median (10)	41	$69,293	761	$71,031	$64,796	$68,078	$71,965
Total	Northeast	Program Year 2	Institutions with Number of ACGME-Accredited Programs Below the Median (10)	40	$71,883	680	$74,663	$67,892	$71,016	$75,225
Total	Northeast	Program Year 3	Institutions with Number of ACGME-Accredited Programs Below the Median (10)	40	$75,554	646	$79,209	$70,619	$74,395	$79,018
Total	Northeast	Program Year 4	Institutions with Number of ACGME-Accredited Programs Below the Median (10)	22	$82,988	148	$87,338	$77,141	$80,299	$86,349
Total	Northeast	Program Year 5	Institutions with Number of ACGME-Accredited Programs Below the Median (10)	16	$86,357	53	$95,180	$80,043	$83,965	$88,910
Total	Northeast	Program Year 6	Institutions with Number of ACGME-Accredited Programs Below the Median (10)	10	$88,559	22	$93,279	$82,234	$86,242	$90,918
Total	Northeast	Program Year 7	Institutions with Number of ACGME-Accredited Programs Below the Median (10)	8	$90,365	2		$84,560	$90,968	$93,736
Total	Northeast	Program Year 8	Institutions with Number of ACGME-Accredited Programs Below the Median (10)	4		0				
General Hospital & Specialty Hospital	Northeast	Program Year 1	Institutions with Number of ACGME-Accredited Programs Below the Median (5)	16	$66,536			$63,126	$67,891	$71,143
General Hospital & Specialty Hospital	Northeast	Program Year 2	Institutions with Number of ACGME-Accredited Programs Below the Median (5)	16	$69,405			$65,793	$71,370	$74,490
General Hospital & Specialty Hospital	Northeast	Program Year 3	Institutions with Number of ACGME-Accredited Programs Below the Median (5)	16	$72,670			$68,230	$74,507	$78,054
General Hospital & Specialty Hospital	Northeast	Program Year 4	Institutions with Number of ACGME-Accredited Programs Below the Median (5)	8	$80,340			$78,396	$80,702	$83,594
General Hospital & Specialty Hospital	Northeast	Program Year 5	Institutions with Number of ACGME-Accredited Programs Below the Median (5)	5	$85,124			$83,000	$85,424	$88,539
General Hospital & Specialty Hospital	Northeast	Program Year 6	Institutions with Number of ACGME-Accredited Programs Below the Median (5)	2						
General Hospital & Specialty Hospital	Northeast	Program Year 7	Institutions with Number of ACGME-Accredited Programs Below the Median (5)	2						
General Hospital & Specialty Hospital	Northeast	Program Year 8	Institutions with Number of ACGME-Accredited Programs Below the Median (5)	1						
Health System & Consortium	Northeast	Program Year 1	Institutions with Number of ACGME-Accredited Programs Below the Median (12)	11	$68,499			$64,262	$65,647	$72,087
Health System & Consortium	Northeast	Program Year 2	Institutions with Number of ACGME-Accredited Programs Below the Median (12)	11	$71,618			$67,892	$68,465	$74,894
Health System & Consortium	Northeast	Program Year 3	Institutions with Number of ACGME-Accredited Programs Below the Median (12)	11	$75,061			$70,607	$71,947	$78,729
Health System & Consortium	Northeast	Program Year 4	Institutions with Number of ACGME-Accredited Programs Below the Median (12)	6	$79,987			$73,064	$77,285	$84,384
Health System & Consortium	Northeast	Program Year 5	Institutions with Number of ACGME-Accredited Programs Below the Median (12)	5	$84,709			$77,101	$83,262	$88,910
Health System & Consortium	Northeast	Program Year 6	Institutions with Number of ACGME-Accredited Programs Below the Median (12)	3						
Health System & Consortium	Northeast	Program Year 7	Institutions with Number of ACGME-Accredited Programs Below the Median (12)	4						
Health System & Consortium	Northeast	Program Year 8	Institutions with Number of ACGME-Accredited Programs Below the Median (12)	3						
Medical School	Northeast	Program Year 1	Institutions with Number of ACGME-Accredited Programs Below the Median (45)	1						
Medical School	Northeast	Program Year 2	Institutions with Number of ACGME-Accredited Programs Below the Median (45)	1						
Medical School	Northeast	Program Year 3	Institutions with Number of ACGME-Accredited Programs Below the Median (45)	1						
Medical School	Northeast	Program Year 4	Institutions with Number of ACGME-Accredited Programs Below the Median (45)	1						
Medical School	Northeast	Program Year 5	Institutions with Number of ACGME-Accredited Programs Below the Median (45)	1						
Medical School	Northeast	Program Year 6	Institutions with Number of ACGME-Accredited Programs Below the Median (45)	1						
Medical School	Northeast	Program Year 7	Institutions with Number of ACGME-Accredited Programs Below the Median (45)	1						
Medical School	Northeast	Program Year 8	Institutions with Number of ACGME-Accredited Programs Below the Median (45)	1						
Other	Northeast	Program Year 1	Institutions with Number of ACGME-Accredited Programs Below the Median (2)	6	$77,223			$66,561	$74,849	$86,329
Other	Northeast	Program Year 2	Institutions with Number of ACGME-Accredited Programs Below the Median (2)	5	$77,936			$73,000	$76,762	$84,916
Other	Northeast	Program Year 3	Institutions with Number of ACGME-Accredited Programs Below the Median (2)	5	$82,210			$77,000	$84,886	$88,313
Other	Northeast	Program Year 4	Institutions with Number of ACGME-Accredited Programs Below the Median (2)	2						
Other	Northeast	Program Year 5	Institutions with Number of ACGME-Accredited Programs Below the Median (2)	0						
Other	Northeast	Program Year 6	Institutions with Number of ACGME-Accredited Programs Below the Median (2)	0						
Other	Northeast	Program Year 7	Institutions with Number of ACGME-Accredited Programs Below the Median (2)	0						
Other	Northeast	Program Year 8	Institutions with Number of ACGME-Accredited Programs Below the Median (2)	0						
Total	Northeast	Program Year 1	Institutions with Number of Resident/Fellows At or Above the Median (140)	44	$72,526	6,738	$72,926	$67,990	$70,800	$78,072
Total	Northeast	Program Year 2	Institutions with Number of Resident/Fellows At or Above the Median (140)	44	$75,728	6,792	$76,056	$71,054	$73,537	$81,226
Total	Northeast	Program Year 3	Institutions with Number of Resident/Fellows At or Above the Median (140)	44	$79,654	6,644	$79,819	$73,978	$77,462	$85,453
Total	Northeast	Program Year 4	Institutions with Number of Resident/Fellows At or Above the Median (140)	44	$82,995	4,980	$83,324	$77,312	$81,016	$89,243
Total	Northeast	Program Year 5	Institutions with Number of Resident/Fellows At or Above the Median (140)	44	$86,381	3,506	$87,887	$79,917	$84,387	$94,153
Total	Northeast	Program Year 6	Institutions with Number of Resident/Fellows At or Above the Median (140)	43	$89,141	1,984	$92,279	$83,536	$87,505	$96,401
Total	Northeast	Program Year 7	Institutions with Number of Resident/Fellows At or Above the Median (140)	40	$92,236	682	$97,535	$86,283	$90,771	$99,182
Total	Northeast	Program Year 8	Institutions with Number of Resident/Fellows At or Above the Median (140)	33	$96,003	186	$104,020	$90,139	$95,583	$101,500
General Hospital & Specialty Hospital	Northeast	Program Year 1	Institutions with Number of Resident/Fellows At or Above the Median (82)	24	$72,993			$68,440	$73,795	$78,072
General Hospital & Specialty Hospital	Northeast	Program Year 2	Institutions with Number of Resident/Fellows At or Above the Median (82)	24	$76,280			$71,128	$76,458	$81,226
General Hospital & Specialty Hospital	Northeast	Program Year 3	Institutions with Number of Resident/Fellows At or Above the Median (82)	24	$80,838			$74,649	$79,891	$85,544
General Hospital & Specialty Hospital	Northeast	Program Year 4	Institutions with Number of Resident/Fellows At or Above the Median (82)	24	$84,250			$78,095	$83,511	$89,416
General Hospital & Specialty Hospital	Northeast	Program Year 5	Institutions with Number of Resident/Fellows At or Above the Median (82)	24	$87,813			$82,726	$87,100	$94,981
General Hospital & Specialty Hospital	Northeast	Program Year 6	Institutions with Number of Resident/Fellows At or Above the Median (82)	23	$91,206			$85,425	$90,082	$100,423
General Hospital & Specialty Hospital	Northeast	Program Year 7	Institutions with Number of Resident/Fellows At or Above the Median (82)	18	$94,817			$89,434	$94,388	$104,254
General Hospital & Specialty Hospital	Northeast	Program Year 8	Institutions with Number of Resident/Fellows At or Above the Median (82)	16	$97,457			$92,060	$96,462	$106,148
Health System & Consortium	Northeast	Program Year 1	Institutions with Number of Resident/Fellows At or Above the Median (186)	12	$70,359			$67,607	$68,997	$71,215
Health System & Consortium	Northeast	Program Year 2	Institutions with Number of Resident/Fellows At or Above the Median (186)	12	$73,061			$70,305	$71,493	$73,352
Health System & Consortium	Northeast	Program Year 3	Institutions with Number of Resident/Fellows At or Above the Median (186)	12	$75,793			$73,122	$74,163	$76,688

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Health System & Consortium	Northeast	Program Year 4	Institutions with Number of Resident/Fellows At or Above the Median (186)	12	$79,055			$75,778	$77,482	$80,707
Health System & Consortium	Northeast	Program Year 5	Institutions with Number of Resident/Fellows At or Above the Median (186)	12	$82,168			$78,854	$80,775	$84,552
Health System & Consortium	Northeast	Program Year 6	Institutions with Number of Resident/Fellows At or Above the Median (186)	12	$85,227			$81,920	$84,324	$88,019
Health System & Consortium	Northeast	Program Year 7	Institutions with Number of Resident/Fellows At or Above the Median (186)	11	$87,901			$83,655	$87,251	$90,513
Health System & Consortium	Northeast	Program Year 8	Institutions with Number of Resident/Fellows At or Above the Median (186)	7	$94,328			$90,339	$91,832	$98,105
Medical School	Northeast	Program Year 1	Institutions with Number of Resident/Fellows At or Above the Median (582.5)	7	$73,474			$68,860	$70,940	$77,681
Medical School	Northeast	Program Year 2	Institutions with Number of Resident/Fellows At or Above the Median (582.5)	7	$76,141			$71,617	$73,601	$80,300
Medical School	Northeast	Program Year 3	Institutions with Number of Resident/Fellows At or Above the Median (582.5)	7	$79,760			$75,161	$77,210	$84,717
Medical School	Northeast	Program Year 4	Institutions with Number of Resident/Fellows At or Above the Median (582.5)	7	$83,217			$78,722	$80,384	$88,203
Medical School	Northeast	Program Year 5	Institutions with Number of Resident/Fellows At or Above the Median (582.5)	7	$86,330			$81,678	$84,050	$90,845
Medical School	Northeast	Program Year 6	Institutions with Number of Resident/Fellows At or Above the Median (582.5)	7	$89,226			$84,644	$87,458	$93,323
Medical School	Northeast	Program Year 7	Institutions with Number of Resident/Fellows At or Above the Median (582.5)	7	$92,638			$87,751	$90,536	$96,928
Medical School	Northeast	Program Year 8	Institutions with Number of Resident/Fellows At or Above the Median (582.5)	7	$95,681			$90,782	$93,276	$100,603
Other	Northeast	Program Year 1	Institutions with Number of Resident/Fellows At or Above the Median (32)	5	$74,783			$70,387	$70,660	$75,876
Other	Northeast	Program Year 2	Institutions with Number of Resident/Fellows At or Above the Median (32)	5	$78,643			$73,473	$73,607	$80,452
Other	Northeast	Program Year 3	Institutions with Number of Resident/Fellows At or Above the Median (32)	5	$82,866			$77,606	$77,775	$85,086
Other	Northeast	Program Year 4	Institutions with Number of Resident/Fellows At or Above the Median (32)	5	$86,203			$81,841	$82,139	$84,598
Other	Northeast	Program Year 5	Institutions with Number of Resident/Fellows At or Above the Median (32)	4						
Other	Northeast	Program Year 6	Institutions with Number of Resident/Fellows At or Above the Median (32)	4						
Other	Northeast	Program Year 7	Institutions with Number of Resident/Fellows At or Above the Median (32)	4						
Other	Northeast	Program Year 8	Institutions with Number of Resident/Fellows At or Above the Median (32)	3						
Total	Northeast	Program Year 1	Institutions with Number of Resident/Fellows Below the Median (140)	39	$68,925	666	$68,591	$64,015	$67,704	$72,551
Total	Northeast	Program Year 2	Institutions with Number of Resident/Fellows Below the Median (140)	38	$71,332	580	$71,377	$66,784	$70,766	$76,250
Total	Northeast	Program Year 3	Institutions with Number of Resident/Fellows Below the Median (140)	38	$74,742	540	$75,022	$68,876	$74,045	$79,315
Total	Northeast	Program Year 4	Institutions with Number of Resident/Fellows Below the Median (140)	21	$81,614	136	$80,692	$76,585	$80,226	$86,217
Total	Northeast	Program Year 5	Institutions with Number of Resident/Fellows Below the Median (140)	15	$84,332	51	$84,940	$79,945	$83,538	$88,911
Total	Northeast	Program Year 6	Institutions with Number of Resident/Fellows Below the Median (140)	10	$85,228	18	$84,256	$81,305	$86,242	$90,918
Total	Northeast	Program Year 7	Institutions with Number of Resident/Fellows Below the Median (140)	8	$88,487	3		$81,264	$90,968	$93,736
Total	Northeast	Program Year 8	Institutions with Number of Resident/Fellows Below the Median (140)	6	$90,113	3		$77,168	$91,880	$96,364
General Hospital & Specialty Hospital	Northeast	Program Year 1	Institutions with Number of Resident/Fellows Below the Median (82)	16	$66,257			$61,504	$66,852	$70,573
General Hospital & Specialty Hospital	Northeast	Program Year 2	Institutions with Number of Resident/Fellows Below the Median (82)	16	$69,439			$64,703	$70,370	$73,101
General Hospital & Specialty Hospital	Northeast	Program Year 3	Institutions with Number of Resident/Fellows Below the Median (82)	16	$72,670			$66,750	$73,816	$77,818
General Hospital & Specialty Hospital	Northeast	Program Year 4	Institutions with Number of Resident/Fellows Below the Median (82)	7	$82,778			$77,793	$79,477	$84,469
General Hospital & Specialty Hospital	Northeast	Program Year 5	Institutions with Number of Resident/Fellows Below the Median (82)	4						
General Hospital & Specialty Hospital	Northeast	Program Year 6	Institutions with Number of Resident/Fellows Below the Median (82)	1						
General Hospital & Specialty Hospital	Northeast	Program Year 7	Institutions with Number of Resident/Fellows Below the Median (82)	1						
General Hospital & Specialty Hospital	Northeast	Program Year 8	Institutions with Number of Resident/Fellows Below the Median (82)	0						
Health System & Consortium	Northeast	Program Year 1	Institutions with Number of Resident/Fellows Below the Median (186)	11	$68,499			$64,262	$65,647	$72,087
Health System & Consortium	Northeast	Program Year 2	Institutions with Number of Resident/Fellows Below the Median (186)	11	$71,618			$67,892	$68,465	$74,894
Health System & Consortium	Northeast	Program Year 3	Institutions with Number of Resident/Fellows Below the Median (186)	11	$75,061			$70,607	$71,947	$78,729
Health System & Consortium	Northeast	Program Year 4	Institutions with Number of Resident/Fellows Below the Median (186)	6	$79,987			$73,064	$77,285	$84,384
Health System & Consortium	Northeast	Program Year 5	Institutions with Number of Resident/Fellows Below the Median (186)	5	$84,709			$77,101	$83,262	$88,910
Health System & Consortium	Northeast	Program Year 6	Institutions with Number of Resident/Fellows Below the Median (186)	3						
Health System & Consortium	Northeast	Program Year 7	Institutions with Number of Resident/Fellows Below the Median (186)	4						
Health System & Consortium	Northeast	Program Year 8	Institutions with Number of Resident/Fellows Below the Median (186)	3						
Medical School	Northeast	Program Year 1	Institutions with Number of Resident/Fellows Below the Median (582.5)	2						
Medical School	Northeast	Program Year 2	Institutions with Number of Resident/Fellows Below the Median (582.5)	2						
Medical School	Northeast	Program Year 3	Institutions with Number of Resident/Fellows Below the Median (582.5)	2						
Medical School	Northeast	Program Year 4	Institutions with Number of Resident/Fellows Below the Median (582.5)	2						
Medical School	Northeast	Program Year 5	Institutions with Number of Resident/Fellows Below the Median (582.5)	2						
Medical School	Northeast	Program Year 6	Institutions with Number of Resident/Fellows Below the Median (582.5)	2						
Medical School	Northeast	Program Year 7	Institutions with Number of Resident/Fellows Below the Median (582.5)	2						
Medical School	Northeast	Program Year 8	Institutions with Number of Resident/Fellows Below the Median (582.5)	2						
Other	Northeast	Program Year 1	Institutions with Number of Resident/Fellows Below the Median (32)	6	$75,042			$66,561	$72,728	$78,637
Other	Northeast	Program Year 2	Institutions with Number of Resident/Fellows Below the Median (32)	5	$74,944			$73,000	$76,762	$77,541
Other	Northeast	Program Year 3	Institutions with Number of Resident/Fellows Below the Median (32)	5	$78,868			$77,000	$79,639	$84,886
Other	Northeast	Program Year 4	Institutions with Number of Resident/Fellows Below the Median (32)	2						
Other	Northeast	Program Year 5	Institutions with Number of Resident/Fellows Below the Median (32)	1						
Other	Northeast	Program Year 6	Institutions with Number of Resident/Fellows Below the Median (32)	1						
Other	Northeast	Program Year 7	Institutions with Number of Resident/Fellows Below the Median (32)	1						
Other	Northeast	Program Year 8	Institutions with Number of Resident/Fellows Below the Median (32)	1						
Total	Southern	Program Year 1	All Institutions	100	$62,198	7,845	$62,704	$58,799	$61,141	$64,150
Total	Southern	Program Year 2	All Institutions	98	$63,743	7,455	$65,169	$60,625	$63,553	$66,733
Total	Southern	Program Year 3	All Institutions	97	$65,944	7,157	$67,491	$62,735	$66,056	$69,220
Total	Southern	Program Year 4	All Institutions	75	$69,233	5,342	$71,136	$65,861	$69,299	$72,601
Total	Southern	Program Year 5	All Institutions	68	$73,409	3,714	$74,992	$69,981	$72,941	$76,757
Total	Southern	Program Year 6	All Institutions	62	$75,893	2,199	$78,002	$72,547	$75,611	$79,867

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Total	Southern	Program Year 7	All Institutions	51	$79,882	695	$81,512	$76,099	$79,918	$83,645
Total	Southern	Program Year 8	All Institutions	35	$84,205	167	$84,272	$81,512	$83,979	$87,464
General Hospital & Specialty Hospital	Southern	Program Year 1	All Institutions	23	$61,922			$58,613	$61,093	$64,342
General Hospital & Specialty Hospital	Southern	Program Year 2	All Institutions	23	$64,429			$61,184	$64,375	$67,699
General Hospital & Specialty Hospital	Southern	Program Year 3	All Institutions	23	$66,692			$62,912	$66,306	$70,374
General Hospital & Specialty Hospital	Southern	Program Year 4	All Institutions	17	$70,390			$65,268	$71,716	$74,433
General Hospital & Specialty Hospital	Southern	Program Year 5	All Institutions	14	$74,609			$72,098	$75,904	$78,157
General Hospital & Specialty Hospital	Southern	Program Year 6	All Institutions	14	$77,286			$74,853	$78,726	$81,002
General Hospital & Specialty Hospital	Southern	Program Year 7	All Institutions	10	$82,774			$81,425	$83,893	$85,041
General Hospital & Specialty Hospital	Southern	Program Year 8	All Institutions	8	$86,078			$85,803	$87,364	$89,130
Health System & Consortium	Southern	Program Year 1	All Institutions	30	$61,366			$58,849	$60,851	$63,949
Health System & Consortium	Southern	Program Year 2	All Institutions	30	$63,525			$60,500	$62,951	$66,666
Health System & Consortium	Southern	Program Year 3	All Institutions	30	$65,771			$62,569	$65,293	$69,014
Health System & Consortium	Southern	Program Year 4	All Institutions	24	$69,262			$66,393	$68,455	$72,380
Health System & Consortium	Southern	Program Year 5	All Institutions	21	$72,661			$69,981	$72,238	$75,620
Health System & Consortium	Southern	Program Year 6	All Institutions	18	$75,973			$72,418	$74,979	$78,445
Health System & Consortium	Southern	Program Year 7	All Institutions	14	$81,600			$76,125	$79,282	$84,206
Health System & Consortium	Southern	Program Year 8	All Institutions	10	$85,199			$81,737	$84,996	$87,557
Medical School	Southern	Program Year 1	All Institutions	29	$61,867			$59,277	$61,935	$64,443
Medical School	Southern	Program Year 2	All Institutions	29	$64,129			$61,711	$64,151	$66,357
Medical School	Southern	Program Year 3	All Institutions	29	$66,293			$64,168	$66,221	$68,742
Medical School	Southern	Program Year 4	All Institutions	26	$69,067			$66,365	$69,299	$71,880
Medical School	Southern	Program Year 5	All Institutions	25	$72,318			$69,666	$72,370	$75,402
Medical School	Southern	Program Year 6	All Institutions	24	$74,910			$72,114	$75,476	$78,036
Medical School	Southern	Program Year 7	All Institutions	22	$77,680			$75,868	$78,521	$81,035
Medical School	Southern	Program Year 8	All Institutions	14	$82,179			$81,129	$83,587	$84,217
Other	Southern	Program Year 1	All Institutions	18	$64,473			$59,039	$60,500	$63,818
Other	Southern	Program Year 2	All Institutions	16	$62,467			$60,694	$61,627	$65,482
Other	Southern	Program Year 3	All Institutions	15	$64,467			$61,515	$65,000	$67,474
Other	Southern	Program Year 4	All Institutions	8	$67,226			$64,952	$68,303	$69,968
Other	Southern	Program Year 5	All Institutions	8	$76,684			$71,860	$72,798	$75,179
Other	Southern	Program Year 6	All Institutions	6	$76,341			$74,718	$75,430	$75,552
Other	Southern	Program Year 7	All Institutions	5	$78,982			$77,504	$78,104	$78,248
Other	Southern	Program Year 8	All Institutions	3						
Total	Southern	Program Year 1	Institutions with Number of ACGME-Accredited Programs At or Above the Median (10)	53	$62,688	6,820	$63,114	$59,786	$63,162	$65,528
Total	Southern	Program Year 2	Institutions with Number of ACGME-Accredited Programs At or Above the Median (10)	54	$65,067	6,590	$65,636	$62,148	$65,276	$68,179
Total	Southern	Program Year 3	Institutions with Number of ACGME-Accredited Programs At or Above the Median (10)	54	$67,402	6,352	$67,974	$64,490	$67,318	$70,909
Total	Southern	Program Year 4	Institutions with Number of ACGME-Accredited Programs At or Above the Median (10)	53	$70,406	5,124	$71,365	$67,121	$70,284	$74,387
Total	Southern	Program Year 5	Institutions with Number of ACGME-Accredited Programs At or Above the Median (10)	53	$73,499	3,641	$75,079	$70,238	$72,955	$77,427
Total	Southern	Program Year 6	Institutions with Number of ACGME-Accredited Programs At or Above the Median (10)	52	$76,356	2,117	$78,288	$73,068	$75,721	$80,458
Total	Southern	Program Year 7	Institutions with Number of ACGME-Accredited Programs At or Above the Median (10)	48	$80,100	660	$82,148	$76,340	$80,056	$83,557
Total	Southern	Program Year 8	Institutions with Number of ACGME-Accredited Programs At or Above the Median (10)	33	$84,486	146	$86,409	$81,579	$83,979	$87,279
General Hospital & Specialty Hospital	Southern	Program Year 1	Institutions with Number of ACGME-Accredited Programs At or Above the Median (5)	12	$64,898			$63,144	$64,342	$67,695
General Hospital & Specialty Hospital	Southern	Program Year 2	Institutions with Number of ACGME-Accredited Programs At or Above the Median (5)	13	$67,302			$65,291	$67,174	$69,996
General Hospital & Specialty Hospital	Southern	Program Year 3	Institutions with Number of ACGME-Accredited Programs At or Above the Median (5)	13	$69,733			$66,726	$69,712	$72,720
General Hospital & Specialty Hospital	Southern	Program Year 4	Institutions with Number of ACGME-Accredited Programs At or Above the Median (5)	13	$72,795			$70,720	$74,386	$75,683
General Hospital & Specialty Hospital	Southern	Program Year 5	Institutions with Number of ACGME-Accredited Programs At or Above the Median (5)	13	$75,579			$73,736	$77,082	$78,332
General Hospital & Specialty Hospital	Southern	Program Year 6	Institutions with Number of ACGME-Accredited Programs At or Above the Median (5)	13	$78,385			$76,083	$79,790	$81,074
General Hospital & Specialty Hospital	Southern	Program Year 7	Institutions with Number of ACGME-Accredited Programs At or Above the Median (5)	10	$82,774			$81,425	$83,893	$85,041
General Hospital & Specialty Hospital	Southern	Program Year 8	Institutions with Number of ACGME-Accredited Programs At or Above the Median (5)	8	$86,078			$85,803	$87,364	$89,130
Health System & Consortium	Southern	Program Year 1	Institutions with Number of ACGME-Accredited Programs At or Above the Median (12)	13	$62,255			$58,798	$60,508	$64,917
Health System & Consortium	Southern	Program Year 2	Institutions with Number of ACGME-Accredited Programs At or Above the Median (12)	13	$64,564			$61,039	$62,600	$67,662
Health System & Consortium	Southern	Program Year 3	Institutions with Number of ACGME-Accredited Programs At or Above the Median (12)	13	$66,990			$63,126	$65,100	$70,532
Health System & Consortium	Southern	Program Year 4	Institutions with Number of ACGME-Accredited Programs At or Above the Median (12)	13	$70,180			$66,485	$68,200	$73,528
Health System & Consortium	Southern	Program Year 5	Institutions with Number of ACGME-Accredited Programs At or Above the Median (12)	13	$73,224			$69,981	$71,000	$76,648
Health System & Consortium	Southern	Program Year 6	Institutions with Number of ACGME-Accredited Programs At or Above the Median (12)	13	$76,101			$72,280	$73,900	$79,893
Health System & Consortium	Southern	Program Year 7	Institutions with Number of ACGME-Accredited Programs At or Above the Median (12)	13	$81,729			$76,034	$78,645	$84,514
Health System & Consortium	Southern	Program Year 8	Institutions with Number of ACGME-Accredited Programs At or Above the Median (12)	9	$85,531			$81,579	$86,819	$87,649
Medical School	Southern	Program Year 1	Institutions with Number of ACGME-Accredited Programs At or Above the Median (45)	15	$62,537			$60,139	$61,174	$66,060
Medical School	Southern	Program Year 2	Institutions with Number of ACGME-Accredited Programs At or Above the Median (45)	15	$64,904			$62,484	$63,686	$68,738
Medical School	Southern	Program Year 3	Institutions with Number of ACGME-Accredited Programs At or Above the Median (45)	15	$67,121			$64,693	$66,221	$70,932
Medical School	Southern	Program Year 4	Institutions with Number of ACGME-Accredited Programs At or Above the Median (45)	15	$69,973			$67,320	$69,299	$73,798
Medical School	Southern	Program Year 5	Institutions with Number of ACGME-Accredited Programs At or Above the Median (45)	15	$73,239			$70,476	$72,941	$77,397
Medical School	Southern	Program Year 6	Institutions with Number of ACGME-Accredited Programs At or Above the Median (45)	15	$75,943			$73,068	$75,721	$79,592
Medical School	Southern	Program Year 7	Institutions with Number of ACGME-Accredited Programs At or Above the Median (45)	15	$79,451			$76,365	$80,193	$81,837
Medical School	Southern	Program Year 8	Institutions with Number of ACGME-Accredited Programs At or Above the Median (45)	11	$83,282			$82,116	$83,759	$85,107
Other	Southern	Program Year 1	Institutions with Number of ACGME-Accredited Programs At or Above the Median (2)	11	$61,560			$59,583	$61,108	$64,434

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Other	Southern	Program Year 2	Institutions with Number of ACGME-Accredited Programs At or Above the Median (2)	11	$63,429			$61,086	$63,840	$66,562
Other	Southern	Program Year 3	Institutions with Number of ACGME-Accredited Programs At or Above the Median (2)	10	$64,922			$61,572	$65,735	$67,505
Other	Southern	Program Year 4	Institutions with Number of ACGME-Accredited Programs At or Above the Median (2)	8	$67,226			$64,952	$68,303	$69,968
Other	Southern	Program Year 5	Institutions with Number of ACGME-Accredited Programs At or Above the Median (2)	7	$72,496			$71,220	$72,641	$73,047
Other	Southern	Program Year 6	Institutions with Number of ACGME-Accredited Programs At or Above the Median (2)	6	$76,341			$74,718	$75,430	$75,552
Other	Southern	Program Year 7	Institutions with Number of ACGME-Accredited Programs At or Above the Median (2)	5	$78,982			$77,504	$78,104	$78,248
Other	Southern	Program Year 8	Institutions with Number of ACGME-Accredited Programs At or Above the Median (2)	3						
Total	Southern	Program Year 1	Institutions with Number of ACGME-Accredited Programs Below the Median (10)	46	$61,731	823	$60,533	$58,417	$60,154	$62,703
Total	Southern	Program Year 2	Institutions with Number of ACGME-Accredited Programs Below the Median (10)	43	$62,176	669	$62,182	$60,265	$62,000	$64,920
Total	Southern	Program Year 3	Institutions with Number of ACGME-Accredited Programs Below the Median (10)	42	$64,171	604	$64,351	$62,008	$64,240	$66,932
Total	Southern	Program Year 4	Institutions with Number of ACGME-Accredited Programs Below the Median (10)	21	$66,514	110	$67,335	$63,500	$66,975	$70,071
Total	Southern	Program Year 5	Institutions with Number of ACGME-Accredited Programs Below the Median (10)	14	$73,536	33	$75,291	$69,949	$72,619	$75,293
Total	Southern	Program Year 6	Institutions with Number of ACGME-Accredited Programs Below the Median (10)	9	$73,938	22	$73,842	$72,320	$74,500	$76,877
Total	Southern	Program Year 7	Institutions with Number of ACGME-Accredited Programs Below the Median (10)	2		1				
Total	Southern	Program Year 8	Institutions with Number of ACGME-Accredited Programs Below the Median (10)	1		0				
General Hospital & Specialty Hospital	Southern	Program Year 1	Institutions with Number of ACGME-Accredited Programs Below the Median (5)	11	$58,676			$56,138	$58,427	$61,019
General Hospital & Specialty Hospital	Southern	Program Year 2	Institutions with Number of ACGME-Accredited Programs Below the Median (5)	10	$60,695			$58,115	$61,054	$63,087
General Hospital & Specialty Hospital	Southern	Program Year 3	Institutions with Number of ACGME-Accredited Programs Below the Median (5)	10	$62,737			$60,162	$62,565	$65,624
General Hospital & Specialty Hospital	Southern	Program Year 4	Institutions with Number of ACGME-Accredited Programs Below the Median (5)	4						
General Hospital & Specialty Hospital	Southern	Program Year 5	Institutions with Number of ACGME-Accredited Programs Below the Median (5)	1						
General Hospital & Specialty Hospital	Southern	Program Year 6	Institutions with Number of ACGME-Accredited Programs Below the Median (5)	1						
General Hospital & Specialty Hospital	Southern	Program Year 7	Institutions with Number of ACGME-Accredited Programs Below the Median (5)	0						
General Hospital & Specialty Hospital	Southern	Program Year 8	Institutions with Number of ACGME-Accredited Programs Below the Median (5)	0						
Health System & Consortium	Southern	Program Year 1	Institutions with Number of ACGME-Accredited Programs Below the Median (12)	17	$60,685			$59,000	$62,267	$63,796
Health System & Consortium	Southern	Program Year 2	Institutions with Number of ACGME-Accredited Programs Below the Median (12)	17	$62,729			$60,500	$64,344	$66,110
Health System & Consortium	Southern	Program Year 3	Institutions with Number of ACGME-Accredited Programs Below the Median (12)	17	$64,839			$62,500	$66,551	$68,394
Health System & Consortium	Southern	Program Year 4	Institutions with Number of ACGME-Accredited Programs Below the Median (12)	11	$68,177			$65,050	$69,940	$72,259
Health System & Consortium	Southern	Program Year 5	Institutions with Number of ACGME-Accredited Programs Below the Median (12)	8	$71,747			$70,848	$75,148	$75,457
Health System & Consortium	Southern	Program Year 6	Institutions with Number of ACGME-Accredited Programs Below the Median (12)	5	$75,638			$75,647	$77,624	$78,296
Health System & Consortium	Southern	Program Year 7	Institutions with Number of ACGME-Accredited Programs Below the Median (12)	1						
Health System & Consortium	Southern	Program Year 8	Institutions with Number of ACGME-Accredited Programs Below the Median (12)	1						
Medical School	Southern	Program Year 1	Institutions with Number of ACGME-Accredited Programs Below the Median (45)	13	$61,414			$59,277	$61,966	$63,725
Medical School	Southern	Program Year 2	Institutions with Number of ACGME-Accredited Programs Below the Median (45)	13	$63,581			$61,711	$64,286	$65,687
Medical School	Southern	Program Year 3	Institutions with Number of ACGME-Accredited Programs Below the Median (45)	13	$65,696			$64,168	$66,221	$68,394
Medical School	Southern	Program Year 4	Institutions with Number of ACGME-Accredited Programs Below the Median (45)	10	$68,200			$66,648	$69,685	$70,975
Medical School	Southern	Program Year 5	Institutions with Number of ACGME-Accredited Programs Below the Median (45)	9	$71,389			$69,666	$72,370	$74,205
Medical School	Southern	Program Year 6	Institutions with Number of ACGME-Accredited Programs Below the Median (45)	8	$73,658			$72,114	$75,090	$77,406
Medical School	Southern	Program Year 7	Institutions with Number of ACGME-Accredited Programs Below the Median (45)	6	$74,630			$75,554	$76,356	$78,028
Medical School	Southern	Program Year 8	Institutions with Number of ACGME-Accredited Programs Below the Median (45)	2						
Other	Southern	Program Year 1	Institutions with Number of ACGME-Accredited Programs Below the Median (2)	7	$69,050			$58,300	$59,155	$60,612
Other	Southern	Program Year 2	Institutions with Number of ACGME-Accredited Programs Below the Median (2)	5	$60,350			$59,775	$61,224	$61,253
Other	Southern	Program Year 3	Institutions with Number of ACGME-Accredited Programs Below the Median (2)	5	$63,558			$62,030	$63,353	$65,000
Other	Southern	Program Year 4	Institutions with Number of ACGME-Accredited Programs Below the Median (2)	0						
Other	Southern	Program Year 5	Institutions with Number of ACGME-Accredited Programs Below the Median (2)	1						
Other	Southern	Program Year 6	Institutions with Number of ACGME-Accredited Programs Below the Median (2)	0						
Other	Southern	Program Year 7	Institutions with Number of ACGME-Accredited Programs Below the Median (2)	0						
Other	Southern	Program Year 8	Institutions with Number of ACGME-Accredited Programs Below the Median (2)	0						
Total	Southern	Program Year 1	Institutions with Number of Resident/Fellows At or Above the Median (140)	53	$62,525	7,091	$62,934	$59,000	$61,553	$65,528
Total	Southern	Program Year 2	Institutions with Number of Resident/Fellows At or Above the Median (140)	54	$64,889	6,929	$65,351	$61,173	$64,503	$68,179
Total	Southern	Program Year 3	Institutions with Number of Resident/Fellows At or Above the Median (140)	54	$67,198	6,717	$67,636	$63,344	$66,847	$70,794
Total	Southern	Program Year 4	Institutions with Number of Resident/Fellows At or Above the Median (140)	54	$70,143	5,237	$71,175	$66,611	$69,674	$74,387
Total	Southern	Program Year 5	Institutions with Number of Resident/Fellows At or Above the Median (140)	52	$73,479	3,656	$74,992	$70,025	$72,948	$77,478
Total	Southern	Program Year 6	Institutions with Number of Resident/Fellows At or Above the Median (140)	51	$76,116	2,169	$78,041	$72,642	$75,574	$80,458
Total	Southern	Program Year 7	Institutions with Number of Resident/Fellows At or Above the Median (140)	48	$79,648	692	$81,508	$75,995	$78,701	$83,557
Total	Southern	Program Year 8	Institutions with Number of Resident/Fellows At or Above the Median (140)	33	$83,958	165	$84,242	$81,444	$83,759	$87,279
General Hospital & Specialty Hospital	Southern	Program Year 1	Institutions with Number of Resident/Fellows At or Above the Median (82)	10	$63,858			$60,417	$64,332	$66,789
General Hospital & Specialty Hospital	Southern	Program Year 2	Institutions with Number of Resident/Fellows At or Above the Median (82)	11	$66,396			$62,821	$67,174	$69,483
General Hospital & Specialty Hospital	Southern	Program Year 3	Institutions with Number of Resident/Fellows At or Above the Median (82)	11	$68,886			$65,196	$69,712	$72,207
General Hospital & Specialty Hospital	Southern	Program Year 4	Institutions with Number of Resident/Fellows At or Above the Median (82)	11	$71,760			$67,870	$74,386	$75,058
General Hospital & Specialty Hospital	Southern	Program Year 5	Institutions with Number of Resident/Fellows At or Above the Median (82)	10	$75,337			$72,345	$77,255	$78,157
General Hospital & Specialty Hospital	Southern	Program Year 6	Institutions with Number of Resident/Fellows At or Above the Median (82)	10	$78,177			$75,248	$80,170	$81,002
General Hospital & Specialty Hospital	Southern	Program Year 7	Institutions with Number of Resident/Fellows At or Above the Median (82)	8	$82,518			$82,569	$83,893	$84,580
General Hospital & Specialty Hospital	Southern	Program Year 8	Institutions with Number of Resident/Fellows At or Above the Median (82)	7	$85,559			$85,455	$87,037	$88,375
Health System & Consortium	Southern	Program Year 1	Institutions with Number of Resident/Fellows At or Above the Median (186)	14	$62,337			$58,565	$60,851	$65,339
Health System & Consortium	Southern	Program Year 2	Institutions with Number of Resident/Fellows At or Above the Median (186)	14	$64,595			$60,555	$62,951	$67,522
Health System & Consortium	Southern	Program Year 3	Institutions with Number of Resident/Fellows At or Above the Median (186)	14	$67,019			$62,862	$65,293	$69,926
Health System & Consortium	Southern	Program Year 4	Institutions with Number of Resident/Fellows At or Above the Median (186)	14	$70,251			$66,611	$68,455	$72,457

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Health System & Consortium	Southern	Program Year 5	Institutions with Number of Resident/Fellows At or Above the Median (186)	13	$73,552			$69,981	$71,760	$75,620
Health System & Consortium	Southern	Program Year 6	Institutions with Number of Resident/Fellows At or Above the Median (186)	13	$76,414			$72,830	$74,942	$78,494
Health System & Consortium	Southern	Program Year 7	Institutions with Number of Resident/Fellows At or Above the Median (186)	12	$79,926			$75,914	$77,773	$83,522
Health System & Consortium	Southern	Program Year 8	Institutions with Number of Resident/Fellows At or Above the Median (186)	9	$85,019			$81,579	$83,173	$87,649
Medical School	Southern	Program Year 1	Institutions with Number of Resident/Fellows At or Above the Median (582.5)	15	$62,548			$60,139	$61,174	$66,060
Medical School	Southern	Program Year 2	Institutions with Number of Resident/Fellows At or Above the Median (582.5)	15	$64,916			$62,484	$63,686	$68,738
Medical School	Southern	Program Year 3	Institutions with Number of Resident/Fellows At or Above the Median (582.5)	15	$67,130			$64,693	$66,221	$70,932
Medical School	Southern	Program Year 4	Institutions with Number of Resident/Fellows At or Above the Median (582.5)	15	$69,957			$67,320	$69,299	$73,798
Medical School	Southern	Program Year 5	Institutions with Number of Resident/Fellows At or Above the Median (582.5)	15	$73,199			$70,476	$72,941	$77,397
Medical School	Southern	Program Year 6	Institutions with Number of Resident/Fellows At or Above the Median (582.5)	15	$75,889			$73,068	$75,721	$79,592
Medical School	Southern	Program Year 7	Institutions with Number of Resident/Fellows At or Above the Median (582.5)	15	$79,198			$76,365	$80,193	$81,837
Medical School	Southern	Program Year 8	Institutions with Number of Resident/Fellows At or Above the Median (582.5)	11	$82,537			$82,116	$83,759	$85,107
Other	Southern	Program Year 1	Institutions with Number of Resident/Fellows At or Above the Median (32)	9	$61,149			$59,166	$61,224	$64,009
Other	Southern	Program Year 2	Institutions with Number of Resident/Fellows At or Above the Median (32)	9	$63,022			$61,171	$63,840	$65,774
Other	Southern	Program Year 3	Institutions with Number of Resident/Fellows At or Above the Median (32)	9	$65,848			$63,288	$67,412	$69,408
Other	Southern	Program Year 4	Institutions with Number of Resident/Fellows At or Above the Median (32)	7	$67,258			$64,302	$69,606	$70,193
Other	Southern	Program Year 5	Institutions with Number of Resident/Fellows At or Above the Median (32)	6	$72,496			$70,615	$72,798	$73,092
Other	Southern	Program Year 6	Institutions with Number of Resident/Fellows At or Above the Median (32)	5	$76,709			$75,373	$75,487	$75,574
Other	Southern	Program Year 7	Institutions with Number of Resident/Fellows At or Above the Median (32)	5	$78,982			$77,504	$78,104	$78,248
Other	Southern	Program Year 8	Institutions with Number of Resident/Fellows At or Above the Median (32)	3						
Total	Southern	Program Year 1	Institutions with Number of Resident/Fellows Below the Median (140)	45	$61,854	754	$60,542	$58,427	$60,944	$62,739
Total	Southern	Program Year 2	Institutions with Number of Resident/Fellows Below the Median (140)	42	$62,323	526	$62,762	$60,228	$62,157	$64,960
Total	Southern	Program Year 3	Institutions with Number of Resident/Fellows Below the Median (140)	42	$64,521	440	$65,263	$62,033	$65,000	$67,062
Total	Southern	Program Year 4	Institutions with Number of Resident/Fellows Below the Median (140)	21	$66,892	105	$69,170	$63,000	$67,000	$70,720
Total	Southern	Program Year 5	Institutions with Number of Resident/Fellows Below the Median (140)	16	$73,181	58	$75,035	$68,780	$72,619	$75,074
Total	Southern	Program Year 6	Institutions with Number of Resident/Fellows Below the Median (140)	11	$74,860	30	$75,193	$73,382	$75,647	$77,587
Total	Southern	Program Year 7	Institutions with Number of Resident/Fellows Below the Median (140)	3		3				
Total	Southern	Program Year 8	Institutions with Number of Resident/Fellows Below the Median (140)	2		2				
General Hospital & Specialty Hospital	Southern	Program Year 1	Institutions with Number of Resident/Fellows Below the Median (82)	13	$60,434			$56,275	$60,944	$63,000
General Hospital & Specialty Hospital	Southern	Program Year 2	Institutions with Number of Resident/Fellows Below the Median (82)	12	$62,626			$58,346	$62,755	$65,073
General Hospital & Specialty Hospital	Southern	Program Year 3	Institutions with Number of Resident/Fellows Below the Median (82)	12	$64,680			$60,485	$65,146	$66,795
General Hospital & Specialty Hospital	Southern	Program Year 4	Institutions with Number of Resident/Fellows Below the Median (82)	6	$67,879			$62,500	$67,360	$71,467
General Hospital & Specialty Hospital	Southern	Program Year 5	Institutions with Number of Resident/Fellows Below the Median (82)	4						
General Hospital & Specialty Hospital	Southern	Program Year 6	Institutions with Number of Resident/Fellows Below the Median (82)	4						
General Hospital & Specialty Hospital	Southern	Program Year 7	Institutions with Number of Resident/Fellows Below the Median (82)	2						
General Hospital & Specialty Hospital	Southern	Program Year 8	Institutions with Number of Resident/Fellows Below the Median (82)	1						
Health System & Consortium	Southern	Program Year 1	Institutions with Number of Resident/Fellows Below the Median (186)	16	$60,516			$59,000	$61,325	$63,321
Health System & Consortium	Southern	Program Year 2	Institutions with Number of Resident/Fellows Below the Median (186)	16	$62,588			$60,500	$63,372	$65,793
Health System & Consortium	Southern	Program Year 3	Institutions with Number of Resident/Fellows Below the Median (186)	16	$64,680			$62,375	$65,521	$68,273
Health System & Consortium	Southern	Program Year 4	Institutions with Number of Resident/Fellows Below the Median (186)	10	$67,877			$64,275	$68,531	$72,117
Health System & Consortium	Southern	Program Year 5	Institutions with Number of Resident/Fellows Below the Median (186)	8	$71,214			$68,826	$73,851	$75,487
Health System & Consortium	Southern	Program Year 6	Institutions with Number of Resident/Fellows Below the Median (186)	5	$74,826			$72,162	$75,647	$78,296
Health System & Consortium	Southern	Program Year 7	Institutions with Number of Resident/Fellows Below the Median (186)	2						
Health System & Consortium	Southern	Program Year 8	Institutions with Number of Resident/Fellows Below the Median (186)	1						
Medical School	Southern	Program Year 1	Institutions with Number of Resident/Fellows Below the Median (582.5)	14	$61,136			$58,823	$61,951	$63,584
Medical School	Southern	Program Year 2	Institutions with Number of Resident/Fellows Below the Median (582.5)	14	$63,286			$61,313	$64,219	$65,557
Medical School	Southern	Program Year 3	Institutions with Number of Resident/Fellows Below the Median (582.5)	14	$65,396			$63,676	$66,120	$68,101
Medical School	Southern	Program Year 4	Institutions with Number of Resident/Fellows Below the Median (582.5)	11	$67,854			$65,269	$69,299	$70,745
Medical School	Southern	Program Year 5	Institutions with Number of Resident/Fellows Below the Median (582.5)	10	$70,995			$69,266	$71,573	$73,889
Medical School	Southern	Program Year 6	Institutions with Number of Resident/Fellows Below the Median (582.5)	9	$73,276			$71,097	$74,459	$77,272
Medical School	Southern	Program Year 7	Institutions with Number of Resident/Fellows Below the Median (582.5)	7	$74,427			$74,283	$76,164	$77,535
Medical School	Southern	Program Year 8	Institutions with Number of Resident/Fellows Below the Median (582.5)	3						
Other	Southern	Program Year 1	Institutions with Number of Resident/Fellows Below the Median (32)	7	$69,661			$59,078	$60,000	$60,500
Other	Southern	Program Year 2	Institutions with Number of Resident/Fellows Below the Median (32)	5	$61,406			$61,000	$61,253	$62,000
Other	Southern	Program Year 3	Institutions with Number of Resident/Fellows Below the Median (32)	5	$63,277			$62,030	$63,353	$65,000
Other	Southern	Program Year 4	Institutions with Number of Resident/Fellows Below the Median (32)	1						
Other	Southern	Program Year 5	Institutions with Number of Resident/Fellows Below the Median (32)	2						
Other	Southern	Program Year 6	Institutions with Number of Resident/Fellows Below the Median (32)	1						
Other	Southern	Program Year 7	Institutions with Number of Resident/Fellows Below the Median (32)	0						
Other	Southern	Program Year 8	Institutions with Number of Resident/Fellows Below the Median (32)	0						
Total	Central	Program Year 1	All Institutions	77	$64,572	6,722	$65,444	$61,836	$64,020	$66,690
Total	Central	Program Year 2	All Institutions	79	$66,339	6,558	$67,980	$63,595	$66,515	$69,126
Total	Central	Program Year 3	All Institutions	79	$68,618	6,298	$70,440	$66,298	$68,437	$71,321
Total	Central	Program Year 4	All Institutions	68	$71,604	4,286	$74,174	$68,505	$71,378	$74,136
Total	Central	Program Year 5	All Institutions	60	$74,400	3,045	$77,930	$70,631	$74,381	$77,781
Total	Central	Program Year 6	All Institutions	54	$77,442	1,672	$81,016	$73,623	$77,461	$81,026
Total	Central	Program Year 7	All Institutions	46	$80,680	616	$84,357	$76,901	$80,833	$84,144

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Total	Central	Program Year 8	All Institutions	30	$86,664	160	$88,686	$83,334	$85,749	$90,154
General Hospital & Specialty Hospital	Central	Program Year 1	All Institutions	23	$64,038			$61,893	$64,000	$66,254
General Hospital & Specialty Hospital	Central	Program Year 2	All Institutions	25	$66,332			$63,484	$66,412	$69,134
General Hospital & Specialty Hospital	Central	Program Year 3	All Institutions	25	$68,687			$66,298	$68,829	$71,853
General Hospital & Specialty Hospital	Central	Program Year 4	All Institutions	18	$72,292			$68,629	$73,151	$75,082
General Hospital & Specialty Hospital	Central	Program Year 5	All Institutions	15	$74,565			$70,636	$75,307	$77,876
General Hospital & Specialty Hospital	Central	Program Year 6	All Institutions	12	$78,211			$76,129	$78,266	$81,152
General Hospital & Specialty Hospital	Central	Program Year 7	All Institutions	10	$80,741			$76,750	$81,312	$83,867
General Hospital & Specialty Hospital	Central	Program Year 8	All Institutions	4						
Health System & Consortium	Central	Program Year 1	All Institutions	28	$64,604			$62,444	$64,861	$66,502
Health System & Consortium	Central	Program Year 2	All Institutions	28	$66,809			$64,391	$66,857	$68,609
Health System & Consortium	Central	Program Year 3	All Institutions	28	$69,033			$66,842	$68,824	$70,766
Health System & Consortium	Central	Program Year 4	All Institutions	26	$71,629			$69,629	$71,160	$73,324
Health System & Consortium	Central	Program Year 5	All Institutions	22	$74,914			$73,496	$74,381	$76,554
Health System & Consortium	Central	Program Year 6	All Institutions	21	$77,438			$75,354	$77,184	$79,414
Health System & Consortium	Central	Program Year 7	All Institutions	18	$80,875			$77,814	$80,707	$83,565
Health System & Consortium	Central	Program Year 8	All Institutions	14	$85,243			$82,236	$83,922	$88,038
Medical School	Central	Program Year 1	All Institutions	18	$63,449			$60,885	$63,302	$64,821
Medical School	Central	Program Year 2	All Institutions	18	$65,559			$62,614	$65,092	$67,378
Medical School	Central	Program Year 3	All Institutions	18	$67,741			$64,461	$67,201	$69,969
Medical School	Central	Program Year 4	All Institutions	18	$70,535			$66,964	$70,251	$72,940
Medical School	Central	Program Year 5	All Institutions	17	$73,143			$69,500	$73,000	$76,000
Medical School	Central	Program Year 6	All Institutions	16	$76,089			$72,510	$75,266	$79,085
Medical School	Central	Program Year 7	All Institutions	13	$79,430			$75,600	$78,036	$82,468
Medical School	Central	Program Year 8	All Institutions	8	$85,874			$83,708	$85,840	$88,431
Other	Central	Program Year 1	All Institutions	8	$68,522			$58,374	$66,897	$70,529
Other	Central	Program Year 2	All Institutions	8	$66,473			$60,235	$68,541	$70,005
Other	Central	Program Year 3	All Institutions	8	$68,927			$62,040	$70,889	$73,188
Other	Central	Program Year 4	All Institutions	6	$72,643			$66,440	$74,447	$76,108
Other	Central	Program Year 5	All Institutions	6	$75,660			$69,257	$77,536	$79,558
Other	Central	Program Year 6	All Institutions	5	$79,941			$79,306	$81,100	$82,680
Other	Central	Program Year 7	All Institutions	5	$83,105			$82,351	$84,800	$87,310
Other	Central	Program Year 8	All Institutions	4						
Total	Central	Program Year 1	Institutions with Number of ACGME-Accredited Programs At or Above the Median (10)	44	$64,753	6,096	$65,695	$62,593	$65,085	$67,030
Total	Central	Program Year 2	Institutions with Number of ACGME-Accredited Programs At or Above the Median (10)	44	$67,078	5,979	$68,285	$64,309	$67,255	$69,935
Total	Central	Program Year 3	Institutions with Number of ACGME-Accredited Programs At or Above the Median (10)	44	$69,388	5,733	$70,766	$66,344	$69,496	$72,785
Total	Central	Program Year 4	Institutions with Number of ACGME-Accredited Programs At or Above the Median (10)	44	$72,069	4,119	$74,344	$69,257	$71,633	$75,418
Total	Central	Program Year 5	Institutions with Number of ACGME-Accredited Programs At or Above the Median (10)	44	$75,058	2,975	$78,053	$72,727	$74,619	$78,249
Total	Central	Program Year 6	Institutions with Number of ACGME-Accredited Programs At or Above the Median (10)	42	$77,773	1,647	$81,091	$75,061	$77,747	$81,026
Total	Central	Program Year 7	Institutions with Number of ACGME-Accredited Programs At or Above the Median (10)	38	$81,099	613	$84,395	$77,711	$81,312	$84,649
Total	Central	Program Year 8	Institutions with Number of ACGME-Accredited Programs At or Above the Median (10)	28	$86,609	160	$88,686	$83,107	$85,733	$90,503
General Hospital & Specialty Hospital	Central	Program Year 1	Institutions with Number of ACGME-Accredited Programs At or Above the Median (5)	12	$64,199			$61,950	$64,454	$66,315
General Hospital & Specialty Hospital	Central	Program Year 2	Institutions with Number of ACGME-Accredited Programs At or Above the Median (5)	12	$66,366			$63,484	$66,986	$68,869
General Hospital & Specialty Hospital	Central	Program Year 3	Institutions with Number of ACGME-Accredited Programs At or Above the Median (5)	12	$68,807			$66,298	$68,863	$71,418
General Hospital & Specialty Hospital	Central	Program Year 4	Institutions with Number of ACGME-Accredited Programs At or Above the Median (5)	12	$71,507			$68,505	$72,064	$74,434
General Hospital & Specialty Hospital	Central	Program Year 5	Institutions with Number of ACGME-Accredited Programs At or Above the Median (5)	12	$74,303			$70,636	$75,180	$77,781
General Hospital & Specialty Hospital	Central	Program Year 6	Institutions with Number of ACGME-Accredited Programs At or Above the Median (5)	9	$78,223			$77,172	$78,692	$80,805
General Hospital & Specialty Hospital	Central	Program Year 7	Institutions with Number of ACGME-Accredited Programs At or Above the Median (5)	7	$80,566			$77,832	$80,958	$83,538
General Hospital & Specialty Hospital	Central	Program Year 8	Institutions with Number of ACGME-Accredited Programs At or Above the Median (5)	2						
Health System & Consortium	Central	Program Year 1	Institutions with Number of ACGME-Accredited Programs At or Above the Median (12)	19	$64,740			$63,368	$65,100	$66,565
Health System & Consortium	Central	Program Year 2	Institutions with Number of ACGME-Accredited Programs At or Above the Median (12)	19	$67,101			$65,465	$67,177	$68,778
Health System & Consortium	Central	Program Year 3	Institutions with Number of ACGME-Accredited Programs At or Above the Median (12)	19	$69,352			$67,981	$69,492	$70,905
Health System & Consortium	Central	Program Year 4	Institutions with Number of ACGME-Accredited Programs At or Above the Median (12)	19	$71,943			$70,936	$71,465	$73,365
Health System & Consortium	Central	Program Year 5	Institutions with Number of ACGME-Accredited Programs At or Above the Median (12)	19	$75,043			$73,549	$74,437	$76,171
Health System & Consortium	Central	Program Year 6	Institutions with Number of ACGME-Accredited Programs At or Above the Median (12)	18	$77,636			$75,566	$77,184	$79,031
Health System & Consortium	Central	Program Year 7	Institutions with Number of ACGME-Accredited Programs At or Above the Median (12)	17	$80,692			$77,615	$80,707	$82,303
Health System & Consortium	Central	Program Year 8	Institutions with Number of ACGME-Accredited Programs At or Above the Median (12)	14	$85,243			$82,236	$83,922	$88,038
Medical School	Central	Program Year 1	Institutions with Number of ACGME-Accredited Programs At or Above the Median (45)	6	$66,788			$65,112	$66,705	$68,460
Medical School	Central	Program Year 2	Institutions with Number of ACGME-Accredited Programs At or Above the Median (45)	6	$69,453			$67,530	$69,124	$71,814
Medical School	Central	Program Year 3	Institutions with Number of ACGME-Accredited Programs At or Above the Median (45)	6	$71,966			$69,971	$71,647	$74,544
Medical School	Central	Program Year 4	Institutions with Number of ACGME-Accredited Programs At or Above the Median (45)	6	$75,087			$72,894	$74,514	$78,104
Medical School	Central	Program Year 5	Institutions with Number of ACGME-Accredited Programs At or Above the Median (45)	6	$78,170			$75,575	$77,599	$81,683
Medical School	Central	Program Year 6	Institutions with Number of ACGME-Accredited Programs At or Above the Median (45)	6	$80,937			$78,137	$80,263	$84,662
Medical School	Central	Program Year 7	Institutions with Number of ACGME-Accredited Programs At or Above the Median (45)	6	$83,920			$81,866	$83,014	$87,373
Medical School	Central	Program Year 8	Institutions with Number of ACGME-Accredited Programs At or Above the Median (45)	6	$87,059			$85,794	$86,812	$89,908
Other	Central	Program Year 1	Institutions with Number of ACGME-Accredited Programs At or Above the Median (2)	6	$65,446			$60,697	$66,897	$69,025
Other	Central	Program Year 2	Institutions with Number of ACGME-Accredited Programs At or Above the Median (2)	6	$67,830			$62,855	$69,591	$70,615

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Other	Central	Program Year 3	Institutions with Number of ACGME-Accredited Programs At or Above the Median (2)	6	$70,352			$64,659	$72,087	$74,163
Other	Central	Program Year 4	Institutions with Number of ACGME-Accredited Programs At or Above the Median (2)	6	$72,643			$66,440	$74,447	$76,108
Other	Central	Program Year 5	Institutions with Number of ACGME-Accredited Programs At or Above the Median (2)	6	$75,660			$69,257	$77,536	$79,558
Other	Central	Program Year 6	Institutions with Number of ACGME-Accredited Programs At or Above the Median (2)	5	$79,941			$79,306	$81,100	$82,680
Other	Central	Program Year 7	Institutions with Number of ACGME-Accredited Programs At or Above the Median (2)	5	$83,105			$82,351	$84,800	$87,310
Other	Central	Program Year 8	Institutions with Number of ACGME-Accredited Programs At or Above the Median (2)	4						
Total	Central	Program Year 1	Institutions with Number of ACGME-Accredited Programs Below the Median (10)	33	$64,331	626	$63,002	$61,711	$63,290	$65,094
Total	Central	Program Year 2	Institutions with Number of ACGME-Accredited Programs Below the Median (10)	35	$65,411	579	$64,824	$63,484	$64,860	$67,580
Total	Central	Program Year 3	Institutions with Number of ACGME-Accredited Programs Below the Median (10)	35	$67,651	565	$67,131	$66,298	$67,000	$70,280
Total	Central	Program Year 4	Institutions with Number of ACGME-Accredited Programs Below the Median (10)	24	$70,752	167	$69,970	$68,505	$70,727	$73,571
Total	Central	Program Year 5	Institutions with Number of ACGME-Accredited Programs Below the Median (10)	16	$72,588	70	$72,668	$70,466	$70,818	$75,308
Total	Central	Program Year 6	Institutions with Number of ACGME-Accredited Programs Below the Median (10)	12	$76,281	25	$76,065	$72,619	$76,788	$78,699
Total	Central	Program Year 7	Institutions with Number of ACGME-Accredited Programs Below the Median (10)	8	$78,688	3		$74,937	$77,832	$82,245
Total	Central	Program Year 8	Institutions with Number of ACGME-Accredited Programs Below the Median (10)	2		0				
General Hospital & Specialty Hospital	Central	Program Year 1	Institutions with Number of ACGME-Accredited Programs Below the Median (5)	11	$63,863			$60,918	$63,290	$65,892
General Hospital & Specialty Hospital	Central	Program Year 2	Institutions with Number of ACGME-Accredited Programs Below the Median (5)	13	$66,300			$64,188	$65,500	$69,134
General Hospital & Specialty Hospital	Central	Program Year 3	Institutions with Number of ACGME-Accredited Programs Below the Median (5)	13	$68,576			$66,412	$67,019	$71,853
General Hospital & Specialty Hospital	Central	Program Year 4	Institutions with Number of ACGME-Accredited Programs Below the Median (5)	6	$73,861			$73,079	$74,113	$75,736
General Hospital & Specialty Hospital	Central	Program Year 5	Institutions with Number of ACGME-Accredited Programs Below the Median (5)	3						
General Hospital & Specialty Hospital	Central	Program Year 6	Institutions with Number of ACGME-Accredited Programs Below the Median (5)	3						
General Hospital & Specialty Hospital	Central	Program Year 7	Institutions with Number of ACGME-Accredited Programs Below the Median (5)	3						
General Hospital & Specialty Hospital	Central	Program Year 8	Institutions with Number of ACGME-Accredited Programs Below the Median (5)	2						
Health System & Consortium	Central	Program Year 1	Institutions with Number of ACGME-Accredited Programs Below the Median (12)	9	$64,316			$61,950	$64,000	$65,188
Health System & Consortium	Central	Program Year 2	Institutions with Number of ACGME-Accredited Programs Below the Median (12)	9	$66,194			$64,189	$66,000	$66,764
Health System & Consortium	Central	Program Year 3	Institutions with Number of ACGME-Accredited Programs Below the Median (12)	9	$68,359			$66,435	$68,000	$68,437
Health System & Consortium	Central	Program Year 4	Institutions with Number of ACGME-Accredited Programs Below the Median (12)	7	$70,776			$68,463	$70,490	$72,190
Health System & Consortium	Central	Program Year 5	Institutions with Number of ACGME-Accredited Programs Below the Median (12)	3						
Health System & Consortium	Central	Program Year 6	Institutions with Number of ACGME-Accredited Programs Below the Median (12)	3						
Health System & Consortium	Central	Program Year 7	Institutions with Number of ACGME-Accredited Programs Below the Median (12)	1						
Health System & Consortium	Central	Program Year 8	Institutions with Number of ACGME-Accredited Programs Below the Median (12)	0						
Medical School	Central	Program Year 1	Institutions with Number of ACGME-Accredited Programs Below the Median (45)	12	$61,780			$60,561	$62,018	$63,302
Medical School	Central	Program Year 2	Institutions with Number of ACGME-Accredited Programs Below the Median (45)	12	$63,612			$62,046	$63,968	$64,796
Medical School	Central	Program Year 3	Institutions with Number of ACGME-Accredited Programs Below the Median (45)	12	$65,628			$63,975	$65,771	$66,851
Medical School	Central	Program Year 4	Institutions with Number of ACGME-Accredited Programs Below the Median (45)	12	$68,259			$66,409	$68,166	$70,280
Medical School	Central	Program Year 5	Institutions with Number of ACGME-Accredited Programs Below the Median (45)	11	$70,401			$68,442	$70,096	$71,808
Medical School	Central	Program Year 6	Institutions with Number of ACGME-Accredited Programs Below the Median (45)	10	$73,180			$71,067	$72,661	$74,568
Medical School	Central	Program Year 7	Institutions with Number of ACGME-Accredited Programs Below the Median (45)	7	$75,581			$73,650	$75,600	$77,093
Medical School	Central	Program Year 8	Institutions with Number of ACGME-Accredited Programs Below the Median (45)	2						
Other	Central	Program Year 1	Institutions with Number of ACGME-Accredited Programs Below the Median (2)	2						
Other	Central	Program Year 2	Institutions with Number of ACGME-Accredited Programs Below the Median (2)	2						
Other	Central	Program Year 3	Institutions with Number of ACGME-Accredited Programs Below the Median (2)	2						
Other	Central	Program Year 4	Institutions with Number of ACGME-Accredited Programs Below the Median (2)	0						
Other	Central	Program Year 5	Institutions with Number of ACGME-Accredited Programs Below the Median (2)	0						
Other	Central	Program Year 6	Institutions with Number of ACGME-Accredited Programs Below the Median (2)	0						
Other	Central	Program Year 7	Institutions with Number of ACGME-Accredited Programs Below the Median (2)	0						
Other	Central	Program Year 8	Institutions with Number of ACGME-Accredited Programs Below the Median (2)	0						
Total	Central	Program Year 1	Institutions with Number of Resident/Fellows At or Above the Median (140)	46	$64,513	6,208	$65,584	$62,099	$64,899	$66,949
Total	Central	Program Year 2	Institutions with Number of Resident/Fellows At or Above the Median (140)	46	$66,812	6,074	$68,169	$64,241	$67,177	$69,645
Total	Central	Program Year 3	Institutions with Number of Resident/Fellows At or Above the Median (140)	46	$69,136	5,825	$70,652	$65,980	$69,492	$72,394
Total	Central	Program Year 4	Institutions with Number of Resident/Fellows At or Above the Median (140)	46	$71,811	4,142	$74,301	$68,629	$71,629	$75,065
Total	Central	Program Year 5	Institutions with Number of Resident/Fellows At or Above the Median (140)	45	$74,877	2,997	$78,014	$71,907	$74,800	$78,065
Total	Central	Program Year 6	Institutions with Number of Resident/Fellows At or Above the Median (140)	42	$77,833	1,643	$81,106	$75,061	$77,797	$81,026
Total	Central	Program Year 7	Institutions with Number of Resident/Fellows At or Above the Median (140)	37	$81,193	612	$84,406	$78,000	$81,665	$84,800
Total	Central	Program Year 8	Institutions with Number of Resident/Fellows At or Above the Median (140)	28	$86,609	160	$88,686	$83,107	$85,733	$90,503
General Hospital & Specialty Hospital	Central	Program Year 1	Institutions with Number of Resident/Fellows At or Above the Median (82)	10	$64,156			$61,950	$64,548	$66,472
General Hospital & Specialty Hospital	Central	Program Year 2	Institutions with Number of Resident/Fellows At or Above the Median (82)	10	$66,605			$63,484	$67,045	$70,149
General Hospital & Specialty Hospital	Central	Program Year 3	Institutions with Number of Resident/Fellows At or Above the Median (82)	10	$69,125			$66,298	$69,648	$72,587
General Hospital & Specialty Hospital	Central	Program Year 4	Institutions with Number of Resident/Fellows At or Above the Median (82)	10	$71,847			$68,505	$72,668	$75,065
General Hospital & Specialty Hospital	Central	Program Year 5	Institutions with Number of Resident/Fellows At or Above the Median (82)	10	$74,727			$70,636	$75,532	$77,970
General Hospital & Specialty Hospital	Central	Program Year 6	Institutions with Number of Resident/Fellows At or Above the Median (82)	8	$78,553			$76,515	$79,428	$81,549
General Hospital & Specialty Hospital	Central	Program Year 7	Institutions with Number of Resident/Fellows At or Above the Median (82)	7	$81,535			$78,313	$82,880	$85,488
General Hospital & Specialty Hospital	Central	Program Year 8	Institutions with Number of Resident/Fellows At or Above the Median (82)	3						
Health System & Consortium	Central	Program Year 1	Institutions with Number of Resident/Fellows At or Above the Median (186)	17	$65,038			$64,126	$65,188	$66,690
Health System & Consortium	Central	Program Year 2	Institutions with Number of Resident/Fellows At or Above the Median (186)	17	$67,451			$66,515	$67,332	$69,117
Health System & Consortium	Central	Program Year 3	Institutions with Number of Resident/Fellows At or Above the Median (186)	17	$69,733			$68,405	$69,492	$71,181
Health System & Consortium	Central	Program Year 4	Institutions with Number of Resident/Fellows At or Above the Median (186)	17	$72,252			$70,958	$71,465	$73,681
Health System & Consortium	Central	Program Year 5	Institutions with Number of Resident/Fellows At or Above the Median (186)	17	$75,235			$73,729	$74,437	$76,937

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Health System & Consortium	Central	Program Year 6	Institutions with Number of Resident/Fellows At or Above the Median (186)	17	$77,770			$76,200	$77,184	$79,414
Health System & Consortium	Central	Program Year 7	Institutions with Number of Resident/Fellows At or Above the Median (186)	16	$80,884			$78,204	$80,707	$83,369
Health System & Consortium	Central	Program Year 8	Institutions with Number of Resident/Fellows At or Above the Median (186)	14	$85,243			$82,236	$83,922	$88,038
Medical School	Central	Program Year 1	Institutions with Number of Resident/Fellows At or Above the Median (582.5)	6	$66,788			$65,112	$66,705	$68,460
Medical School	Central	Program Year 2	Institutions with Number of Resident/Fellows At or Above the Median (582.5)	6	$69,453			$67,530	$69,124	$71,814
Medical School	Central	Program Year 3	Institutions with Number of Resident/Fellows At or Above the Median (582.5)	6	$71,966			$69,971	$71,647	$74,544
Medical School	Central	Program Year 4	Institutions with Number of Resident/Fellows At or Above the Median (582.5)	6	$75,087			$72,894	$74,514	$78,104
Medical School	Central	Program Year 5	Institutions with Number of Resident/Fellows At or Above the Median (582.5)	6	$78,170			$75,575	$77,599	$81,683
Medical School	Central	Program Year 6	Institutions with Number of Resident/Fellows At or Above the Median (582.5)	6	$80,937			$78,137	$80,263	$84,662
Medical School	Central	Program Year 7	Institutions with Number of Resident/Fellows At or Above the Median (582.5)	6	$83,920			$81,866	$83,014	$87,373
Medical School	Central	Program Year 8	Institutions with Number of Resident/Fellows At or Above the Median (582.5)	6	$87,059			$85,794	$86,812	$89,908
Other	Central	Program Year 1	Institutions with Number of Resident/Fellows At or Above the Median (32)	6	$65,446			$60,697	$66,897	$69,025
Other	Central	Program Year 2	Institutions with Number of Resident/Fellows At or Above the Median (32)	6	$67,830			$62,855	$69,591	$70,615
Other	Central	Program Year 3	Institutions with Number of Resident/Fellows At or Above the Median (32)	6	$70,352			$64,659	$72,087	$74,163
Other	Central	Program Year 4	Institutions with Number of Resident/Fellows At or Above the Median (32)	6	$72,643			$66,440	$74,447	$76,108
Other	Central	Program Year 5	Institutions with Number of Resident/Fellows At or Above the Median (32)	6	$75,660			$69,257	$77,536	$79,558
Other	Central	Program Year 6	Institutions with Number of Resident/Fellows At or Above the Median (32)	5	$79,941			$79,306	$81,100	$82,680
Other	Central	Program Year 7	Institutions with Number of Resident/Fellows At or Above the Median (32)	5	$83,105			$82,351	$84,800	$87,310
Other	Central	Program Year 8	Institutions with Number of Resident/Fellows At or Above the Median (32)	4						
Total	Central	Program Year 1	Institutions with Number of Resident/Fellows Below the Median (140)	31	$64,659	514	$63,752	$61,774	$63,654	$65,141
Total	Central	Program Year 2	Institutions with Number of Resident/Fellows Below the Median (140)	33	$65,680	484	$65,604	$63,484	$65,500	$67,600
Total	Central	Program Year 3	Institutions with Number of Resident/Fellows Below the Median (140)	33	$67,897	473	$67,824	$66,298	$67,019	$70,304
Total	Central	Program Year 4	Institutions with Number of Resident/Fellows Below the Median (140)	22	$71,172	144	$70,522	$68,505	$70,996	$73,881
Total	Central	Program Year 5	Institutions with Number of Resident/Fellows Below the Median (140)	15	$72,968	48	$72,675	$70,626	$71,000	$75,309
Total	Central	Program Year 6	Institutions with Number of Resident/Fellows Below the Median (140)	12	$76,074	29	$75,882	$72,619	$75,879	$78,622
Total	Central	Program Year 7	Institutions with Number of Resident/Fellows Below the Median (140)	9	$78,569	4		$75,000	$77,615	$81,665
Total	Central	Program Year 8	Institutions with Number of Resident/Fellows Below the Median (140)	2		0				
General Hospital & Specialty Hospital	Central	Program Year 1	Institutions with Number of Resident/Fellows Below the Median (82)	13	$63,947			$61,836	$63,290	$65,094
General Hospital & Specialty Hospital	Central	Program Year 2	Institutions with Number of Resident/Fellows Below the Median (82)	15	$66,149			$63,836	$65,500	$68,704
General Hospital & Specialty Hospital	Central	Program Year 3	Institutions with Number of Resident/Fellows Below the Median (82)	15	$68,395			$66,355	$67,019	$71,537
General Hospital & Specialty Hospital	Central	Program Year 4	Institutions with Number of Resident/Fellows Below the Median (82)	8	$72,848			$71,501	$73,398	$74,568
General Hospital & Specialty Hospital	Central	Program Year 5	Institutions with Number of Resident/Fellows Below the Median (82)	5	$74,241			$71,000	$75,307	$75,311
General Hospital & Specialty Hospital	Central	Program Year 6	Institutions with Number of Resident/Fellows Below the Median (82)	4						
General Hospital & Specialty Hospital	Central	Program Year 7	Institutions with Number of Resident/Fellows Below the Median (82)	3						
General Hospital & Specialty Hospital	Central	Program Year 8	Institutions with Number of Resident/Fellows Below the Median (82)	1						
Health System & Consortium	Central	Program Year 1	Institutions with Number of Resident/Fellows Below the Median (186)	11	$63,932			$61,894	$64,000	$65,094
Health System & Consortium	Central	Program Year 2	Institutions with Number of Resident/Fellows Below the Median (186)	11	$65,819			$64,030	$66,000	$66,857
Health System & Consortium	Central	Program Year 3	Institutions with Number of Resident/Fellows Below the Median (186)	11	$67,951			$66,367	$68,000	$68,698
Health System & Consortium	Central	Program Year 4	Institutions with Number of Resident/Fellows Below the Median (186)	9	$70,452			$68,420	$70,490	$71,028
Health System & Consortium	Central	Program Year 5	Institutions with Number of Resident/Fellows Below the Median (186)	5	$73,823			$73,159	$73,656	$73,729
Health System & Consortium	Central	Program Year 6	Institutions with Number of Resident/Fellows Below the Median (186)	4						
Health System & Consortium	Central	Program Year 7	Institutions with Number of Resident/Fellows Below the Median (186)	2						
Health System & Consortium	Central	Program Year 8	Institutions with Number of Resident/Fellows Below the Median (186)	0						
Medical School	Central	Program Year 1	Institutions with Number of Resident/Fellows Below the Median (582.5)	12	$61,780			$60,561	$62,018	$63,302
Medical School	Central	Program Year 2	Institutions with Number of Resident/Fellows Below the Median (582.5)	12	$63,612			$62,046	$63,968	$64,796
Medical School	Central	Program Year 3	Institutions with Number of Resident/Fellows Below the Median (582.5)	12	$65,628			$63,975	$65,771	$66,851
Medical School	Central	Program Year 4	Institutions with Number of Resident/Fellows Below the Median (582.5)	12	$68,259			$66,409	$68,166	$70,280
Medical School	Central	Program Year 5	Institutions with Number of Resident/Fellows Below the Median (582.5)	11	$70,401			$68,442	$70,096	$71,808
Medical School	Central	Program Year 6	Institutions with Number of Resident/Fellows Below the Median (582.5)	10	$73,180			$71,067	$72,661	$74,568
Medical School	Central	Program Year 7	Institutions with Number of Resident/Fellows Below the Median (582.5)	7	$75,581			$73,650	$75,600	$77,093
Medical School	Central	Program Year 8	Institutions with Number of Resident/Fellows Below the Median (582.5)	2						
Other	Central	Program Year 1	Institutions with Number of Resident/Fellows Below the Median (32)	2						
Other	Central	Program Year 2	Institutions with Number of Resident/Fellows Below the Median (32)	2						
Other	Central	Program Year 3	Institutions with Number of Resident/Fellows Below the Median (32)	2						
Other	Central	Program Year 4	Institutions with Number of Resident/Fellows Below the Median (32)	0						
Other	Central	Program Year 5	Institutions with Number of Resident/Fellows Below the Median (32)	0						
Other	Central	Program Year 6	Institutions with Number of Resident/Fellows Below the Median (32)	0						
Other	Central	Program Year 7	Institutions with Number of Resident/Fellows Below the Median (32)	0						
Other	Central	Program Year 8	Institutions with Number of Resident/Fellows Below the Median (32)	0						
Total	Western	Program Year 1	All Institutions	69	$71,622	4,127	$75,063	$64,858	$71,064	$74,009
Total	Western	Program Year 2	All Institutions	69	$74,331	4,115	$78,479	$67,415	$73,055	$77,142
Total	Western	Program Year 3	All Institutions	69	$77,858	4,021	$82,152	$70,367	$76,459	$80,869
Total	Western	Program Year 4	All Institutions	50	$82,538	2,949	$88,271	$74,055	$80,607	$87,002
Total	Western	Program Year 5	All Institutions	44	$86,524	2,213	$93,064	$77,807	$84,637	$93,869
Total	Western	Program Year 6	All Institutions	32	$90,204	1,203	$96,978	$81,153	$90,367	$97,390
Total	Western	Program Year 7	All Institutions	26	$97,002	374	$103,188	$86,811	$97,105	$103,586
Total	Western	Program Year 8	All Institutions	18	$99,596	50	$109,194	$88,823	$98,173	$108,367

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General Hospital & Specialty Hospital	Western	Program Year 1	All Institutions	26	$71,665			$65,097	$71,630	$74,539
General Hospital & Specialty Hospital	Western	Program Year 2	All Institutions	27	$74,657			$69,531	$73,500	$77,436
General Hospital & Specialty Hospital	Western	Program Year 3	All Institutions	27	$78,393			$73,087	$77,000	$82,334
General Hospital & Specialty Hospital	Western	Program Year 4	All Institutions	19	$81,173			$75,411	$80,543	$85,393
General Hospital & Specialty Hospital	Western	Program Year 5	All Institutions	17	$85,634			$79,475	$86,000	$90,709
General Hospital & Specialty Hospital	Western	Program Year 6	All Institutions	11	$87,057			$80,909	$90,067	$92,426
General Hospital & Specialty Hospital	Western	Program Year 7	All Institutions	8	$93,752			$88,613	$94,650	$97,576
General Hospital & Specialty Hospital	Western	Program Year 8	All Institutions	7	$97,443			$91,892	$96,948	$101,289
Health System & Consortium	Western	Program Year 1	All Institutions	12	$73,100			$69,274	$71,834	$76,586
Health System & Consortium	Western	Program Year 2	All Institutions	12	$75,706			$71,428	$73,494	$79,326
Health System & Consortium	Western	Program Year 3	All Institutions	12	$79,181			$73,720	$76,848	$83,085
Health System & Consortium	Western	Program Year 4	All Institutions	10	$83,990			$77,842	$83,399	$87,998
Health System & Consortium	Western	Program Year 5	All Institutions	8	$87,137			$79,112	$82,733	$94,312
Health System & Consortium	Western	Program Year 6	All Institutions	5	$90,542			$80,689	$81,706	$97,317
Health System & Consortium	Western	Program Year 7	All Institutions	4						
Health System & Consortium	Western	Program Year 8	All Institutions	3						
Medical School	Western	Program Year 1	All Institutions	13	$72,151			$64,061	$72,301	$75,530
Medical School	Western	Program Year 2	All Institutions	13	$74,924			$66,910	$74,209	$77,378
Medical School	Western	Program Year 3	All Institutions	13	$77,938			$70,367	$78,064	$80,869
Medical School	Western	Program Year 4	All Institutions	13	$81,810			$73,903	$84,123	$87,002
Medical School	Western	Program Year 5	All Institutions	13	$85,508			$77,807	$89,049	$90,672
Medical School	Western	Program Year 6	All Institutions	13	$89,259			$81,307	$93,567	$97,609
Medical School	Western	Program Year 7	All Institutions	11	$96,134			$86,610	$98,513	$103,101
Medical School	Western	Program Year 8	All Institutions	6	$101,851			$91,317	$102,794	$111,018
Other	Western	Program Year 1	All Institutions	18	$70,192			$64,894	$67,046	$71,406
Other	Western	Program Year 2	All Institutions	17	$72,388			$67,000	$69,010	$72,661
Other	Western	Program Year 3	All Institutions	17	$76,015			$70,000	$72,485	$75,500
Other	Western	Program Year 4	All Institutions	8	$85,147			$74,894	$77,832	$87,367
Other	Western	Program Year 5	All Institutions	6	$90,432			$79,979	$80,928	$93,884
Other	Western	Program Year 6	All Institutions	3						
Other	Western	Program Year 7	All Institutions	3						
Other	Western	Program Year 8	All Institutions	2						
Total	Western	Program Year 1	Institutions with Number of ACGME-Accredited Programs At or Above the Median (10)	26	$74,905	3,363	$76,207	$64,829	$73,653	$81,635
Total	Western	Program Year 2	Institutions with Number of ACGME-Accredited Programs At or Above the Median (10)	26	$77,572	3,482	$79,588	$67,654	$76,493	$84,211
Total	Western	Program Year 3	Institutions with Number of ACGME-Accredited Programs At or Above the Median (10)	26	$81,307	3,427	$83,225	$70,897	$79,745	$87,787
Total	Western	Program Year 4	Institutions with Number of ACGME-Accredited Programs At or Above the Median (10)	26	$85,137	2,813	$88,611	$74,331	$84,396	$91,435
Total	Western	Program Year 5	Institutions with Number of ACGME-Accredited Programs At or Above the Median (10)	26	$88,690	2,150	$93,396	$78,224	$88,225	$95,397
Total	Western	Program Year 6	Institutions with Number of ACGME-Accredited Programs At or Above the Median (10)	24	$92,418	1,172	$97,396	$81,307	$93,330	$98,972
Total	Western	Program Year 7	Institutions with Number of ACGME-Accredited Programs At or Above the Median (10)	21	$98,380	370	$103,271	$86,980	$98,513	$104,350
Total	Western	Program Year 8	Institutions with Number of ACGME-Accredited Programs At or Above the Median (10)	15	$100,934	50	$109,194	$89,922	$99,397	$109,631
General Hospital & Specialty Hospital	Western	Program Year 1	Institutions with Number of ACGME-Accredited Programs At or Above the Median (5)	10	$74,044			$70,285	$71,630	$77,355
General Hospital & Specialty Hospital	Western	Program Year 2	Institutions with Number of ACGME-Accredited Programs At or Above the Median (5)	11	$76,033			$72,355	$73,500	$79,196
General Hospital & Specialty Hospital	Western	Program Year 3	Institutions with Number of ACGME-Accredited Programs At or Above the Median (5)	11	$79,329			$76,033	$76,707	$82,306
General Hospital & Specialty Hospital	Western	Program Year 4	Institutions with Number of ACGME-Accredited Programs At or Above the Median (5)	10	$81,294			$78,692	$80,772	$83,424
General Hospital & Specialty Hospital	Western	Program Year 5	Institutions with Number of ACGME-Accredited Programs At or Above the Median (5)	10	$84,866			$80,289	$85,285	$87,347
General Hospital & Specialty Hospital	Western	Program Year 6	Institutions with Number of ACGME-Accredited Programs At or Above the Median (5)	8	$89,446			$85,705	$90,367	$93,339
General Hospital & Specialty Hospital	Western	Program Year 7	Institutions with Number of ACGME-Accredited Programs At or Above the Median (5)	7	$95,020			$91,843	$95,471	$97,932
General Hospital & Specialty Hospital	Western	Program Year 8	Institutions with Number of ACGME-Accredited Programs At or Above the Median (5)	6	$98,913			$95,473	$99,074	$101,334
Health System & Consortium	Western	Program Year 1	Institutions with Number of ACGME-Accredited Programs At or Above the Median (12)	4						
Health System & Consortium	Western	Program Year 2	Institutions with Number of ACGME-Accredited Programs At or Above the Median (12)	4						
Health System & Consortium	Western	Program Year 3	Institutions with Number of ACGME-Accredited Programs At or Above the Median (12)	4						
Health System & Consortium	Western	Program Year 4	Institutions with Number of ACGME-Accredited Programs At or Above the Median (12)	4						
Health System & Consortium	Western	Program Year 5	Institutions with Number of ACGME-Accredited Programs At or Above the Median (12)	4						
Health System & Consortium	Western	Program Year 6	Institutions with Number of ACGME-Accredited Programs At or Above the Median (12)	3						
Health System & Consortium	Western	Program Year 7	Institutions with Number of ACGME-Accredited Programs At or Above the Median (12)	3						
Health System & Consortium	Western	Program Year 8	Institutions with Number of ACGME-Accredited Programs At or Above the Median (12)	2						
Medical School	Western	Program Year 1	Institutions with Number of ACGME-Accredited Programs At or Above the Median (45)	7	$76,452			$68,679	$74,009	$84,544
Medical School	Western	Program Year 2	Institutions with Number of ACGME-Accredited Programs At or Above the Median (45)	7	$79,577			$71,678	$77,378	$88,537
Medical School	Western	Program Year 3	Institutions with Number of ACGME-Accredited Programs At or Above the Median (45)	7	$82,834			$75,580	$80,869	$91,591
Medical School	Western	Program Year 4	Institutions with Number of ACGME-Accredited Programs At or Above the Median (45)	7	$86,496			$79,311	$87,002	$94,779
Medical School	Western	Program Year 5	Institutions with Number of ACGME-Accredited Programs At or Above the Median (45)	7	$90,069			$83,428	$90,473	$98,215
Medical School	Western	Program Year 6	Institutions with Number of ACGME-Accredited Programs At or Above the Median (45)	7	$93,437			$87,437	$93,622	$101,465
Medical School	Western	Program Year 7	Institutions with Number of ACGME-Accredited Programs At or Above the Median (45)	7	$96,864			$90,932	$98,513	$104,478
Medical School	Western	Program Year 8	Institutions with Number of ACGME-Accredited Programs At or Above the Median (45)	5	$104,496			$99,397	$106,190	$112,627
Other	Western	Program Year 1	Institutions with Number of ACGME-Accredited Programs At or Above the Median (2)	10	$71,672			$64,894	$66,099	$69,759
Other	Western	Program Year 2	Institutions with Number of ACGME-Accredited Programs At or Above the Median (2)	10	$73,772			$67,104	$68,714	$71,996
Other	Western	Program Year 3	Institutions with Number of ACGME-Accredited Programs At or Above the Median (2)	10	$77,465			$70,044	$71,307	$74,746

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Other	Western	Program Year 4	Institutions with Number of ACGME-Accredited Programs At or Above the Median (2)	6	$86,500			$73,453	$77,050	$90,472
Other	Western	Program Year 5	Institutions with Number of ACGME-Accredited Programs At or Above the Median (2)	5	$92,511			$79,960	$81,822	$97,904
Other	Western	Program Year 6	Institutions with Number of ACGME-Accredited Programs At or Above the Median (2)	3						
Other	Western	Program Year 7	Institutions with Number of ACGME-Accredited Programs At or Above the Median (2)	3						
Other	Western	Program Year 8	Institutions with Number of ACGME-Accredited Programs At or Above the Median (2)	2						
Total	Western	Program Year 1	Institutions with Number of ACGME-Accredited Programs Below the Median (10)	42	$69,580	764	$70,024	$64,894	$69,455	$72,166
Total	Western	Program Year 2	Institutions with Number of ACGME-Accredited Programs Below the Median (10)	42	$72,332	633	$72,375	$67,701	$71,885	$74,703
Total	Western	Program Year 3	Institutions with Number of ACGME-Accredited Programs Below the Median (10)	42	$75,744	594	$75,961	$70,429	$74,963	$78,852
Total	Western	Program Year 4	Institutions with Number of ACGME-Accredited Programs Below the Median (10)	24	$79,722	136	$81,238	$74,359	$79,670	$84,862
Total	Western	Program Year 5	Institutions with Number of ACGME-Accredited Programs Below the Median (10)	18	$83,397	63	$81,721	$78,364	$82,132	$87,671
Total	Western	Program Year 6	Institutions with Number of ACGME-Accredited Programs Below the Median (10)	8	$83,561	31	$81,169	$79,028	$83,406	$90,490
Total	Western	Program Year 7	Institutions with Number of ACGME-Accredited Programs Below the Median (10)	5	$91,211	4		$85,515	$88,347	$95,471
Total	Western	Program Year 8	Institutions with Number of ACGME-Accredited Programs Below the Median (10)	3		0				
General Hospital & Specialty Hospital	Western	Program Year 1	Institutions with Number of ACGME-Accredited Programs Below the Median (5)	15	$70,057			$62,576	$69,805	$72,442
General Hospital & Specialty Hospital	Western	Program Year 2	Institutions with Number of ACGME-Accredited Programs Below the Median (5)	15	$73,691			$67,969	$72,290	$76,895
General Hospital & Specialty Hospital	Western	Program Year 3	Institutions with Number of ACGME-Accredited Programs Below the Median (5)	15	$77,799			$71,496	$77,982	$82,334
General Hospital & Specialty Hospital	Western	Program Year 4	Institutions with Number of ACGME-Accredited Programs Below the Median (5)	9	$81,038			$73,903	$80,139	$85,969
General Hospital & Specialty Hospital	Western	Program Year 5	Institutions with Number of ACGME-Accredited Programs Below the Median (5)	7	$86,731			$79,079	$88,228	$94,641
General Hospital & Specialty Hospital	Western	Program Year 6	Institutions with Number of ACGME-Accredited Programs Below the Median (5)	3						
General Hospital & Specialty Hospital	Western	Program Year 7	Institutions with Number of ACGME-Accredited Programs Below the Median (5)	1						
General Hospital & Specialty Hospital	Western	Program Year 8	Institutions with Number of ACGME-Accredited Programs Below the Median (5)	1						
Health System & Consortium	Western	Program Year 1	Institutions with Number of ACGME-Accredited Programs Below the Median (12)	8	$70,517			$67,754	$69,844	$72,060
Health System & Consortium	Western	Program Year 2	Institutions with Number of ACGME-Accredited Programs Below the Median (12)	8	$72,944			$69,589	$72,586	$74,180
Health System & Consortium	Western	Program Year 3	Institutions with Number of ACGME-Accredited Programs Below the Median (12)	8	$76,040			$72,602	$75,415	$77,848
Health System & Consortium	Western	Program Year 4	Institutions with Number of ACGME-Accredited Programs Below the Median (12)	6	$80,009			$75,514	$79,597	$84,762
Health System & Consortium	Western	Program Year 5	Institutions with Number of ACGME-Accredited Programs Below the Median (12)	4						
Health System & Consortium	Western	Program Year 6	Institutions with Number of ACGME-Accredited Programs Below the Median (12)	2						
Health System & Consortium	Western	Program Year 7	Institutions with Number of ACGME-Accredited Programs Below the Median (12)	1						
Health System & Consortium	Western	Program Year 8	Institutions with Number of ACGME-Accredited Programs Below the Median (12)	1						
Medical School	Western	Program Year 1	Institutions with Number of ACGME-Accredited Programs Below the Median (45)	6	$67,133			$62,870	$67,911	$72,166
Medical School	Western	Program Year 2	Institutions with Number of ACGME-Accredited Programs Below the Median (45)	6	$69,496			$64,950	$70,111	$73,985
Medical School	Western	Program Year 3	Institutions with Number of ACGME-Accredited Programs Below the Median (45)	6	$72,225			$67,381	$73,280	$77,596
Medical School	Western	Program Year 4	Institutions with Number of ACGME-Accredited Programs Below the Median (45)	6	$76,344			$70,341	$76,552	$82,892
Medical School	Western	Program Year 5	Institutions with Number of ACGME-Accredited Programs Below the Median (45)	6	$80,187			$72,967	$80,124	$88,125
Medical School	Western	Program Year 6	Institutions with Number of ACGME-Accredited Programs Below the Median (45)	6	$84,384			$75,860	$83,406	$93,465
Medical School	Western	Program Year 7	Institutions with Number of ACGME-Accredited Programs Below the Median (45)	4						
Medical School	Western	Program Year 8	Institutions with Number of ACGME-Accredited Programs Below the Median (45)	1						
Other	Western	Program Year 1	Institutions with Number of ACGME-Accredited Programs Below the Median (2)	8	$68,342			$65,440	$68,371	$71,895
Other	Western	Program Year 2	Institutions with Number of ACGME-Accredited Programs Below the Median (2)	7	$70,411			$68,005	$70,160	$72,989
Other	Western	Program Year 3	Institutions with Number of ACGME-Accredited Programs Below the Median (2)	7	$73,944			$71,526	$74,160	$76,245
Other	Western	Program Year 4	Institutions with Number of ACGME-Accredited Programs Below the Median (2)	2						
Other	Western	Program Year 5	Institutions with Number of ACGME-Accredited Programs Below the Median (2)	1						
Other	Western	Program Year 6	Institutions with Number of ACGME-Accredited Programs Below the Median (2)	0						
Other	Western	Program Year 7	Institutions with Number of ACGME-Accredited Programs Below the Median (2)	0						
Other	Western	Program Year 8	Institutions with Number of ACGME-Accredited Programs Below the Median (2)	0						
Total	Western	Program Year 1	Institutions with Number of Resident/Fellows At or Above the Median (140)	23	$74,747	3,293	$76,558	$70,185	$74,009	$80,444
Total	Western	Program Year 2	Institutions with Number of Resident/Fellows At or Above the Median (140)	23	$77,521	3,426	$79,884	$72,267	$76,540	$83,103
Total	Western	Program Year 3	Institutions with Number of Resident/Fellows At or Above the Median (140)	23	$80,863	3,382	$83,482	$75,546	$80,793	$87,202
Total	Western	Program Year 4	Institutions with Number of Resident/Fellows At or Above the Median (140)	23	$84,603	2,798	$88,718	$77,958	$84,718	$91,310
Total	Western	Program Year 5	Institutions with Number of Resident/Fellows At or Above the Median (140)	23	$88,336	2,139	$93,498	$79,821	$89,049	$95,264
Total	Western	Program Year 6	Institutions with Number of Resident/Fellows At or Above the Median (140)	20	$92,408	1,166	$97,484	$82,509	$93,595	$98,972
Total	Western	Program Year 7	Institutions with Number of Resident/Fellows At or Above the Median (140)	19	$97,328	368	$103,371	$88,419	$98,513	$104,257
Total	Western	Program Year 8	Institutions with Number of Resident/Fellows At or Above the Median (140)	14	$101,801	50	$109,194	$92,026	$100,388	$109,900
General Hospital & Specialty Hospital	Western	Program Year 1	Institutions with Number of Resident/Fellows At or Above the Median (82)	12	$74,056			$70,804	$72,109	$76,349
General Hospital & Specialty Hospital	Western	Program Year 2	Institutions with Number of Resident/Fellows At or Above the Median (82)	12	$76,748			$72,595	$74,277	$81,197
General Hospital & Specialty Hospital	Western	Program Year 3	Institutions with Number of Resident/Fellows At or Above the Median (82)	12	$80,174			$76,246	$78,511	$84,425
General Hospital & Specialty Hospital	Western	Program Year 4	Institutions with Number of Resident/Fellows At or Above the Median (82)	11	$82,554			$79,084	$81,476	$85,974
General Hospital & Specialty Hospital	Western	Program Year 5	Institutions with Number of Resident/Fellows At or Above the Median (82)	11	$86,159			$81,103	$87,185	$89,469
General Hospital & Specialty Hospital	Western	Program Year 6	Institutions with Number of Resident/Fellows At or Above the Median (82)	8	$89,657			$85,705	$91,213	$93,339
General Hospital & Specialty Hospital	Western	Program Year 7	Institutions with Number of Resident/Fellows At or Above the Median (82)	6	$94,945			$90,850	$95,524	$98,289
General Hospital & Specialty Hospital	Western	Program Year 8	Institutions with Number of Resident/Fellows At or Above the Median (82)	5	$98,456			$94,981	$96,948	$101,379
Health System & Consortium	Western	Program Year 1	Institutions with Number of Resident/Fellows At or Above the Median (186)	4						
Health System & Consortium	Western	Program Year 2	Institutions with Number of Resident/Fellows At or Above the Median (186)	4						
Health System & Consortium	Western	Program Year 3	Institutions with Number of Resident/Fellows At or Above the Median (186)	4						
Health System & Consortium	Western	Program Year 4	Institutions with Number of Resident/Fellows At or Above the Median (186)	4						
Health System & Consortium	Western	Program Year 5	Institutions with Number of Resident/Fellows At or Above the Median (186)	4						
Health System & Consortium	Western	Program Year 6	Institutions with Number of Resident/Fellows At or Above the Median (186)	3						

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Health System & Consortium	Western	Program Year 7	Institutions with Number of Resident/Fellows At or Above the Median (186)	3						
Health System & Consortium	Western	Program Year 8	Institutions with Number of Resident/Fellows At or Above the Median (186)	2						
Medical School	Western	Program Year 1	Institutions with Number of Resident/Fellows At or Above the Median (582.5)	7	$76,452			$68,679	$74,009	$84,544
Medical School	Western	Program Year 2	Institutions with Number of Resident/Fellows At or Above the Median (582.5)	7	$79,577			$71,678	$77,378	$88,537
Medical School	Western	Program Year 3	Institutions with Number of Resident/Fellows At or Above the Median (582.5)	7	$82,834			$75,580	$80,869	$91,591
Medical School	Western	Program Year 4	Institutions with Number of Resident/Fellows At or Above the Median (582.5)	7	$86,496			$79,311	$87,002	$94,779
Medical School	Western	Program Year 5	Institutions with Number of Resident/Fellows At or Above the Median (582.5)	7	$90,069			$83,428	$90,473	$98,215
Medical School	Western	Program Year 6	Institutions with Number of Resident/Fellows At or Above the Median (582.5)	7	$93,437			$87,437	$93,622	$101,465
Medical School	Western	Program Year 7	Institutions with Number of Resident/Fellows At or Above the Median (582.5)	7	$96,864			$90,932	$98,513	$104,478
Medical School	Western	Program Year 8	Institutions with Number of Resident/Fellows At or Above the Median (582.5)	5	$104,496			$99,397	$106,190	$112,627
Other	Western	Program Year 1	Institutions with Number of Resident/Fellows At or Above the Median (32)	7	$68,031			$64,149	$65,637	$68,453
Other	Western	Program Year 2	Institutions with Number of Resident/Fellows At or Above the Median (32)	7	$70,459			$66,728	$68,557	$70,766
Other	Western	Program Year 3	Institutions with Number of Resident/Fellows At or Above the Median (32)	7	$73,067			$69,079	$70,614	$73,993
Other	Western	Program Year 4	Institutions with Number of Resident/Fellows At or Above the Median (32)	5	$78,209			$72,732	$75,615	$78,485
Other	Western	Program Year 5	Institutions with Number of Resident/Fellows At or Above the Median (32)	4						
Other	Western	Program Year 6	Institutions with Number of Resident/Fellows At or Above the Median (32)	2						
Other	Western	Program Year 7	Institutions with Number of Resident/Fellows At or Above the Median (32)	2						
Other	Western	Program Year 8	Institutions with Number of Resident/Fellows At or Above the Median (32)	2						
Total	Western	Program Year 1	Institutions with Number of Resident/Fellows Below the Median (140)	43	$68,732	834	$69,158	$64,275	$68,036	$71,760
Total	Western	Program Year 2	Institutions with Number of Resident/Fellows Below the Median (140)	43	$71,457	689	$71,493	$67,053	$70,160	$74,209
Total	Western	Program Year 3	Institutions with Number of Resident/Fellows Below the Median (140)	43	$74,799	639	$75,114	$70,103	$74,000	$78,064
Total	Western	Program Year 4	Institutions with Number of Resident/Fellows Below the Median (140)	26	$78,964	151	$79,989	$73,289	$78,862	$84,643
Total	Western	Program Year 5	Institutions with Number of Resident/Fellows Below the Median (140)	20	$82,369	74	$80,521	$77,025	$80,556	$86,557
Total	Western	Program Year 6	Institutions with Number of Resident/Fellows Below the Median (140)	11	$82,407	37	$81,034	$78,740	$80,689	$87,786
Total	Western	Program Year 7	Institutions with Number of Resident/Fellows Below the Median (140)	6	$90,156	6		$85,040	$86,931	$93,690
Total	Western	Program Year 8	Institutions with Number of Resident/Fellows Below the Median (140)	4		0				
General Hospital & Specialty Hospital	Western	Program Year 1	Institutions with Number of Resident/Fellows Below the Median (82)	12	$67,907			$60,818	$67,964	$71,760
General Hospital & Specialty Hospital	Western	Program Year 2	Institutions with Number of Resident/Fellows Below the Median (82)	13	$71,468			$66,910	$71,201	$75,348
General Hospital & Specialty Hospital	Western	Program Year 3	Institutions with Number of Resident/Fellows Below the Median (82)	13	$75,360			$70,367	$75,687	$79,115
General Hospital & Specialty Hospital	Western	Program Year 4	Institutions with Number of Resident/Fellows Below the Median (82)	8	$79,274			$73,052	$78,529	$81,900
General Hospital & Specialty Hospital	Western	Program Year 5	Institutions with Number of Resident/Fellows Below the Median (82)	6	$84,673			$78,443	$82,460	$91,535
General Hospital & Specialty Hospital	Western	Program Year 6	Institutions with Number of Resident/Fellows Below the Median (82)	3						
General Hospital & Specialty Hospital	Western	Program Year 7	Institutions with Number of Resident/Fellows Below the Median (82)	2						
General Hospital & Specialty Hospital	Western	Program Year 8	Institutions with Number of Resident/Fellows Below the Median (82)	2						
Health System & Consortium	Western	Program Year 1	Institutions with Number of Resident/Fellows Below the Median (186)	8	$70,517			$67,754	$69,844	$72,060
Health System & Consortium	Western	Program Year 2	Institutions with Number of Resident/Fellows Below the Median (186)	8	$72,944			$69,589	$72,586	$74,180
Health System & Consortium	Western	Program Year 3	Institutions with Number of Resident/Fellows Below the Median (186)	8	$76,040			$72,602	$75,415	$77,848
Health System & Consortium	Western	Program Year 4	Institutions with Number of Resident/Fellows Below the Median (186)	6	$80,009			$75,514	$79,597	$84,762
Health System & Consortium	Western	Program Year 5	Institutions with Number of Resident/Fellows Below the Median (186)	4						
Health System & Consortium	Western	Program Year 6	Institutions with Number of Resident/Fellows Below the Median (186)	2						
Health System & Consortium	Western	Program Year 7	Institutions with Number of Resident/Fellows Below the Median (186)	1						
Health System & Consortium	Western	Program Year 8	Institutions with Number of Resident/Fellows Below the Median (186)	1						
Medical School	Western	Program Year 1	Institutions with Number of Resident/Fellows Below the Median (582.5)	6	$67,133			$62,870	$67,911	$72,166
Medical School	Western	Program Year 2	Institutions with Number of Resident/Fellows Below the Median (582.5)	6	$69,496			$64,950	$70,111	$73,985
Medical School	Western	Program Year 3	Institutions with Number of Resident/Fellows Below the Median (582.5)	6	$72,225			$67,381	$73,280	$77,596
Medical School	Western	Program Year 4	Institutions with Number of Resident/Fellows Below the Median (582.5)	6	$76,344			$70,341	$76,552	$82,892
Medical School	Western	Program Year 5	Institutions with Number of Resident/Fellows Below the Median (582.5)	6	$80,187			$72,967	$80,124	$88,125
Medical School	Western	Program Year 6	Institutions with Number of Resident/Fellows Below the Median (582.5)	6	$84,384			$75,860	$83,406	$93,465
Medical School	Western	Program Year 7	Institutions with Number of Resident/Fellows Below the Median (582.5)	4						
Medical School	Western	Program Year 8	Institutions with Number of Resident/Fellows Below the Median (582.5)	1						
Other	Western	Program Year 1	Institutions with Number of Resident/Fellows Below the Median (32)	10	$67,973			$65,230	$67,766	$71,122
Other	Western	Program Year 2	Institutions with Number of Resident/Fellows Below the Median (32)	9	$69,986			$67,000	$70,000	$71,769
Other	Western	Program Year 3	Institutions with Number of Resident/Fellows Below the Median (32)	9	$73,289			$70,000	$73,052	$74,425
Other	Western	Program Year 4	Institutions with Number of Resident/Fellows Below the Median (32)	2						
Other	Western	Program Year 5	Institutions with Number of Resident/Fellows Below the Median (32)	1						
Other	Western	Program Year 6	Institutions with Number of Resident/Fellows Below the Median (32)	0						
Other	Western	Program Year 7	Institutions with Number of Resident/Fellows Below the Median (32)	0						
Other	Western	Program Year 8	Institutions with Number of Resident/Fellows Below the Median (32)	0						

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Exhibit 11:
SJC-AMA-000000626
Six Things Medical Students Should Know About Physician Compensation

www.ama-assn.org /medical-students/specialty-profiles/6-things-medical-students-should-know-about-physician

6 things medical students should know about physician compensation

Specialty Profiles

By

Brendan Murphy , Senior News Writer

Jun 1, 2022 | 4 Min Read

Even before the completion of medical school, future physicians have a number hovering over their heads that may shape their future—the balance owed on their medical student loans.

The ultimate guide to succeeding in medical school

Grow your leadership, advocacy and research skills and set yourself apart for residency with this helpful AMA guide.

Learn More

According to data from the Association of American Medical Colleges, the typical medical student graduates with about $200,000 in medical education debt. Those medical student-loan debt figures may inspire some

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trainees to factor earning potential into their career plans.

For medical students looking to understand the role compensation may play in a career path, here are a few things to keep in mind.

It takes years to realize your earning potential. As a physician, you will not maximize your earnings until the completion of your graduate medical education.The average first-year resident physician makes about $60,000, and there's not much wiggle room.

Resident salaries are determined by an institution and correlate with training year rather than specialty. So, in a given training institution, all residents who are in their third year of training typically get the same salary, and all in their sixth year are paid the same as well.

Learn some key budgeting techniques for resident physicians.

Surgical specialties typically pay more. The highest-paying medical specialties are generally procedure-based. According to a 2022 online survey of more than 13,000 physicians across 29 specialties by *Medscape*, the highest-paying medical specialties are:

- Plastic surgery—$576,000 per year.
- Orthopedics—$557,000.
- Cardiology—$490,000.
- Otolaryngology—$469,000.
- Urology—$461,000.

Related Coverage

It matters how your practice is paid. A primer for young doctors.

The report found that physicians working in primary care fields earn an average of $260,000, while specialists make $368,000 on average. It's not surprising, then, that some of the lowest-paying specialties are in the fields associated with primary care, with internal medicine ($264,00), family medicine ($255,000) and pediatrics ($244,000) being listed among the bottom six specialties in annual compensation.

Consult FREIDA's Specialty Guide for highlights on specialties, Match data and career statistics.

Get residency-ready with AMA benefits

- Find your perfect match with FREIDA™, the AMA Residency & Fellowship Database®
- Distinguish yourself with AMA leadership opportunities

Supporting you today as a medical student. Protecting your future as a physician.

Join the AMA Today

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Lucrative specialties require more training. Trainees who do pursue a career in a higher-paying specialty may have a smaller window for optimal earning. Those specialties tend to require the most training between residency and a subspecialty-focused fellowship.

The primary care specialties earn less by comparison but require less time in training. With some primary care programs offering pathways for physicians to go through medical school and residency in as little as six years, students in these programs can reduce med school debt and earn more money quicker by spending less time in residency.

Find out why training length shouldn't be a key factor in specialty choice.

Compensation is rebounding. The 2022 survey marked the first time in the 11-year history of the *Medscape* report that every specialty saw an increase in salary from the prior year's version. That can, at least partially be attributed pandemic-related declines that took place during the prior year.

With a 13% increase year over year, otolaryngology saw the biggest specialty salary increase. Five other specialties—gastroenterology (12%); dermatology (11%); pediatrics (10%); ophthalmology (10%); and plastic surgery (10%)—also saw double-digit increases in average salary figures.

Related Coverage

How value-based care is making payor contracts even more complex

More bang for your buck in the South. Survey respondents indicated that Kentucky and Tennessee, at $364,000, were the top paying states for physicians. Other states in the top five include Alabama ($358,000) and Missouri ($357,000). The report indicates that Southern states have made an extra effort to recruit physicians.

Those four states all rank in the top 20 states in the country in terms of the lowest cost of living. So, if you practice in one of those states you have the opportunity to make more money and it will get you further.

Ownership can pay off. The data indicated that self-employed physicians, those who owned a stake of the practice in which they worked, regardless of specialty choice, earned about $385,000. That compares with average earnings closer to $320,000 for employed physicians.

One somewhat unexpected nugget in that data is that, although a relatively small share of the group, physicians under the age of 45 ($404,000) were making more than those over 45 ($381,000) in ownership settings.

The AMA offers a number of resources that offer guidance on the pros and cons of practice settings and general career guidance.

MORE RESOURCES

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Exhibit 12:
NRMP_0004595
Residency Match Process Under Scrutiny Again, This Time by AMA

www.medscape.com

Residency Match Process Under Scrutiny Again, This Time by AMA

Avery Hurt

June 29, 2023

The American Medical Association (AMA) is considering whether to study alternatives to the current residency matching program in an effort to improve residents' compensation and other job-related issues. A recent call-to-action resolution by the AMA's House of Delegates is the latest in a long string of debates about whether to change the annual process that matches future doctors with compatible residency programs.

AMA's Resident and Fellow Section introduced the resolution in March, and the delegates approved it earlier this month at AMA's annual meeting. The resolution states that the match process of the National Resident Matching Program (NRMP) "poses significant anticompetition concerns." Those include preventing residents from negotiating for higher wages, better benefits, and improved working conditions, according to the approved resolution.

The full AMA board still has to consider the resolution and hasn't set a date for that review, though it's expected to be in the next few months, according to Jennifer Sellers, AMA's public information officer. She told *Medscape Medical News* that the organization declined to comment, wanting to hold off until the board decides how to proceed.

The NRMP, which oversees the matching process, told Medscape that the AMA doesn't play a role in the Match.

The organization doesn't believe studying alternative placement methods benefits applicants and residents, and returning to a pre-Match environment would harm applicants and programs, according to Donna Lamb, DHSc, MBA, BSN, president and CEO.

"The NRMP has no role in determining, publishing, or setting resident salaries nor does the NRMP have a role in the contracting or employment of residents and it never has."

Lamb said changing the Match would "subject applicants to undue pressure and coercion to accept an offer of training. This will exacerbate disparities in candidate selection already evident in medical education and potentially result in salary reductions in more competitive specialties and in more desirable geographic locations."

The latest push to reform the match process dates back two decades to a 2002 class action antitrust lawsuit by residents and doctors against the NRMP and other organizations involved in the Match.

The residents argued at that time that by restraining competition among teaching hospitals, the matching system allowed hospitals to keep residents' wages artificially low. The defendants, which included large teaching hospitals, successfully lobbied Congress for an exemption to the antitrust laws, and the case was subsequently dismissed.

The AMA was one of the defendants, so if it moves forward to review the match process, it likely would pit the organization against the NRMP.

Sherman Marek, the attorney who represented the residents, told Medscape he was not surprised by the latest AMA resolution. "Maybe the AMA leadership has come around to the idea that it's better for young physicians to not have the match in place," he says. "I would applaud that sort of evolution."

Tyler Ramsey, DO, an internal medicine resident and AMA member, said he believes the group's current president, Jesse Ehrenfeld, MD, MPH, empathizes with doctors in training. "I think he understands [our] views and is more progressive."

The NRMP also has considered ways to improve the match process to make it easier and more equitable for applicants. In its latest effort, the organization is studying whether programs should certify their rank order list in advance of applicants. This change would give applicants more flexibility to visit residency locations before the programs consider changing their rankings, Lamb explained. The NRMP also is mulling the possibilities of a two-phase match after deciding last year not to move forward with a previous version of the proposal.

The recent House of Delegates resolution states that "residents are using other means to obtain fair wages, safe working conditions, and other benefits that are unable to be negotiated within the current system."

Ramsey, who trains in North Carolina, said the "other means" may include negotiating through a union. "The AMA realizes that there is a problem, and that people are unionizing," he said. "Obviously, as an organization, we're not doing something correctly, to the point where people are feeling the need to get their rights a different way."

CONFIDENTIAL NRMP_0004595

The Committee of Interns and Residents, which represents 30,000 members, reported a rise in medical trainee unions across the country last year.

Not everyone believes that ditching the Match would benefit applicants and residents. Sam Payabvash, MD, assistant professor of radiology at Yale School of Medicine, tweeted about the resolution as part of a larger Twitter discussion that alternatives are likely to be "more onerous and expensive for applicants."

An advantage of the Match, Lamb argued, is that it "improves the reach of applicants into medically underserved communities through widespread program participation."

Ramsey agreed that the match program has benefits and drawbacks, but he believes it favors programs over residents. "It comes as no surprise that numerous residents suffer from depression and our suicide rates are the highest amongst all professions due to the lack of control or negotiation of fair salary and working conditions. Overall, the way things are now, residents just do not have a lot of rights."

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Cite this: Residency Match Process Under Scrutiny Again, This Time by AMA - *Medscape* - Jun 29, 2023.

Exhibit 13:
AOA Production – Part 3 – Final
pages 325-331
The Role of the ACGME in the Pathway to Medical Practice

THE ROLE OF THE ACGME IN THE PATHWAY TO MEDICAL PRACTICE

INTRODUCTION

Welcome to the Accreditation Council for Graduate Medical Education, often referred to as the ACGME. This course, “The Role of the ACGME in the pathway to medical practice,” is designed to help you understand the professional pathway required to become a practicing physician in the United States. The content included in this course will describe how a person progresses from college through medical school and into medical practice, hopefully providing you with a better understanding of the role for Graduate Medical Education (or GME) and your role in this process. Along the way, you will hear of the many medical organizations that have an impact on medical education. If you want to explore further, there will be links to these organizations where you can learn more.

COLLEGE

So how exactly does a person start the journey toward becoming a practicing physician? Many individuals may have a unique story but for the most direct route in the United States, students start their pathway while they’re in college. In most countries across the world, students start their medical training right out of high school. The United States is unique in that physician training typically occurs after a four-year college degree, which is seen as an important maturation and developmental phase. Pathways can on occasion, especially in the case of International Medical Graduates.

While pursuing undergraduate degrees, students can study and major in any subject. However, the sciences are a popular choice because biology, chemistry, physics and a few courses in the humanities are requisite for medical school entry. Students take their first step toward medical education by taking the Medical College Admissions Test (known as the MCAT), usually during their junior year. Developed by the American Association of Medical Colleges, this standard multiple-choice examination assesses what students know about natural, behavioral and social science concepts, and their problem solving skills. Most students apply for medical school during the summer after their junior year. There are those who may have completed their undergraduate degrees in the past, but who apply for medical school when they decide to change careers. Medical schools conduct applicant interviews in the fall and winter, and, typically, students learn of the decision between December and May.

MEDICAL SCHOOL

There are two different medical degrees a student can earn in the United States. Allopathic medical schools grant the Medical Doctor (MD) degree and osteopathic medical schools grant the Doctor of Osteopathic Medicine (DO) degree. Osteopathic medical schools offer an emphasis on osteopathic principles and practice, which focus on promoting the body’s natural tendency toward self-healing and health. Allopathic schools are accredited by the Liaison Committee for Medical Education (LCME), a committee jointly sponsored by the American Association of Medical Colleges (AAMC) and the American Medical Association, (AMA), which

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February 2022

together accredit the 134 medical school programs in the USA and 17 in Canada), while the 35 osteopathic medical schools are accredited by the American Osteopathic Association's Commission on Osteopathic College Accreditation. Both types of medical school are typically four years long and follow the academic calendar that starts in the fall and ends in the spring.

The first two years of medical school focus on the basic sciences of anatomy, biochemistry, microbiology, pathology and physiology but also include clinical rotations with patient care experiences. In these first years, medical students are taught to perform physical examination, conduct a medical interview, and discuss a patient's diagnosis. Focus on professionalism while practicing these skills is included as part of the medical curriculum. The third and fourth years include rotations (a time limited immersive patient care assgniment in a specialty or subspecialty, often 4-6 weeks long.) or educational experiences in the general specialties, These rotations are four to six weeks long, and provide a background for every medical student. Typically, the required rotations in the third and fourth years of medical school include internal medicine, pediatrics, general surgery, psychiatry, obstetrics and gynecology, and sometimes neurology and emergency medicine.

These is also opportunity for elective rotations in more specialties such as anesthesiology or urology and subspecialties which cover a more focused practice within a specialty. Under internal medicine, for instance, nephrology, and critical care are subspecialties. https://www.sgu.edu/blog/medical/ultimate-list-of-medical-specialties/.

Medical students often make a decision regarding their choice of specialty during their third year of medical school – by choosing experiences in a number of specialties and subspecialties not unlike an undergraduate student declaring a major). The fourth year is particularly busy for medical students, with much of their time spent learning about the specialty they have chosen, and interviewing for residency positions.

It's worth noting that by the time a medical student has gone through four years of medical school, they find themselves, on average, around $200,000 in debt. As the cost of medical school has risen over the years, this debt is thought to be one reason about why some medical students may gravitate away from primary care specialties to higher paying specialties. This may shape the numbers and distribution of specialists available for patient care across the U.S. as a whole.

At the end of the second year, allopathic medical students take step one of three of the United States Medical Licensing Examination (USMLE) and osteopathic students take step one of three of the Comprehensive Osteopathic Medical Licensing Examination (COMLEX). These exams test students' basic science knowledge and are stressful for many since these scores are frequently used by residency program directors as screening criteria during the application process.

The second step of the USMLE and COMLEX exams are taken in the fourth year and both examinations include a clinical skills test using standardized simulated patients, in addition to a written knowledge test.

> According to the Association of American Medical Colleges (AAMC), medical school tuition averages about $37,000 for instate public schools and $60,000 for private schools per year. The total cost of attendance, including living expenses, for four years is $244,000 for public schools and $323,000 for private schools. As a result, about 75% of all graduating medical students have debt from their education and that debt averages $190,000 per student, 70% of which is from medical school. This debt is thought to be one reason about why some medical students may gravitate away from primary care specialties to higher paying specialties.

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RESIDENCY

Upon successful completion of medical school, graduates receive a medical degree, but are not yet eligible for a license to practice. As students, they have had exposure to multiple specialties and have developed a strong theoretical framework in medicine and the basic sciences. However, they lack the practical clinical experience to practice independently. In order to gain clinical experience, medical school graduates continue their learning in a residency program. Residency is designed to be primarily a clinical experience where residents take care of patients in a specific specialty. Because of the limited expertise when they enter residency, these residents are initially closely supervised. The goal of residency is to gradually provide the physician with increasing responsibility to provide them with the ability to practice independently.

The residency application process begins in the summer before the fourth year of medical school. A student might apply to about 20 or more residency programs within their specialty using the Electronic Residency Application System (ERAS). An applicant can expect approximately half of those applications to result in an invitation for an interview, depending on the specialty. Residency interviews usually take place between November and January. After the application and recruitment processes are over, both medical students and programs enter their preferences on a Rank Order List most often organized by the National Residency Match Program (NRMP). The NRMP uses a computer algorithm to match the applicants' and programs' preferences. Programs and applicants send the NRMP their Rank Order List in mid-February. On "Match Day" in mid-March, the NRMP announces where each residency applicant will be doing their residency. About half of applicants match to their first choice and three quarters match to one of their top three choices. This is true for about 18,000 allopathic and 5,000 osteopathic graduates every year. Some specialties use other smaller matching programs instead of the NRMP, such as the San Francisco Match for Ophthalmology, Plastic Surgery, the military match and the Urology match. The application and recruitment season is time-consuming, expensive and grueling for both applicants and programs. After graduation in May or June, the newly minted physicians start residency training, in late June or early July.

Individuals who graduate from medical schools outside the US are identified as International Medical Graduates (or IMGs). Many are citizens of other countries who are seeking residency training in the US. The largest number of international medical graduates come from India, the Philippines, Mexico and Pakistan. As non-citizens, these students are required to obtain a visa to work in the US. The most common visas issued are J-1 training visas sponsored by the Educational Council for Graduate Medical Education (ECFMG), although some sponsoring institutions offer a H-1 work visa. US citizens who go to international medical schools are also considered IMGs. Because overseas medical schools are not accredited by the LCME or the AOA, it is difficult to verify the quality of the school and training so their graduates often find it more difficult to obtain a residency position than those graduating from accredited American schools.

The core, or pipeline, residency is the first residency a graduate enters out of medical school and usually takes between three and seven years to complete. Residents learn a core specialty during this time.

Because every specialty has different planned clinical experiences for their residents, a general description will apply only to some specialties. That said, in general, life as a post-graduate year

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one (commonly referred to as a PG-1) resident, previously known as an intern, is busy and stressful. It is one of the most important years of growth and transition for physicians in training. The PG1 resident is learning to take on a professional role as a physician while caring for patients under direct supervision by more advanced or senior residents. These may be PG2 residents or chief residents who are in their last year of training and are themselves always under the supervision of an attending or faculty physician. While medical students have a limited workload, such as caring for one or two patients at a time, most PG1 residents care for four or five times that number. Typically, residents rotate in blocks of one to three months before moving on to a different service. Each service provides a different clinical experience and sometimes a different specialty. For example, a rotation in the critical care unit may have residents from anesthesiology, emergency medicine and surgery all learning together but with different learning objectives that apply to their own specialty. The focus for each rotation might be outpatient or inpatient. A rotation may include providing care for a certain type of disease, such as on an oncology service, critically ill patients in intensive care units (ICU), specialty units such as coronary care units (CCU) or organ-based units such as pulmonary medicine. In addition to block rotations, there may be some longitudinal rotations which last for months or years. A resident may have a weekly outpatient clinic experience where they care for a panel of patients through the entire length of their residency.

Some specialties, such as radiology or anesthesiology, require a preliminary general clinical year to allow for the development of fundamental clinical skills. This may be in a Transitional year program, as the first 12 months of a medicine or surgery program, called a Preliminary medicine year or a Preliminary surgery year. During this fundamental clinical skills year residents rotate as PG-1s through several specialties or subspecialties prior to starting their core residency program.

Residency and fellowship are often a time of personal and professional growth. The stress, the uncertainty and responsibility for patients is a challenge for every resident and each resident has a different level of resilience and ability to handle these stresses. Many residents have signs of burn-out or depression and while most complete training successfully, recover and continue their careers successfully, there is recognition that the educational and patient care environment needs to change to improve the wellness of residents and faculty. The ACGME offers education for physicians in avoiding burnout and promoting well-being through such resources as the ACGME Well-Being and Resilience Education curriculum and app. Burnout and wellness are important considerations for practicing physicians and other health care workers as well as residents and fellows.

The PG2 year involves taking on more responsibility and making more patient care decisions, while still learning new concepts. Some of a PG2's educational experiences include supervising PG1 residents. Experiences for senior residents at the PG3 level and above involve a higher level of responsibility, and consequently, supervision by an attending or faculty physician. Advanced residents also receive additional education and learning experiences with quality improvement, patient safety, administration and management, as well as in leading a team, all while taking a greater role in teaching the more junior residents. In most specialties a few of the senior residents have additional leadership and administrative responsibilities and are recognized as chief residents. In many surgical specialties, every resident in the last year of training is deemed a chief resident, while Internal medicine and pediatric chief residents spend an additional year after in this role after having completed their residency

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In addition to receiving ongoing formative feedback during their residency, residents undergo a formal assessment on their progress at least twice a year. This includes progress on the specialty Milestones, which measures the resident's progress on reaching the expected skills and competencies defined by their specialty. These are organized into the six Core Competencies of Professionalism, Medical Knowledge, Patient Care, Interpersonal communication, Practice-based learning and System-based practice. All residents' progress is determined by a committee of the program faculty called the Clinical Competency Committee, (known as the CCC).

FELLOWSHIP

Upon completion of residency, many physicians pursue additional training to become subspecialists (referred to as a fellowship). This takes an additional one to three years after completion of the core residency program. For example, internal medicine and general surgery are core residencies; of which cardiology and pediatric surgery are subspecialty fellowships respectively.

Fellows are typically a PG4 or beyond, have graduated from a core residency program, and choose to further specialize by learning a subspecialty. Because they have already completed a core residency, where they have become competent in Professionalism, Interpersonal communication, Practice-based learning and System-based practice the focus is more on the competencies of Medical Knowledge and Patient Care specific to their subspecialty. Many fellowships also include much more emphasis on research or other scholarly activities.

THE ROLE OF THE ACGME

What is the role of the ACGME in this process? While medical schools are accredited by the LCME or the AOA, a majority of residency and fellowship programs in the United States are accredited by the ACGME. The ACGME also provides accreditation for sponsoring institutions or the organizations that sponsor ACGME accredited residency and fellowship programs. There are some subspecialties that have chosen to not be ACGME accredited such as most ophthalmology subspecialties

"The mission of the ACGME is to improve health care and population health by assessing and advancing the quality of resident physicians' education through accreditation." This is accomplished by a systematic and thoughtful process of peer review.

Published standards, known as the Institutional Requirements and Program Requirements, are determined by experts for each specialty and subspecialty with input from the public. The accreditation process involves review of each accredited sponsoring institution and each residency or fellowship program by a review committee composed of peers in the specialty. The primary role of these specialty Review Committees is to assess how programs meet the published standards. In the past, the AOA accredited osteopathic institutions, residencies and fellowships, but with the Single GME Accreditation System, the ACGME now provides accreditation for all osteopathic institutions and programs since June 30, 2020. To learn more about the single accreditation system, click here.

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BOARD CERTIFICATION

At the end of residency or fellowship, most fully trained physicians apply for specialty or subspecialty board certification. While board certification is voluntary and not required to practice medicine, it as an important peer review quality indicator for the individual physician. In addition, board certification is often a requirement for hospital privileges or insurance credentialing.

The vast majority of physicians in the United States are board-certified by a member board of the American Board of Medical Specialties (ABMS) or the American Osteopathic Association. The requirements for board certification include successful completion of an ACGME-accredited residency and for subspecialties, successful completion of an ACGME accredited fellowship. Some specialties require documentation for a minimum number of cases performed. There are a number of physicians certified by non-ABMS or non-AOA certifying boards which may or may not require specified ACGME training.

Originally, board certification was conferred once and considered valid for a physician's entire career. In recent years, allopathic certifying boards have a program of ongoing Maintenance of Certification (MOC), and osteopathic certifying boards adopting Osteopathic Continuing Certification (OCC). These ongoing recertification processes include activities designed to demonstrate that a physician is engaged in lifelong learning and remains up to date and involved in continuous quality improvement efforts. MOC and OCC are controversial, as some physicians question the value of the current MOC/OCC programs as too expensive, time-consuming, and not relevant to actual practice. As a result, the ABMS and AOA are currently reassessing and modifying the MOC/OCC processes.

LICENSURE

Unlike certification, all physicians must apply for and have a license to practice medicine. Medical licensure is under the jurisdiction of, and granted by each state or territory. The licensing requirements vary by state but all 70 licensing jurisdictions require at least one or two years of ACGME accredited residency. Some states require completion of the residency. Though each state is independent, the licensing boards are all members of the Federation of State Medical Boards (FSMB) which serves as a non-binding forum for these organizations to discuss topics of mutual interest. Physicians are required to renew their license every one or two years.

Once physicians are in independent practice, the state license typically requires physicians to complete between 20 and 60 continuing medical education (CME) credits every year. The Accreditation Council of Continuing Medical Education (ACCME) and the Council on Osteopathic Continuing Medical Education (COCME)-- —are mostly responsible for accrediting the organizations that provide CME courses.

Physicians may have their license restricted or revoked if the state board believes the physician may be unfit to practice. Some of these reasons include substance abuse or criminal behavior.

Most physicians work in hospitals or group practices which additionally require physicians to demonstrate minimal training and credentials. They may require documentation of successful completion of medical school, residency and fellowship training, as well as a certain number of

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documented cases in a case log, peer recommendations and other credentials. Programs are asked to confirm that their graduates have successfully completed their residency or fellowship each time a physician changes jobs or hospital sites throughout the rest of that physician's career. Physicians renew their hospital privileges every two years, as required by The Joint Commission (TJC), one of several organizations that accredit hospitals, clinics and other patient care sites.

CLOSING

Practicing physicians work to meet board certification, licensure and hospital requirements continuously through life-long learning. Learning may be motivated by continuing requirements, by personal interest, or by the changing needs of their patients and communities. As the practice of medicine advances and evolves, physicians work hard to stay up-to-date on the medical needs of the public. Along with its partner organizations, the ACGME ensures the educational pathway stays relevant, timely, and rigorous as physicians learn to provide effective care for patients.

Thank you for taking the time to view this course, and for your contributions to graduate medical education.

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Exhibit 14:
SJC-AMA-000000324
January 8, 2024 NRMP Submission

THE MATCH
NATIONAL RESIDENT MATCHING PROGRAM®

455 Massachusetts Ave NW, Suite 310, Washington, DC 20001
www.nrmp.org Email: support@nrmp.org
Toll Free: (866) 653-NRMP Phone: (202) 400-2233

January 8, 2024

Dear [redacted], et al

I trust this letter finds you well and looking forward to the New Year. Following our conversations about the upcoming Counsel on Medical Education meeting and subsequent House of Delegates meeting, I have provided you with the information requested. This includes

- the history of the NRMP and the Match
- the value of the Match and how it optimizes experience
- an understanding of the meaning of the antitrust agreement
- rebuttal of the 2006 paper relied on by the Resident and Fellow Section when making the recommendation to study alternatives to the Match to the AMA House of Delegates.

While I recall you indicating that you cannot guarantee you will use any or all of the materials provided, I request that you provide the complete document to the Counsel on Medical Education, the Resident and Fellow Section, and the House of Delegates.

Please let me know if you have further questions or need additional information. I appreciate the opportunity to work with you through this process and look forward to next steps.

Sincerely

[redacted]

Cc.: NRMP Board of Directors

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On the Benefits and Antitrust Implications of the National Resident Matching Program's Match

January 8, 2024

Introduction and Executive Summary

Every year, the National Resident Matching Program (NRMP) facilitates the entry of tens of thousands of medical school graduates into residency and fellowship programs across the United States. This process, known as "the Match," enables residents and programs to express their preferences over which programs they would most like to be matched with in a fair and efficient manner. Before the Match, the labor market for residents was plagued by inefficient unraveling, with unmatched and unfilled positions, as well as the inefficiencies associated with contracts that were being signed years in advance of the beginning of training.

At the 2023 Annual Meeting of the House of Delegates for the American Medical Association (AMA), the Resident and Fellow Section (AMA-RFS) resolved AMA to "study alternatives to the current residency and fellowship Match process which would be less restrictive on free market competition for applicants" (hereafter, the "Resolution").[1] In support of the Resolution, the AMA-RFS relies upon an academic paper, "Matching and Price Competition", by Jeremy Bulow and Jonathan Levin (hereafter, the "Bulow-Levin paper").[2] AMA-RFS asserts that this paper provides evidence of some superior alternative to the Match and, by extension, to allege NRMP, ACGME,[3] AAMC,[4] teaching hospitals, residency and fellowship programs, and others (all necessary components of the process for matching medical school graduates with post-graduate training) have conspired in violation of the antitrust laws to compress wages paid by programs to their residents and fellows.

The NRMP welcomes the opportunity raised by the AMA-RFS's resolution to (a) give background on the history of the Match and its benefits, (b) provide a summary of the current state of the economic research on the competitive and welfare implications of the Match, and (c) clarify AMA-RFS's understanding of applicable antitrust issues and their implications for the Match. Our high-level conclusions are as follows.

First, NRMP's administration of the Match unquestionably benefits residents and fellows. The Match was designed to efficiently match prospective medical residents with available positions at teaching hospitals. Its matching algorithm focuses on ensuring stability for both applicant and program preferences, such that no participant could achieve a more desirable outcome.

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[1] AMA-RFS, *Resolution 302 (A-23) - Antitrust Legislation Regarding the AAMC, ACGME, NRMP, and Other Relevant Associations or Organizations*, AMA, https://www.ama-assn.org/system/files/a23-302.pdf.

[2] Jeremy Bulow & Jonathan Levin, *Matching and Price Competition*, American Economic Review, 96(3): 652-68 (2006).

[3] The Accreditation Council for Graduate Medical Education, https://www.acgme.org/.

[4] The Association of American Medical Colleges, https://www.aamc.org/.

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Abandoning this approach would only serve to harm students, raise costs, and promote disparity in selection outcomes.

Second, the current state of the economic literature does not support the conclusion that the Match has had the effect of lowering and compressing resident salaries. The one economic study that is frequently cited to support the claim that the Match could lead to lower or more compressed resident salaries is the Bulow-Levin paper. However, that paper itself was highly simplified and unrealistic, and much research has been done since that paper was published. The current research suggests that contrary to the conclusions that are often drawn from the Bulow-Levin paper, there is no robust theoretical or empirical basis for the claim that the Match could lead to lower or more compressed resident salaries.

Third, given there is no theoretical or empirical support for the conclusion that the Match has led to lower or more compressed resident salaries, AMA-RFS should cease its unfounded claims of antitrust violations by NRMP and the broader set of stakeholders that participate in the Match. AMA-RFS does not refute the benefits of the Match for both applicants and programs, and those widespread benefits substantially outweigh any nominal reduction in competition that comes from the brief 45-day binding commitment period that ensures applicants and programs honor their mutually preferred selections. Finally, there is no need for AMA-RFS to pursue these antitrust attacks to advocate for increased resident and fellow wages. Congress's recognition of the benefits of algorithmic matching for post-graduate medical training programs is not exclusive to the Match, does not insulate NRMP from competition (whether via a matching algorithm or otherwise), and does not immunize price-fixing by any Match participants.

Effecting real, structural change for residents and fellows requires a collaborative approach. To date, AMA-RFS has sought to distract and divide. NRMP hopes that this submission puts an end to those misdirected efforts and stands ready to work with AMA leadership and related stakeholders in a productive manner.

1. Background on NRMP and the Match

The following section provides a historical reflection and summary of the matching algorithm developed and administered by NRMP.

Post-Graduate Medical Training Before the Match

The internship was formalized in the early 1900s (but began in the 1870s) as a critical component of medical education. By the 1930s, a market had formed, and hospitals raced to sign medical students to training. As internship positions outnumbered the graduating medical school seniors available to fill them, hospitals extended offers to students (via telegram and, more urgently, by telephone) as early as their second year in medical school. Students had only hours to accept or reject these offers. Mullin noted that the competition and absence of structure bred unfairness, inequality, and unwarranted pressure.[5]

In 1927, the *Bulletin of the Association of American Medical Colleges* published a letter from Dr. William Darrach, dean of Columbia University College of Physicians and Surgeons, to Dr. Fred C. Zapffe, executive secretary of the Association of American Medical Colleges (AAMC),

[5] F.J. Mullin, *A Proposal for Supplementing the Cooperative Plan for Appointment of Interns*, Journal of the Association of American Medical Colleges, 25(6): 437-442 (1950).

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announcing a plan for deferred acceptance of interns (i.e., waiting to appoint interns to residency positions until all candidates had been considered) at Presbyterian Hospital in New York City.[6] The letter was published as support for changes to a process described in an editorial note as having "proven to be a most vexatious matter in the past. Courses have been disrupted by the scramble for hospital positions; the [students'] work has suffered and hospitals have not profited." It was Darrach's desire to see other hospitals and schools, "…act in a similar manner." In the 1930s and 1940s, others advocated for changes to the "prevalent disorder" in intern selection and "chaotic situation" in schools and hospitals that led to "an epidemic of worry" among students.[7] In 1945, national organizations like the AAMC voted to support a "Cooperative Plan" that, namely, called for a uniform release date for student appraisals (called the "School Date", which holds today for uniform release of the MSPE (the Medical Student Performance Evaluation) every October 1) and a uniform "acceptance date" before which students should not be offered internships.[8] This was perhaps the most successful proposal to date to generate national adoption of a streamlined process for effecting the transition to internship training.

Establishing the National Intern Matching Program

In 1950, a centralized clearinghouse for internship placement was proposed by the National Interassociation Committee on Internships (NICI), which included the AAMC, the AMA's Council on Medical Education, national hospital associations like the American Hospital Association, the American Protestant Hospital Association and the American Catholic Hospital Association, as well as Federal agencies like Offices of the Surgeon General of the US Air Force and the United States Public Health Service.[9] The NICI had endorsed the earlier Cooperative Plan, and although there was some sentiment that its uniform school and acceptance dates were an improvement on the process of transitioning students into internships, students still found themselves having to accept offers under increasingly compressed deadlines.[10] According to Mullin, a centralized clearinghouse would improve on the Cooperative Plan by allowing students and internship programs to submit rank lists of preferences that would be processed by an algorithm.[11]

A group of Harvard Medical School students, led by W. Hardy Hendren III, were dissatisfied with the design of the proposed model for the clearinghouse and approached the school's leadership in 1951 to oppose the proposed algorithm.[12] Proposed modifications to the

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[6] William Darrach, *Time of Appointment of Interns*, Bulletin of the Association of American Medical Colleges, 2(1): 68 (1927).

[7] Reginald Fitz, *Concerning Interns and Internships*, Journal of the Association of American Medical Colleges, 14(2): 101-112 (1939); Joseph Turner, *Intern Selection: Wanted, An Orderly Plan*, Journal of the Association of American Medical Colleges, 20(1): 26-32 (1945).

[8] Turner, *supra* note 7.

[9] Mullin, *supra* note 5.

[10] Alvin E. Roth, *The Origins, History and Design of the Resident Match*, Journal of the American Medical Association, 289(7):909-912 (2003).

[11] Mullin, *supra* note 5.

[12] Don K. Nakayama & W. Hardy Hendren, *The 1951 Harvard Student Uprising Against the Intern Match*, Surgery 161(6): 1728-1734 (2017).

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Cooperative Plan had students submitting preferred hospitals in rank order while hospitals expressed their choices by ranking applicants within groups ranging from 'most desirable' to 'not acceptable.'[3] Hendron and his fellow student colleagues argued that program "grouping" of students into tiers of preferences penalized students for using their first rank for training to "reach" for positions (see Roth (2003) for discussion). Hendron and colleagues rallied the class presidents at the 79 existing U.S. medical schools to push for an algorithm that was more equitable for students. The Boston Pool algorithm, a "deferred acceptance" model, proved to be more suitable, and the NICI ultimately agreed to the change in time for the 1952 NICI Match.[13] The National Intern Matching Program (NIMP) was incorporated as a 501(c)(3) organization in 1953.

Broadening NIMP into Today's Match

The NIMP operated throughout the 1950s and 1960s focusing on the placement of medical school seniors into internship positions. In 1966, the AMA-commissioned Millis Commission Report offered a sweeping examination of medical education in the United States.[14] Specific to the transition, the report examined the length and quality of graduate medical education and argued for a broader move from stand-alone internships to integrated residency training. In 1968, the NIMP became the National Intern and Resident Matching Program (NIRMP) in recognition of the broadening landscape of graduate medical education. However, because The Match had been built exclusively to place students into internships, the influx of integrated residency training options (not required to be placed in the Match) threatened to erode the benefits of the NIRMP. Student groups including AMSA and the AAMC Organization of Student Representatives (AAMC-OSR) passed resolutions that supported The Match and demanded broader use. In 1972, the NIRMP revised its participation requirement in two ways: 1) the Match expanded to include all PGY-1 positions (internship or integrated programs) and 2) the NIRMP required all institutions participating in the Match to select U.S. senior students in allopathic medical schools only through the Match. By 1975, the NIRMP had become the NRMP, and the internship officially was abandoned.

A timeline that describes how the Match has evolved and benefited medical residents is in the Appendix at the end of this paper.

About the NRMP Matching Algorithm

For a matching market to thrive, a few essential components must exist:

- The market must be *thick* – there must be a high number of options available and include a high number of applicants
- There must be *low congestion* – there must be ample time to consider applications, meet with candidates, and finalize selections

[13] Roth, *supra* note 10; Nakayama & Hendren, *supra* note 12.

[14] Citizens Commission on Graduate Medical Education and American Medical Association, *The Graduate Education of Physicians: The Report of the Citizens Commission on Graduate Medical Education : Commissioned by the American Medical Association*, Council on Medical Education, American Medical Association (1966).

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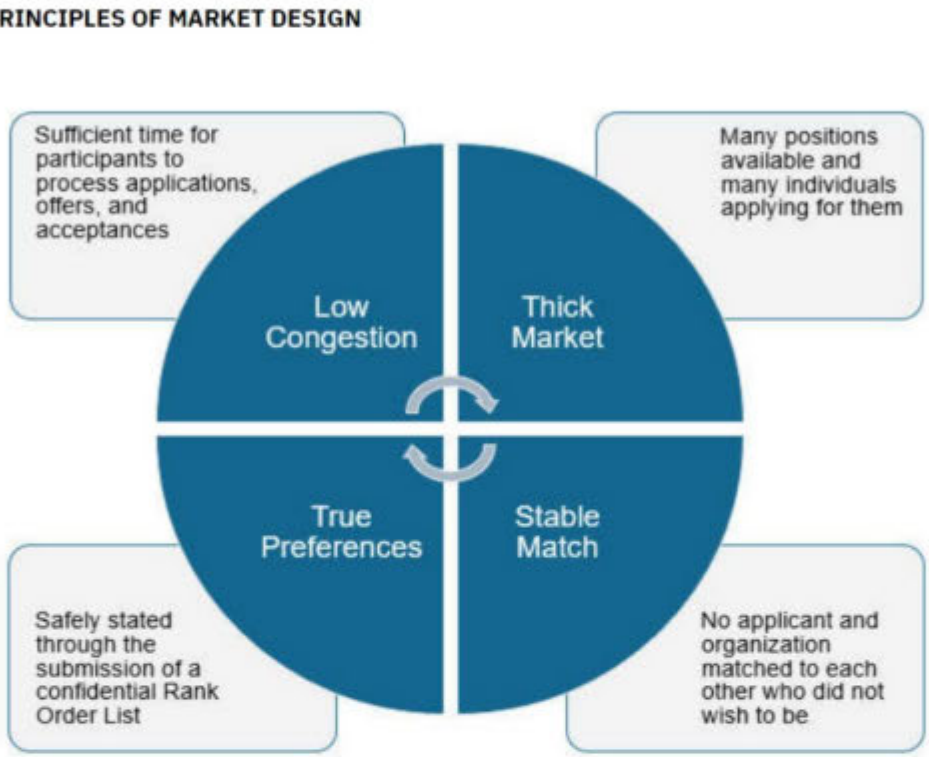
- The matching environment must be *safe* – participants in the market must be able to reveal their true preferences without being harmed by doing so.[15]

The matching algorithm utilized by the NRMP is built on these core components, which lends itself to consistently achieving the most important outcome of the residency matching market: *stability*. When matching markets are stable, no participant could achieve a more desirable outcome outside of the market.



In 1962, David Gale and Lloyd Shapley penned an article explaining how stability in matching markets could be achieved.[16] This seminal piece illuminated the significance of stability in establishing optimum outcomes in selection through "deferred acceptance" whereby an individual tentatively matched to a position could be displaced by an applicant more preferred for that position, but with the algorithm considering all possible arrangements before the outcomes are made final.[17] The NRMP matching algorithm is a deferred-acceptance algorithm.

The concerns initially voiced by Dr. Hendron and colleagues in the 1950s about the proposed algorithm for the inaugural NICI Match lay bare the need for true preference ranking in a matching market in order to achieve optimum (and thus stable) outcomes for all parties. The

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[15] Itai Ashlagi, Ephy Love, Jason I. Reminick, Alvin E. Roth, *Early vs Single Match in the Transition to Residency: Analysis Using NRMP Data from 2014-2021*, J Grad Med Educ., 15(2):219-227 (2023).

[16] David Gale & Lloyd Shapley, *College Admissions and the Stability of Marriage*, The American Mathematical Monthly, 69;9-15 (1962).

[17] *Id.*; Alvin E. Roth, *Deferred Acceptance Algorithms: History, Theory, Practice, and Open Questions*, International Journal of Game Theory, 36;537-569 (2008).

NRMP has always encouraged applicants and programs to submit true preference ranking for the matching algorithm and has implemented robust policies to encourage true preferencing by protecting against coercion and pressure. Ashlagi et al. define the existence and dangers of mutually-dissatisfied pairs, or "blocking pairs" when matching markets are unstable.[18] In such instances, individuals matched with each other, but who prefer others matched to different individuals, will look at the match outcome unfavorably. Gamesmanship and other risky behavior could ensue: potential changes in applicant and program ranking behaviors, unexpected or unintended strategies implemented during the Supplemental Offer and Acceptance Program (SOAP). When participants engage in risky, strategic behaviors, the Match could destabilize and unravel.[19]

To further emphasize the NRMP's commitment to a stable matching market for students, its matching algorithm is "applicant proposing". In 1995, the NRMP Board of Directors commissioned a study to determine whether the existing matching algorithm favored hospital preferences over student preferences.[20] Although the investigation found that the new algorithm would have changed Match outcomes for only 1 of 1,000 applicants participating in prior Matches, the NRMP adopted the new algorithm at its May 1997 Board Meeting and has used it since the 1998 Match.

Summary

Throughout the NRMP's history, and for all its growth, the organization has remained true to its roots. As Stalnaker and Smith[21] wrote in 1954:

> Thus, in full freedom of choice, the plan works as a clearing house, not interfering with, but giving effect to the choices of both hospital and student. It has removed, insofar as possible, the great pressures that caused recriminations once common to the internship placement scene. The broken contracts, the pressuring and signing up of students long before the senior year for internship commitments and other undesirable aspects have now largely disappeared… The matching program does *not* allocate, distribute, or otherwise control interns or internships. It does *not* set quota or approve hospitals for internship training. It does *not*, by its nature, favor any group of hospitals or in any way advise students where to intern.

Those founding principles remain true today. The NRMP is not an application service, a recruitment company, or an accrediting body for graduate medical education. It is not a physician employer nor is it a financial planner for institutions. Through its matching programs, the NRMP strives for parity of experience and promotes reasonable participation timelines, protects participants' rights to maintain confidentiality and generate true preference ranking, and reduces coercive practices by programs. As important, the NRMP matching market and

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[18] Ashlagi, Love, Reminick & Roth, *supra* note 15.

[19] *Id.*

[20] Alvin E. Roth & Elliot Peranson, *The Redesign of the Matching Market for American Physicians: Some Engineering Aspects of Economic Design*, The American Economic Review, 89(4): 748-780 (1999).

[21] John M. Stalnaker & Edward C. Smith, *The Third Year Of Operation Of The National Intern Matching Program*, Journal of Medical Education, 29(8):32-39 (1954).

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algorithm fosters equity in selection. Various participant groups could be harmed by a market that did not incorporate the principles of market design utilized by the NRMP, and the resident physician market could experience greater disparity in selection outcomes.

2. Current Economic Research Does Not Support the Conclusions that the Match Could or Has Led to Lower or More Compressed Resident Salaries

In this section, we first explain the simplified theoretical model and hypotheses of the Bulow-Levin paper and highlight why it is an inadequate guide for assessing the competitive effects of the Match, which the paper itself recognizes (*see* Section 2.1). We then turn to subsequent theoretical research that corrects for some of the unrealistic assumptions of the Bulow-Levin paper, which shows that the purported wage compression found by Bulow and Levin disappears under settings that more closely approximate the real world (*see* Section 2.2). Further, empirical analyses of the effect of wage-setting in the Match and its effect on medical wages disproves the Bulow-Levin paper – there is no empirical evidence to suggest that the Match has lowered resident wages (*see* Section 2.3). We then discuss the literature addressing the fact that the Bulow-Levin model sets aside and does not account for the substantial welfare benefits of the Match and simply assumes that a perfectly competitive market would spring into existence without the Match (*see* Section 2.4). Finally, to the extent that AMA-RFS believes resident salaries should be higher, there are strong economic reasons separate and apart from the Match (mainly the funding structure for graduate medical education) that explains existing compensation levels (*see* Section 2.5). Overall, there is little merit in the belief that the Match harms residents – to the contrary it provides many benefits (*see* Section 2.6 for a summary).

2.1 Overview of the Bulow-Levin Model and Results

The Bulow-Levin paper is a simplified theoretical model of the Match. It shows that compared with the contrived scenario of perfect competition, in which hospitals and doctors take the wages as given, the Match may generate a more compressed (i.e., less spread out) distribution of wages and that average wages may be lower under the Match as compared to this contrived scenario.

Before setting out the assumptions that this paper is based on, it should be noted that nowhere in the Bulow-Levin paper is it suggested that the Match allows hospitals to collude (directly or indirectly) on setting wages or that collusion of any kind is responsible for the compression observed in the Bulow-Levin model. Nor does the Bulow-Levin model address or account for imperfect information and other market conditions that could affect resident salaries. Instead, the model that Bulow and Levin develop focuses on one specific feature of the Match, which is that hospitals compete with each other in attracting the most desirable doctors with wages set based on how residents are matched to the program they are selected into. To be sure, this is a stylized and simplified model, which Bulow and Levin recognize, as they themselves explicitly write that they "do not intend to cast negative aspersions on the NRMP.[22]" Indeed, they also state that "the [M]atch was designed for efficiency purposes" and conclude that their own "model suggests that efficiency should be high, even relative to an idealized competitive

[22] Bulow & Levin, *supra* note 2, at 654.

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equilibrium."[23] In addition, their simplified approach limits the conclusions that can be drawn from their model. As Bulow and Levin state explicitly, "we have chosen our assumptions for analytical simplicity and transparency, not as the most realistic possible model of the residency match."[24]

The Bulow-Levin paper relies on a set of limiting assumptions that are not capable of capturing the full reality of the Match. We discuss each of these assumptions in turn.

- **Assumption 1: A competitive equilibrium is assumed to be feasible:** Bulow-Levin compare the outcome of their model of the Match with that of a *perfectly* competitive market, in which doctors and hospitals take wages as given. Supposing that a perfectly competitive market exists is a strong and unrealistic assumption.[25] The reason that the Match was initially introduced was precisely that a competitive market did not develop – the market instead unraveled with contracts being signed earlier and earlier and doctors given "exploding offers" or forced to respond to offers under time pressure. Instead of simply assuming a perfectly competitive market to exist, a more appropriate comparison would be to a set of other rules that could in practice be used in the absence of a centralized matching process. The absence of rules or abolishing the Match does not imply that a competitive market could be created from whole cloth. In practice, there are many market failures that (a) prevent a perfectly competitive market from arising and (b) must be addressed by market design mechanism (such as the Match): search costs, limited awareness of hospitals and doctors, and time and information constraints (e.g., understanding one's preferences over doctors and hospitals).

  Bulow-Levin seek to justify their use of competitive wages by noting that these would arise if hospitals were participating in a particular type of auction. In doing so, they ignore that the auction that they have in mind *would also involve a centralized matching system*. So rather than comparing a centralized system like the Match with a supposedly anarchic "free and competitive market," they actually are comparing it to a different, simplified, and likely impossible centralized system.

  The model therefore posits an unrealistic and idealized competitive market benchmark, that few or no markets could be expected to achieve in the real world. The history of the market for medical residents before the Match instead suggests that nothing resembling a competitive market would arise in its absence. Thus, in seeking to rely on the Bulow-Levin article, AMA-RFS thus mistakes a *theoretical, unattainable* ideal for a real-world alternative to the Match.

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[23] *Id.*

[24] *Id.*

[25] Economists widely understand that "perfect competition" is not a real-world concept. *See, e.g.*, Dennis W. Carlton & Jeffrey M. Perloff, *Modern Industrial Organization* 57 (4th ed. 2005) ("[P]erfect competition is rarely, if ever, encountered in the real world."); Robert S. Pindyck & Daniel L. Rubinfeld, *Microeconomics* 269 (9th ed. 2017) ("Apart from agriculture, few real-world markets are perfectly competitive."); Willian J. Baumol, *Contestable Markets: An Uprising in the Theory of Industry Structure*, American Economic Review, 72(1):1-15 at 2 (1982) ("[P]erfectly contestable markets do not populate the world of reality any more than perfectly competitive markets do.").

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- **Assumption 2: Residents only care about wages:** Bulow-Levin assume that residents care exclusively about the wage offered by a hospital. The higher the wage offered by a hospital, the more preferred it is by a resident. Hospitals in the model of Bulow-Levin do not differ in other terms, such as location, reputation of the training, cohort size, or hours worked. Therefore, this model cannot capture the main purpose of the Match, namely allowing residents (and hospitals) to express their preferences over possible matchings and to have those preferences be respected in some way. The wages a hospital can profitably pay depend in a complementary way on the hospital's own productivity and that of the resident matched to it.

  Bulow-Levin themselves highlight that their restrictive assumption on resident preferences is material to their results. They acknowledge that an alternative model in which residents can have some idiosyncratic preferences for hospitals would "add[] an additional layer of realism, but also a substantial complication because once firms are differentiated, they have some market power, making it nontrivial even to define an appropriate competitive benchmark."[26]

  The Bulow-Levin model therefore oversimplifies the preferences of residents by assuming that the only thing that matters are wages, when in fact the purpose of the Match is to ensure that different preferences for location and other program-specific factors can be considered.

- **Assumption 3: Hospitals each hire only one resident:** Bulow-Levin assume for simplicity that each hospital may only hire one resident (and, somewhat more realistically, that each resident can only work at one hospital). In reality, hospitals hire multiple residents, which may lead to an intensification of wage competition among hospitals for residents. Moreover, as will be shown below, extending the Bulow-Levin model to account for the hiring of multiple residents can significantly change the results of the Bulow-Levin paper.

  Thus, by assuming that hospitals can only hire a single resident when in reality they hire multiple residents, the model assumes away a factor that is likely to generate greater wage competition and, therefore, a competitive dynamic that would put a downward pressure on resident salaries.[27]

- **Assumption 4: Hospitals only care about resident quality and all hospitals perceive the same resident quality:** Bulow-Levin also assume that all residents can be ranked along a single dimension – their productivity, and that all hospitals perceive a given resident's productivity equally. This again oversimplifies that hospitals may have very diverse views on various candidates and, given that they hire more than one resident, may also prefer a diverse group of students.

  Thus, by assuming that the matching of residents to programs is based solely on a resident's level of productivity (which Bulow and Levin also assume is a dimension that is not only measurable, but also puts residents into a rank order that all hospitals would agree on), the model is, again, too stylized and simplistic. Indeed, the reason why there is a Match in the

[26] Bulow & Levin, *supra* note 2, at 665.

[27] The Bulow-Levin model makes other assumptions that could put a downward pressure on residents' salaries. For example, the model assumes that demand perfectly equals supply. But the reality is that there are more applicants for residency positions than there are residency positions. This surplus of applicants would tend to put a downward pressure on resident salaries – especially in an alternative (non-Match) scenario where programs are not required to disclose salaries to applicants during the interview phase.

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first place is that residency programs are differentiated in important ways and that physicians have different locational and other preferences that both residency programs and residency applicants view as being factors that should factor into the ultimate allocation of applicants to residency positions. Similarly, the Match affords programs the structured opportunity to interview a diverse pool of applicants and to reap the many benefits afforded by a diverse resident class.

- **Assumption 5: Everyone's preferences and productivity are common knowledge:** Not only are the preferences of residents and hospitals severely restricted in Bulow-Levin, but in addition everyone's preferences are also common knowledge for all others. Hence, every hospital knows (a) which applicants are the highest productivity residents and (b) which hospitals have the highest productivity. This means that, right from the start, the typical role of markets, such as the Match, in uncovering information that is dispersed among market participants is moot: there is already full and complete information held by everyone. In such situations, neither a Match nor a competitive market would be needed to achieve good outcomes – every resident would already know which hospital to attend, given their respective productivities and no market mechanism would be needed at all. This clearly omits a key benefit of the Match, which is to reveal information on which residents like which hospitals and vice versa and incorporate those preferences into match outcomes.

  Thus, by assuming that all preferences of residents and their productivity are commonly known to all market participants, the Bulow-Levin model assumes away the need to even have a Match. Indeed, an important function (and welfare-enhancing benefit of the Match) is to allow residency programs and residency applicants to reveal their preferences.

- **Assumption 6: Hospitals must offer the same wage to all residents:** In the Bulow-Levin model, all hospitals must decide what wage to set before they know which resident they hire. This is not an incidental feature of their model, but a key component. As Bulow and Levin themselves write, the "firms' [hospitals'] inability to target their offers leads to greater profits."[28] And that it is "this nondiscrimination feature that we regard as the focus of our study."[29] This requirement, however, does not exist in the real world. There is no Match policy that compels nondiscrimination in resident salaries, just as there is no Match policy that sets salaries paid by participating programs. Hospitals can and do negotiate their salaries in advance with applicants who interview for their program(s), and residents remain free to renegotiate salaries once a match has been made.

  Thus, by assuming nondiscrimination, the model misses an important real world aspect of compensation determination. In reality, hospitals don't have to make the same compensation offer to all residents. Indeed, they can and do make bilateral deals with individual residents, which can lead to higher compensation offers if a match occurs. This dynamic, however, is not in the Bulow-Levin model.

In summary, the Bulow-Levin paper may be a valid theoretical contribution to the analysis of a matching process for employers and employees, but it is a poor foundation for the claim that the actual Match in any way harms residents in the real world.

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[28] Bulow & Levin, *supra* note 2, at 665.

[29] Bulow & Levin, *supra* note 2, at 654.

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2.2 The Results of the Theoretical Research Since the Bulow-Levin Article

The Bulow-Levin article develops a theoretical model that, like any theoretical model, necessarily abstracts from reality to focus on particular issues or mechanisms of interest. What matters, then, is whether the results of the model are robust to changes in model assumptions and specification. In this section we explain that if some of the underlying assumptions in the model are changed to be more realistic, then the results of the Bulow-Levin article no longer hold.

Since the Bulow-Levin article was published, there have been extensions to the model that relax a number of the assumptions listed above. We will highlight three such papers. One paper extends the Bulow-Levin model by allowing hospitals to hire more than one doctor. A second paper extends the Bulow-Levin model by allowing hospitals to use so-called "reversions"[30] of positions to conditionally offer alternative positions if their initial positions cannot be filled. A third paper compares the results of the Bulow-Levin model to an alternative where hospitals bargain bilaterally with doctors over wages without the Match.

These changes to the Bulow-Levin model increase the realism of the assumptions, moving closer to a representation of the real world Match. The simple changes in the first two papers are sufficient to overturn the result of Bulow-Levin, meaning that the outcome of the Match may be closer to those that could be obtained in an idealized competitive market.

A model that allows hospitals to hire more than one resident[31]

Economist Fuhito Kojima extended the Bulow-Levin article by developing a model so that there is no longer the assumption that one hospital can hire exactly one resident (i.e., Assumption 3 in Section 1 above). In a model where a hospital can hire more than one resident, it is no longer the case that wages under the Match are lower on average than in an idealized competitive market. In fact, there may be situations in which the average worker wage is higher with the Match than it would be in a competitive equilibrium. Thus, when residency programs can hire more than one physician, the model gets closer to the perfectly competitive outcome (where there is perfect and common information by all parties) that Bulow and Levin have in mind.

The intuition behind this conclusion is as follows. A hospital with multiple positions that competes for a high productivity resident will have an incentive to set a high wage under the Match to attract this resident. Because of the maintained assumption of nondiscrimination, this will also lead to that same hospital setting a higher wage for lower productivity residents that it hires. In the original Bulow-Levin setting such spillover benefits from a hospital pursuing high productivity workers could not arise because of the assumption of a hospital hiring only a single resident. The same mechanism (nondiscriminatory wage offers) at the heart of Bulow-Levin may thus overturn their results, in a slightly changed situation.[32]

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[30] The Match allows hospitals that are unable to fill a position in one program to revert that position to another program. For additional details, see below.

[31] Fuhito Kojima, *Matching and Price Competition: Comment*, American Economic Review, 97(3): 1027-1031 (2007).

[32] The Kojima model may suggest that, to the extent certain programs unilaterally elect to pay a nondiscriminatory salary to all residents, that lower ranked (i.e., less productive) residents

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A model that allows hospitals to make flexible wage offers using reversions[33]

Another way in which the Match deviates from the stylized theoretical description in Bulow-Levin is the possibility of "reversions." Institutions have the option to revert unfilled positions in one program to another during the matching process.[34] Economist Muriel Niederle has amended the basic Bulow-Levin framework to take reversions (what she calls ordered contracts) into account (which effectively relaxes Assumption 6 in Section 1 above). Her findings are as follows.

First, she finds that hospitals in the Bulow-Levin framework have an incentive to use reversions. Second, if all hospitals use reversions, then her model may produce an idealized competitive outcome (that is, the benchmark outcome that Bulow-Levin used). She puts her conclusion this way: "a match with ordered contracts, which provides a description of the actual possibilities offered by the NRMP algorithm, allows for competitive outcomes, and does not necessarily result in lower wages."[35]

The intuition behind these results is that hospitals can use reversions to offer "star programs" for particularly good doctors (and, thus, do not accept lower productivity doctors, which creates additional competitive pressure thus lowering wages to the competitive level. Hence, a change in the Bulow-Levin model that makes it more realistic to the actual Match implies that the key result of the Bulow-Levin paper (resident wage compression) disappears.[36]

A model that compares the Match to a more realistic alternative outcome[37]

Economists Hideo Konishi and Margarita Sapozhnikov evaluate the outcome of the Match by modeling what would happen if hospitals were to compete for residents on the basis of compensation. Specifically, they considered the scenario where hospitals make take-it-or-

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could receive lower compensation under an alternative non-Match scenario than they currently would expect to earn now.

[33] Muriel Niederle, *Competitive Wages in a Match with Ordered Contracts*, American Economic Review, 97(5): 1957-1969 (2007).

[34] The NRMP offers institutions the option to revert, or donate, unfilled positions in one program to another during the matching process. If a donor program does not fill its quota, a designated number (equal to or less than the quota) of its unfilled positions can be added automatically to the quota of a receiver program. The reversion process is available for all Matches and offers a degree of protection against the possibility that positions at an institution will be unfilled. See also the NRMP's guide to reversions, available at https://www.nrmp.org/wp-content/uploads/2021/08/Reversions-IOIAPD.pdf.

[35] Niederle, *supra* note 33, at 1961.

[36] Niederle notes that during the 1990s only 7% of programs used reversions. *See* Niederle, *supra* note 33, at 1961. This does not reduce the reliability of her results, since in her model the use of reversions is not a certainty and because she keeps all the other unrealistic assumptions of Bulow-Levin, including the exclusive preference of residents for wages. When residents care about program characteristics other than wages, the incentives of hospitals to use reversions to compete more aggressively on wages may be dampened. This may explain the relatively low use of reversions.

[37] Hideo Konishi & Margarita Sapozhnikov, *Decentralized Matching Markets with Endogenous Salaries*, Games and Economic Behavior, 64(1): 193-218 (2008).

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leave-it salary offers to doctors (which replaces assumption 1 in Section 1 above). Thus, instead of a world where residents and hospitals take residents' wages as given (i.e., a competitive market), Konishi-Sapozhnikov consider a more realistic decentralized labor market in which residency programs make salary offers to the residents. With this change, they find that the "competitive salary vector is the best-case scenario for applicants in the decentralized market. [… T]he reference salary vector adopted by Bulow and Levin (2006) for the decentralized market outcome might not have a strong justification, and could be regarded as rather optimistic." [38]

The intuition is that hospitals could offer low wages to residents in the hope that the resident receiving the wage offer did not receive other offers. In this bilateral bargaining setting, it may well happen that some doctors receive multiple offers, while others receive none, resulting in an inefficient allocation. Hence, in the absence of the Match, inefficient bilateral bargaining may ensue rather than the idealized conditions of perfectly competitive markets. This work shows that the conclusions of the Bulow-Levin model no longer hold when compared to a more realistic counterfactual.

In summary, subsequent theoretical research shows Bulow-Levin's conclusion that the Match reduces wages is very fragile. It disappears as soon as one allows for hospitals to hire more than one resident or as programs can use reversions to compete more aggressively for residents. In addition, subsequent research has also shown that alternatives to the perfectly competitive counterfactual adopted by Bulow-Levin is too optimistic about outcomes in the absence of the Match. An alternative with bilateral bargaining would likely yield lower average wages than a competitive market.

2.3 Empirical Evidence on the Effect of the Match on Residents' Salaries

While subsequent theoretical research has changed many of the conclusions of the Bulow-Levin paper, there has also been empirical research on the effect of the Match on salaries and salaries of medical residents in general. What these studies show is that (a) the Match has not reduced residents' wages, (b) in medical specialties where a centralized matching process is not used hospitals did not offer higher salaries and (c) once one considers locational preferences and the value of training, resident salaries are decidedly not below the competitive level. This empirical evidence directly contradicts the theoretical findings of Bulow-Levin, and supports the subsequent theoretical research that generally concludes that the Match is unlikely to lead to a reduction in resident salaries. The combination of both theoretical and empirical evidence is why the Bulow-Levin model cannot be relied upon as the conceptual basis for the claim that the Match is the reason why resident salaries may be viewed as being "too low." Thus, any reliance on the Bulow-Levin model by AMA-RFS would suffer from two serious flaws—relying on a model whose results are (a) not robust when the assumptions are changed to reflect real world market conditions and (b) not supported by the empirical evidence.

There are four empirical studies that are worth noting, and we summarize them below:

[38] Konishi & Sapozhnikov, *supra* note 37, at 195.

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- A 2003 study by Muriel Niederle and Alvin Roth[39] found that wages for fellowships in subspecialties of internal medicine using the "Medical Specialties Matching Program" (MSMP, a centralized matching process)[40] were on average $41,964 while those not using a centralized matching process had average wages of $41,171. In other words, wages with a centralized match were, if anything, higher than without. Likewise, the median, minimum and maximum wage as well as the standard distribution of the wage distribution were all greater when using a centralized matching process. They conclude that "a match is not the feature of these markets that determines wages" and that "eliminating the resident match would not necessarily increase residents' wages."[41]

- A 2004 study by Muriel Niederle and Alvin Roth studied the case of the gastroenterology fellowship market. In this market, a Match was used between 1986 and the late 1990s.[42] This thus offers a possibility of directly observing whether the abandonment of the Match in the late 1990s increased fellowship wages. Niederle and Roth found, however, that there was no evidence that the Match affected wages. In addition, it was found that without the Match the market became more local and less national (i.e., fellows being less likely to be getting a position away from their original institution), the recruitment of fellows started earlier and became more dispersed in time than in internal medicine subspecialties continuing with the Match. They summarize their findings this way: "the demise of the Match has had substantial effects on the timing of the market for GI fellows and on their mobility. However, wages of GI fellows have not diverged substantially from those of fellows in other internal medical subspecialties, including those that continue to use the Match."[43]

- A 2006 study by Muriel Niederle, Deborah Proctor, and Alvin Roth,[44] again focusing on the gastroenterology market, found that without the Match, 94% of program directors offered the same wage to all their fellows (as well as other job aspects, such as the number of hours on call) as they had offered when the Match was being used. All of the program directors also said that they did not adjust salary offers to outside offers and that that terms were not negotiable. If salary offers were not negotiated when the Match was not being used, then this suggests that the Match is not (1) the reason why negotiations do not take place between programs and individual residents and (2) the reason why there is a lack of variation in salaries. The authors conclude that "if the match is not successfully restarted, there is every reason to believe that the troubles presently afflicting the decentralized

[39] Muriel Niederle & Alvin E. Roth, *Relationship between Wages and Presence of a Match in Medical Fellowships*, Journal of the American Medical Association, 290(9): 1153-54 (2003).

[40] As Niederle & Roth state, residencies and fellowships share similarities but also have differences. Both the MSMP and NRMP use the same matching algorithm. Unlike residencies, fellowships are an optional part of doctors' career path.

[41] Niederle & Roth, *supra* note 39, at 1153.

[42] Muriel Niederle & Alvin E Roth, *The Gastroenterology Fellowship Match: How it Failed and Why It Could Succeed Once Again*, Gastroenterology, 127(2): 658-66 (2004). *See also* Muriel Niederle & Alvin E Roth, *Unraveling Reduces Mobility in a Labor Market: Gastroenterology with and without a Centralized Match*, Journal of Political Economy, 111(6): 1342-1352 (2003).

[43] Niederle & Roth (2004), *supra* note 42, at 664.

[44] Muriel Niederle, Deborah D. Proctor & Alvin E. Roth, *What Will Be Needed for the New Gastroenterology Fellowship Match to Succeed?*, Gastroenterology, 130: 218-224 (2006).

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market will get worse. […] The resulting decentralized market, with dispersed and early offers of short duration, reduces mobility of fellows and is widely perceived as unfair to applicants and as discouraging entry into gastroenterology."[45]

- In 2015, Nikhil Agarwal[46] attempted to explain why resident salaries may be lower compared to the "perfect competition salary benchmark" that was alleged by the plaintiffs in the 2002 lawsuit that was brought against NRMP and various other stakeholders in post-graduate medical training. He found that there are other market factors that are causing residents' salaries to be below a perfectly competitive benchmark. Specifically, he found that there were two factors—residents' willingness to pay for desirable programs and capacity constraints that limited residency slots—that caused salaries in a competitive market to be approximately more than $23,000 below the competitive benchmark (i.e., the marginal product of labor for a resident). Agarwal concludes from his work that "the Match is not the likely cause of low salaries."[47]

We also have surveyed the literature, and we are not aware of any empirical evidence that shows that the Match has lowered residents' wages. Instead, the Match appears to have, at most, a neutral effect on wages. The Match does, however, facilitate the mobility of residents, thereby giving them more choices and opportunities to find a training hospital that is a good fit for their needs. To the extent that residents' salaries are low, this can be explained by preferences over locations, the value for training that residents receive, and the excess supply of residents relative to available training slots.

In summary, the empirical findings are not consistent with the outcomes predicted by the Bulow-Levin model, which suggests that the Bulow-Levin model is too stylized, simplified, and unrealistic to be useful as the basis for a claim that the Match is causing residents' wages to be "too low." The empirical findings, however, do strengthen the more recent theoretical research (which we highlighted in the previous Section), which concluded that either (a) the Match, as it exists, could lead to competitive outcomes or (b) an alternative world where there was no Match would be unlikely to result in competitive outcomes.

2.4 Bulow and Levin Recognize that the Match Yields Significant Welfare Benefits

Bulow-Levin themselves note that the Match "was developed for efficiency reasons, and on that score it appears to do quite well."[48] Those efficiency reasons for the introduction of the Match in the 1950s in its basic form have been explained by Nobel prize winner Alvin Roth in a number of well-known papers.[49] Indeed, Professor Roth was awarded the Nobel Prize "for

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[45] *Id.* at 223.

[46] Nikhil Agarwal, *An Empirical Model of the Medical Match*, American Economic Review, 105(7): 1939-1978 (2015).

[47] *Id.* at 1939.

[48] Bulow & Levin, *supra* note 2, at 652.

[49] Alvin E. Roth, *The Evolution of the Labor Market for Medical Interns and Residents: A Case Study in Game Theory*, Journal of Political Economy, 92:991-1016 (1984); *see also* Alvin E. Roth and Xiaoling Xing, *Jumping the Gun: Imperfections and Institutions Related to the Timing of Market Transactions*, American Economic Review, 84(4): 992-1044 (1994).

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the theory of stable allocations and the practice of market design," and his work in developing the Match was explicitly recognized by the Nobel Foundation:

> How to bring different players together in the best possible way is a key economic problem. Lloyd Shapley studied different matching methods theoretically and, beginning in the 1980s, Alvin Roth used Shapley's theoretical results to explain how markets function in practice. Through empirical studies and lab experiments, Roth demonstrated that stability was critical to successful matching methods. Roth has also developed systems for matching doctors with hospitals, school children with schools, and organ donors with patients.[50]

In the absence of the Match, hospitals would (and in fact did) compete for residents not by offering higher wages, but by racing to sign residents with binding contracts earlier and earlier in a student's career. This was seen as costly by both hospitals, who hired residents without knowing their final grades, and medical students, whose senior year was disrupted by seeking desirable positions.[51] Roth describes this phenomenon as an "unraveling" of the market because the market for positions moves further away from the optimal time at which decisions should be made as hospitals set earlier dates for signing residents. One role of a market is to provide "thickness", that is they need to attract a sufficient proportion of potential market participants. If a market unravels, it will lack "thickness" which means that welfare-improving trade may not take place.

The unraveling of the market for residents is well known, and while solutions not involving a centralized matching market have been tried, none have been entirely successful. For example, unraveling could be prevented if there was a way to set and enforce uniform dates before which no resident could be hired. Indeed, such solutions have been tried in various markets, though with limited success as market participants continue to have incentives to sign contracts before the uniformly set date.[52]

The Association of American Medical Colleges (AAMC) also tried to solve the problem of earlier and earlier signing of contracts by not releasing information about medical students before some fixed date. While this effectively prevented contracts being signed early, it created a congestion problem. A student who was offered a position at their third-choice hospitals, but waitlisted by their second-choice hospital would have an incentive to wait as long as possible before confirming the third-choice hospital's offer, in the hope that the second-choice hospital would make a firm offer. Hospitals in turn had incentives to pressure students into accepting their offers, often by setting a short deadline for students to respond to an offer.[53] A student accepting the offer from their third-choice hospital might then later feel regret if they ended up receiving a firm offer from their second-choice hospital.

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[50] The Nobel Prize, *Alvin E. Roth – Facts*, https://www.nobelprize.org/prizes/economic-sciences/2012/roth/facts.

[51] Roth (1984), *supra* note 49, at 993.

[52] Roth and Xing, *supra* note 49, at 1014-1018.

[53] Roth (1984), *supra* note 49, at 994-995.

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The problem of unraveling and market failure is not unique to medical residents. Alvin Roth and Xiaoling Xing provide a list of examples of other markets that suffer from unravelling and congestion:[54]

- Scheduling of postseason college football bowls by the National Collegiate Athletic Association
- Federal court clerkships
- American law firm internships, organized by the National Association for Law Placement
- Entry-level business school markets for new marketing professors
- Japanese university graduates
- Clinical psychology internships
- Optometry residencies
- Fraternity rushes

In these markets—in addition to the market for medical internships and residencies prior to the introduction of the Match—matches need to be made among different groups of agents and competition takes place not by offering lower prices, but by signing binding contracts earlier and earlier. As a result, in the absence of a centralized matching process wages do not correspond to those in a competitive market. Instead, wages appear mostly fixed and so competition becomes focused on other factors, such as the timing at which offers are made. This may be a form of non-price competition, but it was not viewed as being very beneficial for workers (including residents), however, which is why a fully decentralized approach may result in lower welfare than a centralized matching system.

In markets where unraveling is a problem, Roth's conclusion is that a centralized matching system can improve the welfare of all participants in that market. As Roth states, a centralized matching system, such as the Match, can address both the unraveling and the congestion problem, depending on its design: "a clearinghouse [the Match] can persistently attract the participation of a high proportion of the potential participants, and when it does so it solves the problem of establishing a thick market [i.e. solving the unraveling problem]. A computerized clearinghouse like those in use for medical labour markets also solves the congestion problem, since all operations of the clearinghouse can be conducted essentially simultaneously."[55]

In the case of medical residents, the Match uses a variant of a matching algorithm known as Deferred-Acceptance.[56] This algorithm is known to have several desirable properties:[57]

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[54] Roth and Xing, *supra* note 49, at 993 tbl.1.

[55] Alvin E. Roth, *What Have We Learned from Market Design?*, Economic Journal, 118: 285-310, 290-291 (2008).

[56] The current version of the algorithm is explained in Alvin E. Roth & Elliot Peranson, *The Redesign of the Matching Market for American Physicians: Some Engineering Aspects of Economic Design*, The American Economic Review, 89(4): 748-780 (1999).

[57] The properties below hold for any residents hospital matching problem without couples. When there are couples, stable matchings may not exist, *see* Roth (1984), *supra* note 49, at 1008 (Theorem 10). It can be shown, however, that in larger markets with few couples the problems due to the existence of couples tend to be of minor importance, *see* Fuhito Kojima, Parag A. Pathak & Alvin E. Roth, *Matching with Couples: Stability and Incentives in Large Markets*, Quarterly Journal of Economics, 128(4): 1585-1632 (2013).

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- **Stability**: With the Match, the outcome is "stable" in the sense that it is impossible to find an applicant and a hospital, who are not matched, but who would prefer to be matched compared to their allocated hospital/doctor under the Match.[58] This means that participants in the Match do not have an incentive to engage in contracting outside of the Match, which limits unravelling.[59]

- **Efficiency and a Mechanism that Enhances the Welfare of Residents**: With the Match, the outcome is efficient for residents in the sense that, given the wages set by hospitals, there is no other matching (stable or otherwise) that is preferred by all residents .[60]

- **There Is No Incentive to Game the Process**: With the Match, residents have an incentive to correctly state their rank-order list of hospitals in a truthful manner. They cannot benefit by misrepresenting or strategizing over what rank-order list to submit.[61]

These benefits are not explicitly modeled in the Bulow-Levin paper, which means that the Bulow-Levin model does not account for some of the more important and well-recognized benefits of the Match.

In summary, the market for medical residents in the absence of the Match is characterized by unraveling and congestion problems that are detrimental both to hospitals and students. A well-designed centralized matching algorithm, like the Match, can overcome these challenges. In addition, the algorithm used by the Match is stable, efficient (and welfare enhancing) and avoids the potential for participants in the market to game the process. It is thus a good solution to an otherwise difficult problem.

2.5 There Are Many Reasons Why Resident Salaries May be Lower than Expected

The preceding three sections show that the conclusion that many have drawn from the Bulow-Levin model (i.e., that the Match would lead to lower wages compared to a competitive market), is not supported by more recent theoretical research (Section 2.2) or by the many empirical studies that have been done on resident wages (Section 2.3). In addition, a call to abandon or eliminate the Match would ignore the many welfare benefits provided by the Match to residents and hospitals (Section 2.4). Moreover, there is no evidence that the Match is the cause or reason why salaries of medical residents may appear to be "low" or lower than expected. If the findings in the Bulow-Levin paper are the primary evidence that the AMA-

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[58] Alvin E. Roth and Marilda A. Oliveira Sotomayor, *Two-Sided Matching: A Study in Game-Theoretic Modelling and Analysis* Ch. 5 (1990).

[59] Alvin E. Roth, *The Economist as Engineer: Game Theory, Experimentation, and Computation as Tools for Design Economics*, Econometrica, 70(4): 1341-1378, 1350-1352 (2002).

[60] Alvin E. Roth, *The Economics of Matching: Stability and Incentives*, Mathematics of Operations Research, 7(4): 617-628, 626 (Theorem 6) (1982).

[61] While hospitals may have incentives to strategize in general, for sufficiently large markets it can be shown that this incentive is quite small and thus likely of no practical relevance, *see* Fuhito Kojima and Parag A Pathak, *Incentives and Stability in Large Two-Sided Matching Markets*, American Economic Review, 99(3): 608-627 (2009).

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RFS relies on when assessing resident salaries, then the preceding discussion would suggest that there is no reason to believe that the Match is the reason why medical resident salaries are "too low." Why, then, might salaries of medical residents be viewed as "low" or "lower than expected"?

There are at least three more important market and institutional determinants of medical resident salaries. The first factor is that resident salaries are largely funded by Medicare, where the budget is set by Congress. Hence, to increase resident salaries, spending by CMS on resident salaries would have to be increased. To the extent this funding structure and funding levels remain constant, resident salaries resemble a zero-sum game. Thus, any increase in one resident's salary would be offset by a decrease in another resident's salary and/or the elimination of existing resident slots.

A second factor is the productivity of medical residents compared to other healthcare professionals. In his 2015 paper, economist Nikhil Agarwal noted allegations that salaries of starting physicians, nurse practitioners, and physician assistants were $86,000 in 2010, while medical residents earned about $47,000.[62] Agarwal observes, however, that residents who are still in need of training may have a lower productivity level compared to these other professionals as they are still in a training phase of their career.[63] Agarwal provides a range of estimates of the implicit tuition, but finds that the "average estimated implicit tuition is upward of the $40,000 salary difference between medical residents and physician assistants."[64] Agarwal concludes that "limited supply of heterogeneous residency positions, due to barriers to entry such as accreditation requirements, can cause significant salary depression, and weighs against the view that the match is primarily responsible for low resident salaries."[65]

A third factor is the number of available residency positions compared to the number of applicants for those slots. When there are more applicants than positions, the outcome is more likely to be lower salaries, not higher salaries. In 2020, for example, there were 45,000 applicants, but just over 37,000 positions.[66] Here, it is important to recognize that the Match does not control or determine the number of residency positions that are available in any given year.[67] There is no reason to believe that the elimination of the Match would result in an increase in the number of available positions or otherwise alleviate downward pressure on wages induced by a relative excess supply of applicants.

2.6 Summary

AMA-RFS's stated justification for exploring alternatives to the Match relies on the purely theoretical Bulow-Levin paper. This paper presents a stylized, unrealistic model of the Match and compares it to a benchmark of perfect competition, finding that the Match leads to lower wages than in perfect competition. Bulow-Levin themselves state that their paper is not intended to deny the welfare benefits of the Match. The paper itself does not argue that hospitals

[62] Agarwal, *supra* note 46, at 1968-9.

[63] *Id.* at 1974-5.

[64] *Id.* at 1974.

[65] *Id.* at 1976.

[66] NRMP, *Results and Data: 2020 Main Residency Match*, https://www.nrmp.org/wp-content/uploads/2021/12/MM_Results_and-Data_2020-rev.pdf.

[67] Agarwal, *supra* note 46, at 1969 n.31.

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are in any sense colluding over wages or that hospitals no longer have an incentive to offer higher wages to attract better doctors under the Match.

The Bulow-Levin paper makes many simplifying assumptions. It is not even clear that perfect competition could arise in the absence of the Match and the main justification that Bulow-Levin give for why a competitive outcome could arise is that it would resemble the outcome of a particular type of auction – another type of centralized allocation procedure. Additional unrealistic assumptions are (a) that all residents care only about wages, (b) that hospitals all hire only one resident each, (c) that all hospitals only care about residents' productivity which is assumed to be seen the same by all hospitals, (d) that all preferences are common knowledge to all participants and (e) that hospital must offer the same wage to all residents.

Subsequent theoretical research has shown that by relaxing some of these assumptions the central result of Bulow-Levin disappears: the Match may produce competitive wages. First, if hospitals can and do hire more than resident, the resulting wages may correspond to competitive wages. Second, in reality hospitals can use reversions to transfer unfilled positions from one program to another, which can intensify price competition so that the Match may also lead to competitive outcomes. In addition, subsequent research has also challenged the assumption implicit in Bulow-Levin that without the Match there would be perfect competition. In a more realistic model in which hospitals can make wage offers to residents, wages will be lower than in perfect competition – in the absence of the Match.

Subsequent empirical research has generally found that the evidence does not support the predictions of the Bulow-Levin paper. Wages in subspecialties using the Match are not statistically significantly below those in subspecialties not using the Match. Wages in gastroenterology did not rise when the Match was discontinued and did not fall when it was reintroduced. The wages of residents not only reflect their productivity but also the value of locational preferences and training. Taking these into account, it can be shown that observed wages are not below competitive wages.

Without a centralized Match, many entry-level labor markets (including that for medical residencies and internships) experience problems of unraveling (contracts are signed earlier and earlier) or congestion (medical school seniors face time pressure and exploding offers). In the absence of a centralized match, competition is focused on the timing of offers, rather than on lowering prices. Well-designed centralized matching systems, like the Match, can solve the unraveling and congestion problems, while delivering stable outcomes that yield a high level of welfare for residents. These benefits are simply ignored in Bulow-Levin's framework.

Even if one were to accept that resident salaries are too low for reasons outside Bulow-Levin's framework, a lack of funding by Medicare and implicit tuition suggest that in any case residents' salaries would be below those of other medical professionals performing similar tasks. Funding and slot limitations likewise contribute to perceived salary deficits. These constraints are exogenous to the Match, and there is no evidence to suggest that alleviating those constraints would not result in positive wage pressure under the existing Match structure

In summary, the Match has been a remarkably successful program that brings many benefits to hospitals and doctors alike. There is no theoretical or empirical evidence that would suggest that the results of the Bulow-Levin paper could be found to apply for the Match. Instead, the

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Match has inspired many emulators across the world and was itself recognized as one of the instances in which economics-based market design can be used for good.[68]

3. Response to Prior Antitrust Positions Taken by AMA-RFS

Our final section addresses past comments by AMA-RFS in support of the Resolution and prior draft resolutions concerning the Match's status under applicable antitrust laws. We note that the final draft of the Resolution, as adopted by AMA's House of Delegates, resolves only to "study alternatives to the current residency and fellowship Match process," and does not adopt or repeat AMA-RFS's prior unfounded accusations of antitrust violations by Match participants. NRMP addresses the subject only to ensure these past arguments are not left unrebutted and expects that such misstatements will not be repeated in any purported study of alternatives by AMA.[69]

This section focuses on three issues. First, we address AMA-RFS's understanding of the scope and purpose of the antitrust laws, especially in light of the foregoing economic analysis. Second, we clarify important factual inaccuracies regarding Match processes and the unilateral compensation determinations by participating programs. Third, we confirm that congressional recognition of algorithmic matching for post-graduate medical training does not suppress competition for residents.

The Match Does Not Offend the Purpose or Intent of the Antitrust Laws

Prior statements by AMA-RFS regarding the Match's status under the antitrust laws are premised on a fundamental misunderstanding of the Sherman Act, the principal U.S. antitrust statute.[70] In particular, AMA-RFS appears to conflate the 1890 text of the Sherman Act (declaring illegal "[e]very contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce") with the actual scope of the law under today's controlling legal precedents. This is clear error, as the Sherman Act has never been understood to criminalize any and all "restraints" of trade. As one justice of the United States Supreme Court observed, the express language of the Sherman Act "is too broad to be taken at face value" because "every contract restrains trade insofar as it imposes obligations on the parties to deal with each other on certain terms rather than with other parties on other terms."[71] In practice, the effective scope of the Sherman Act has been honed by 134 years of evolving

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[68] Economic Sciences Prize Committee of the Royal Swedish Academy of Sciences, *Stable Allocations and the Practice of Market Design*, Scientific Background on the Sveriges Riksbank Prize in Economic Sciences in Memory of Alfred Nobel 2012 § 4 (2012).

[69] To be sure, NRMP reserves all rights and remedies concerning any disparaging statements regarding NRMP, the Match, and Match participants.

[70] 15 U.S.C. §1 *et al.*

[71] Samuel A. Alito Jr., *Alito: The Origin of the Baseball Antitrust Exemption*, The Baseball Research Journal, https://sabr.org/journal/article/alito-the-origin-of-the-baseball-antitrust-exemption/.

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economic policy and judicial opinions integrating such policies into the law. Activity that is not unlawful under this body of precedent is not unlawful under the Sherman Act.

As a general matter, controlling legal precedents hold that the Sherman Act only prohibits conduct that *unreasonably* restrains competition. Such prohibitions may apply categorically to conduct where economic experience demonstrates the practice to always or almost always unreasonably harm competition; or it may apply on a case-by-case basis where specific economic evidence establishes that the practice's procompetitive effects are outweighed by their anticompetitive harm. In either scenario, the antitrust laws look to observable economic effects when differentiating between lawful and unlawful practices.

Here, the available economic evidence does not suggest that the Match unreasonably restrains competition. As discussed above, AMA-RFS cannot rely on the Bulow-Levin paper to credibly associate the Match with perceived resident wage compression, and even Bulow and Levin themselves acknowledge procompetitive, legitimate benefits of the Match. Moreover, AMA-RFS fails to consider the real inputs on programs' ability and/or willingness to pay higher compensation levels for residents, such as the existing funding mechanisms for resident salaries, the fixed number of resident slots, and the relative excess supply of applicants for the number of available slots in recent years. In sum, the economic evidence provides no support for AMA-RFS's prior accusations of antitrust violations by Match participants.

Match Participants Are Free to Engage in Bilateral Compensation Negotiations

AMA-RFS has justified the Resolution on an incorrect understanding of Match policies and residents' compensation, bargaining power, and ability to renegotiate their compensation during their residency. NRMP has previously reached out to AMA-RFS to correct this misunderstanding and now reiterates the following facts: **NRMP has no process, policy, guidance, or control regarding resident salaries offered to applicants or paid for any subsequent training year.** Participating hospitals and programs are free to compensate residents at varying levels of compensation (e.g., offering top prospects higher compensation during the Match interview phase to improve their chances of top prospects ranking the program higher).

Moreover, NRMP allows residents to make an informed decision on their compensation by requiring programs to provide applicants – before they submit their rank order lists – with a copy of the appointment agreement (including compensation terms) that matched applicants will be expected to sign. Applicants are free to use this information to negotiate with a program for a higher compensation package or to preference their rank ordered list toward programs that offer greater compensation. Thus, the Match does not place any restraints on resident compensation, and the only Match policy that relates to resident compensation actually benefits applicants and enables competition over resident salaries by ensuring applicants know how they will be compensated by their potential employers.

AMA-RFS also confuses the Match's limited "binding commitment" that mutually applies to hospitals and applicants that successfully match. Specifically, AMA-RFS seems to argue that this commitment ensures programs will fill their available slots, such that programs have little incentive to compete for residents based on salary and/or applicants have no ability to negotiate. But this view is incorrect on all fronts. NRMP does not act as a central planner who "allocates" residents to slots for the purpose of maximizing the number of filled positions. Match

participants do not agree to accept any available program or resident. Rather, the Match solely effectuates the affirmative, express preferences of participants' rank ordered lists. If no applicants rank a given program, that program will not receive any residents through the Match. Conversely, no applicant matches to a program at a given hospital system unless that applicant affirmatively chose that program on that applicant's rank order list following the interview and recruitment phase of The Match.

Because Match policies ensure applicants know the terms of a program's offer prior to submitting their rank ordered lists, all match participants have the ability to bargain and compete. For example, applicants are free to not rank programs they believe are offering compensation that is too low. Likewise, programs must assume that non-competitive salary offers will limit their ability to recruit residents. Additionally, the Match's binding commitment exists through the first 45 calendar days of the start date of the relevant appointment contract. Following those initial 45 days, both applicants and programs are free to negotiate and bargain as they see fit, including as to the terms of any existing agreements or potential agreements for subsequent training years. This fact further suggests that any perceived compression in wages, if persistent across training years, is likely to result from causes other than the Match. Properly understood, Match policies promote competition over resident salaries as compared to an alternative scenario where salaries are unknown or if residents could have their offers rescinded prior to the start of their employment contracts.

Congressional Recognition of Matching Algorithms Does Not Reduce Competition

The Sherman Act is a product of the legislative branch, and Congress therefore retains the constitutional power to declare certain acts and practices as sufficiently valuable to society that they are outside the scope of the antitrust laws. In the context of post-graduate medical training, Congress has confirmed "that the antitrust laws do not prohibit sponsoring, conducting, or participating in a graduate medical education residency matching program, or agreeing to do so."[72] This is because Congress recognized that prior to using a matching system, medical school seniors were subject to an "inefficient, chaotic, and unfair" process that pressured them to accept offers from residency programs before "they were in a position to make an informed decision about a medical specialty or a residency program and before residency programs could make an informed assessment of students' qualifications."[73] Congress noted that the lack of an organized process "did not serve the interests of either medical students or residency programs" and that use of a matching algorithm was instituted in response to "widespread complaints."[74] Congress further found that use of a mathematical algorithm allowed students to "obtain a residency position in the most highly ranked program on their list that has ranked them sufficiently high among its preferences," and this process is an "integral part of an educational system that has produced the finest physicians and medical researchers in the world."[75]

However, this is not the only instance where Congress has specifically recognized the benefits of collective action by physicians. For example, the Health Care Quality Improvement Act of

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[72] 15 U.S. Code § 37b.

[73] *Id.*

[74] *Id.*

[75] *Id.*

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1986 ("HCQIA") gives physicians a limited immunity from the antitrust laws for collective disciplinary decisions undertaken in a peer review process where the quality of the subject's professional care is at issue.[76] Like Congress's findings regarding post-graduate medical training, the legislative history associated with HCQIA demonstrates Congress acted from a concern that physicians could not engage in meaningful peer review if they were "sufficiently fearful of the threat of litigation," which ultimately would jeopardize patient safety and erode trust in the medical profession.[77] Accordingly, Congress acted to provide legal certainty for specific collective action that they found socially desirable and economically beneficial.[78] As previously noted, such conduct does not violate the Sherman Act.

Over the last several years, AMA-RFS has never refuted Congress's findings regarding the concerns that motivated the Match or its subsequent benefits from programs and residents. Rather, the AMA-RFS has mischaracterized Congress's approval of matching algorithms as permitting teaching hospitals to suppress resident wages and granting the Match a monopoly. Both of these claims are demonstrably false. First, Congress has not prevented AMA-RFS or anyone else from engaging in petitioning activity to increase resident wages (even though those efforts have been misdirected, as discussed above). To the contrary, the statute expressly addresses this issue and states: "Nothing in this section shall be construed to exempt from the antitrust laws any agreement on the part of 2 or more graduate medical education programs to fix the amount of the stipend or other benefits received by students participating in such programs."[79]

Second, Congress's approval of matching algorithms is not specific to NRMP and applies to any entity that "uses an algorithm and matching rules to match students in accordance with the preferences of students and the preferences of graduate medical education programs."[80] Congress did not preference NRMP or otherwise prohibit the development of a rival matching program. Rather, Congress's recognition of the value of matching algorithms is likely a significant driver behind the growth of other matching programs used by various medical professions in the United States and other countries. In disparaging congressional recognition of matching algorithms, AMA-RFS threatens to undo decades of pro-competitive growth and return medical school seniors to the inefficient, chaotic, and unnecessary processes of the past.

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[76] 42 U.S.C. §§ 11111–11152.

[77] H.R. Rep. No. 903, 99th Cong., 2d Sess. 3 (1986).

[78] Indeed, Congress's recognition of algorithmic matching for post-graduate medical training reflects an express concern that antitrust lawsuits could "divert the scarce resources of our country's teaching hospitals and medical schools from their crucial missions of patient care, physician training, and medical research" and lead to the abandonment of the "highly efficient, pro-competitive" matching process used in graduate medical education." 15 U.S. Code § 37b.

[79] 15 U.S. Code § 37b.

[80] 15 U.S. Code § 37b.

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Conclusion

NRMP appreciates your consideration of this submission and looks forward to engaging with AMA leadership in a productive, cooperative manner. Please let us know if you have any questions or would like to further discuss this matter.

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Appendix

Timeline of NRMP History: Achievements and Expansion of the Match to Benefit Residents

Time period	Event
1950–1951	Centralized clearinghouse proposed for internship appointments; learners push for utilization of an algorithm that better favors learners' ranking preferences
1952	First Match conducted by the National Interassociation Committee on Internships (NICI)
1953	The National Intern Matching Program (NIMP) incorporated as a 501(c)3
1960s	NIMP becomes National Intern and Resident Matching Program (NIRMP) in recognition of broadening PGY-1 specialties training; NIRMP establishes "exclusive commitment" to protect students and require MD seniors to be offered training positions only through a matching plan
1974	NIRMP becomes NRMP (formal abandonment of the independent internship)
1980s	Couples matching introduced; PGY-2 positions added to the Match for full course of training; WebROLIC introduced (first web-based iteration of the R3 system)
1990s	"Applicant proposing" algorithm commissioned by the NRMP Board of Directors in 1995 (first used in the 1998 Match) to ensure most favorable outcomes possible for learners
2012	The Match Week Supplemental Offer and Acceptance Program (SOAP) launched for applicants who remain unmatched when the algorithm is processed
2013	All In Policy for Match-participating residency programs implemented to maximize learner options for placement
2020	First Single Match; DO senior students join U.S. MD senior students as sponsored applicants in the Match

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Exhibit 15:
STANFORD-119HJC-0000037
pages 75-82
Match Day 101: How Does the Medical Residency Match Work

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Match Day 101: How does the medical residency match work?

Nina Bai

March 13, 2024

At exactly 9 a.m. Pacific Time on every third Friday of March, anxious graduating medical students around the country tear open envelopes to reveal where they matched for their residencies.

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These three- to seven-year residency programs, usually based at hospitals, are essentially their first jobs out of medical school and the next stage of their training to become fully fledged and licensed physicians.

Match Day might sound like a combination of the Oscars and one of Harry Potter's Sorting Hat ceremonies, but it's the result of an algorithm to create the ideal pairings between tens of thousands of applicants and residency programs. Here's how it works.

What history tells us

The modern residency match originated in the 1950s to tame an increasingly chaotic system. Hospitals competing to hire the best medical students were offering positions earlier and earlier, sometimes locking in students who were only halfway through medical school.

When rules were made to limit offers to the fourth year, programs began pressuring students to accept or reject offers on shorter and shorter deadlines -- sometimes within 12 hours of an offer being sent by telegram. Hospitals scrambled to hire the top students while students tried to delay their decisions until they had all offers on the table.

Enter 'the algorithm'

In 1952, a centralized matching system -- which would become the National Resident Matching Program -- was introduced. Students submit a ranked list of their preferred programs, and the programs submit a ranked list of their preferred students. A mathematical algorithm then decides on the matches optimized for both parties.

The algorithm is designed to achieve stable matches, so that no student and program who were not matched together would prefer each other over their assigned matches. (Only students and programs that have ranked each other can match.)

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- **Read about Stanford Medicine Match Day 2023 [https://med.stanford.edu/news/all-news/2023/03/match-day.html]**

"It's the most fair and equitable way to give everyone across the country an opportunity to participate and to see everything that's out there," said Nounou Taleghani [https://profiles.stanford.edu/noushafarin-taleghani] , MD, PhD, the academic advising dean for the Stanford School of Medicine and clinical professor of emergency medicine.

Over the years, the algorithm has been tweaked to keep up with the times. Stanford economist Alvin Roth [https://profiles.stanford.edu/alvin-roth] , PhD, helped redesign the current version in 1998, which takes into consideration new factors such as couples hoping to match in the same program or city and specialties that require two residencies. The current algorithm is "applicant-proposing," meaning it starts at the top of the applicant's rank list. Roth shared the 2012 Nobel Prize in economics for his work in market design.

How todays' match works

Medical students apply to residency programs in September of their final year. Over the subsequent few months, they are invited to interview by some of the programs.

The number of programs that students apply to can vary depending on the competitiveness of their specialty. For example, in this year's match [https://www.aamc.org/data-reports/data/eras-statistics-data] , students applying to pediatrics residencies submitted an average of 44 applications and those applying to surgery residencies submitted an average of 70 applications.

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Since the pandemic, residency interviews that used to require travel can now take place online, and students have applied to and interviewed at more programs. Students can rank only programs they've interviewed for and vice versa.

Prior to Match Day, students and programs are banned from communicating their preferences to each other with one possible exception: Students can indicate their inclination to the program they intend to rank first.

Photo by Steve Fisch

"A program can't call a student and say, 'We're planning to put you down as No. 1. Are you going to put us down as No. 1?'" Taleghani said. Such communications are considered a match violation.

By early February, students and programs submit their ranked lists to the National Resident Matching Program, which runs the data through the algorithm -- and then the wait begins.

On the Monday before Match Day, students are notified by email whether, but not where, they have matched. This allows those who have not matched to quickly apply to unfilled positions over the next few days in what's known as the Supplemental Offer and Acceptance Program. The final matches are revealed on Friday at the Match Day ceremony and simultaneously by email.

Match Day by the numbers

42,952: In the 1952 residency match, just 6,000 students applied for 10,400 positions. In 2023, 42,952 students vied for 40,375 positions in nearly 50 specialties.

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81.1%: The overall percentage of applicants -- including international applicants -- who matched last year, though rates vary among specialties, ranging from rates in the 60% range for plastic surgery and orthopaedic surgery, to above 97% for pediatrics, emergency medicine and internal medicine.

98%: The number of Stanford Medicine students who typically match each year. "The overwhelming majority of our students match, and a lot of them get their first choice," Taleghani said.

Photo by Steve Fisch

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Advice to students

The National Resident Matching Program advises [https://www.nrmp.org/residency-applicants/rank-your-programs-main/] students to rank according to their true preferences even if they think they have little chance of matching at their top choices: "The matching algorithm attempts to place you in the most preferred program possible, so be sure to rank programs in order of your true preference and not where you think you will match. Go for your 'reach' program."

In a computational study [https://stanford.edu/~alroth/phase1.html] of the algorithm, Roth concluded, "Both applicants and programs can be safely advised that, at the point in the process when they decide what Rank Order Lists to submit, they are extraordinarily unlikely to be able to influence the outcome of the match in their favor by submitting a list different from their true preferences."

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Conversely, students should not rank any program they are unwilling to commit to because the match is considered a contractual agreement, Taleghani said. "If they match there, they have to go."

Taleghani still remembers vividly her own Match Day nearly 30 years ago. "I remember walking up to the dean and getting the envelope and opening it. It's as if it was yesterday," she said.

"The event is that memorable for everyone because it is the culmination of all that hard work."

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Exhibit 16:
AOA Production – Part 1 – Final
pages 153-282
Results and Data: 2022 Main Residency Match

THE MATCH®
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Results and Data

2022 Main Residency Match®

May 2022

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Requests for permission to use these data, as well as questions about the content of this publication or any National Resident Matching Program data, may be directed to NRMP at datarequest@nrmp.org.

Questions about the NRMP should be directed to Donna L. Lamb, D.HSc., M.B.A., B.S.N., President and CEO at admin@nrmp.org.

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About the NRMP

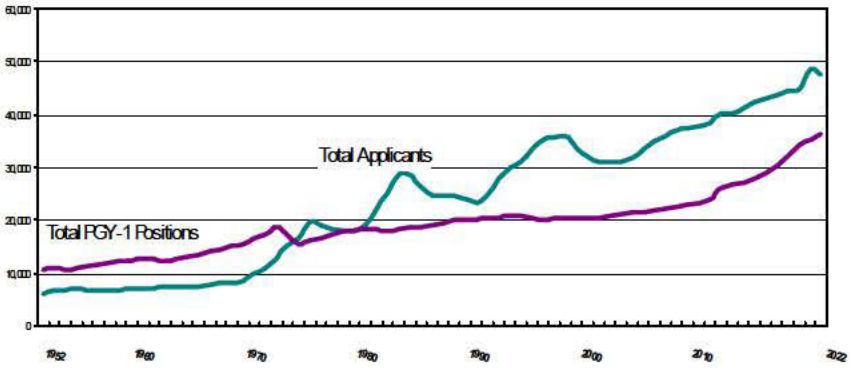
The National Resident Matching Program® (NRMP®) is a private, not-for-profit corporation established in 1952 to optimize the rank-ordered choices of applicants and program directors for clinical training in the United States. The NRMP is not an application processing service; rather, it provides an impartial venue for matching applicants' and programs' preferences for each other using an internationally recognized mathematical algorithm.

The first Main Residency Match® ("the Match") was conducted in 1952 when 10,400 internship positions were available for 6,000 graduating U.S. medical school seniors. By 1973, there were 19,000 positions for just over 10,000 graduating U.S. seniors. Following the demise of internships in 1975, the number of first-year post-graduate (PGY-1) positions declined to 15,700; however, the number of PGY-1 positions gradually increased through 1994 before declining slowly until 1998. Since that time, the number of PGY-1 positions has only increased. This year, an all-time high 36,277 PGY-1 positions were offered (Figure 1), the nineteenth consecutive annual increase. The total number of positions, at 39,205, also was an all-time high.

The trend in the total number of applicants is more dramatic, rising from 6,000 in 1952 to 36,056 in 1999. After a decline of 5,052 applicants from 1999 to 2003, the number had risen each year since the 2004 Match until this year. In 2022, there were 47,675 registrants, representing a decrease of 1,025 from 2021.

For more information about the NRMP, please visit: www.nrmp.org. Additional data and reports for the Main Residency Match and the Specialties Matching Service® (SMS®) are at: http://www.nrmp.org/match-data-analytics/residency-data-reports and http://www.nrmp.org/match-data-analytics/fellowship-data-reports/. Instructions on how to request NRMP data also are provided.

Figure 1 Applicants and 1st Year Positions in the Match, 1952 - 2022



Definitions/Organizations

ACGME — Accreditation Council for Graduate Medical Education.

Active Applicant — An applicant who submits a certified rank order list of programs.

All In Policy — Any program registering for the Match must attempt to fill all positions through the Match or another national matching plan.

Applicant Type — The NRMP classifies applicants for the Main Residency Match into eight types:

- A 4th-year medical student in a U.S. allopathic medical school accredited by the Liaison Committee on Medical Education (LCME) with a graduation date after July 1 in the year before the Match; also referred to as a *U.S. MD senior*.
- A 4th-year medical student in a U.S. osteopathic medical school accredited by the Commission on Osteopathic College Accreditation (COCA) with a graduation date after July 1 in the year before the Match; also referred to as *a U.S. DO senior*.
- *Previous Graduate of U.S. MD Medical School* (U.S. MD Grad): A graduate of a U.S. allopathic school of medicine accredited by the LCME with a graduation date before July 1 in the year before the Match. Previous U.S. graduates are not sponsored by their medical schools.
- *Previous Graduate of U.S. DO Medical School* (U.S. DO Grad): A graduate of a U.S. osteopathic school of medicine accredited by the COCA with a graduation date before July 1 in the year before the Match. Previous U.S. DO graduates are not sponsored by their medical schools.
- *Student/Graduate of Canadian Medical School* (Canadian): A senior student or graduate of a Canadian school of medicine accredited by the Committee on Accreditation of Canadian Medical Schools (CACMS).
- *Graduate of Fifth Pathway Program* (5th Pathway): A graduate of a U.S. Fifth Pathway program.
- *U.S. Citizen Student/Graduate of International Medical School* (U.S. IMG): A U.S. citizen who attended an international medical school.
- *Non-U.S. Citizen Student/Graduate of International Medical School* (Non-U.S. IMG): A non-U.S. citizen who attended an international medical school.

In this report, applicant types are sometimes combined into a smaller number of groups.

- *Foreign-Trained Physicians:* Includes U.S. citizen and non-U.S. citizen students and graduates of international medical schools.
- *Others*: Includes previous graduates of MD and DO medical schools, Canadian and Fifth Pathway applicants.

Couple — Any two applicants who register as a couple in the Match. The NRMP allows couples to form pairs of choices on their primary rank order lists, which are considered in rank order when the matching algorithm is processed. Couples match to the most preferred pair of programs where each partner has been offered a position.

PGY-1 & PGY-2 — Post-graduate year one and post-graduate year two.

Program Type — The NRMP classifies programs for the Main Residency Match into five types:

- *Categorical* (C) programs: Programs that begin in the PGY-1 year and provide the full training required for specialty board certification.
- *Primary* (M) programs: Categorical programs in primary care medicine and primary care pediatrics that begin in the PGY-1 year and provide the full training required for specialty board certification.
- *Preliminary* (P) programs: One-year programs that begin in the PGY-1 year and provide prerequisite training for advanced programs.
- *Advanced* (A) programs: Programs that begin in the PGY-2 year after a year of prerequisite training.
- *Physician* (R) programs: Programs that are reserved for physicians who have had prior graduate medical education. Reserved programs offer PGY-2 positions that begin in the year of the Match and thus are not available to senior medical students.

SOAP — The Supplemental Offer and Acceptance Program® (SOAP®) is a process by which eligible unmatched applicants in the Main Residency Match apply for and are offered positions that did not fill when the matching algorithm was processed.

Introduction

This report summarizes data from the National Resident Matching Program (NRMP) 2022 Main Residency Match, the largest in NRMP history when measured by the number of positions offered (39,205) and filled (36,943). The 36,277 PGY-1 positions offered constituted an all-time high and an increase of 1,083 over 2021; more than half the increase was attributable to growth in Family Medicine and Internal Medicine. The number of active applicants (42,549) was also at an all-time high, with 41 more active applicants compared to 2021. The 2022 Match was the first since 2003 in which the number of registrants decreased compared to the prior year (47,675 in 2022 vs 48,700 in 2021).

Position Fill Rate

A successful Match is measured not just by volume, but also by how well it matches the preferences of applicants and program directors who submitted certified rank order lists. Based on that criterion, the overall position fill rate for the 2022 Match was 94.2 percent. After the matching algorithm was processed, 2,262 of the 39,205 positions were unfilled. There were an additional 96 positions that were unfilled in programs that did not submit a rank order list, bringing the total unfilled to 2,358. Of those, 2,262 were placed in the Match Week Supplemental Offer and Acceptance Program (SOAP). There were 99 SOAP-participating programs with 151 positions unfilled at the conclusion of SOAP. A total of 162 programs and 247 positions remained on the List of Unfilled Programs at the conclusion of SOAP, prior to the List opening for program updates.

Applicant Trends

This year, 42,549 active applicants (those who submitted certified rank order lists of programs) vied for the 36,277 first-year and 2,928 second-year (including physician (R)) residency positions. U.S. MD senior students comprised 19,902 of the active applicants, 36 more than in 2021. The PGY-1 match rate for U.S. MD seniors was 92.9 percent. Historically, the PGY-1 match rate for U.S. MD seniors has been 92-95 percent.

The number of U.S. DO senior students continues to grow. An all-time high of 7,303 U.S. DO seniors submitted rank order lists of programs, 202 more than in 2021, and 6,664 of them matched to PGY-1 positions. The PGY-1 match rate for U.S. DO seniors in 2022 was 91.3 percent, up 2.2 percentage points from last year.

Fewer U.S. citizen and non-U.S. citizen students and graduates of international medical schools (IMGs) registered for the Match than in 2021. Of the 5,048 U.S. IMGs who submitted rank order lists of programs, 3,099 matched to a PGY-1 position for a match rate of 61.4 percent. Of the 7,864 non-U.S. citizen IMGs who submitted rank order lists of programs, 4,571 matched to a PGY-1 position for a match rate of 58.1 percent.

Other features of interest include:

- In 2022, the overall number of registered applicants was 47,675, the second highest in the history of the Match.
- The number of registered non-U.S. citizen IMGs was 10,094, 624 fewer than last year.
- Among all matched U.S. MD seniors, 48.5 percent matched to their first-choice programs (an increase of 2.1 percentage points over 2021); 74.5 percent of U.S. MD seniors matched to one of their top three choices (an increase of 2.2 percentage points over 2021).
- Among all matched U.S. DO seniors, 47.7 percent matched to their first-choice programs (an increase of 5.3 percentage points over 2021); 76.7 percent matched to one of their top three choices (an increase of 4.5 percentage points over 2021).

Couples

The NRMP began offering the couples match in 1984. In the 2022 Match, 2,444 individuals participated as couples, 4 fewer than 2021. The PGY-1 match rate was 93.7 percent.

Other Notable Trends

Match results can serve as indicators of future physician workforce trends. Highlights in 2022 include:

- With a total of 19,902 active U.S. MD senior applicants, the ratio of PGY-1 positions per active U.S. MD senior was 1.82, the highest since 1976. 7,303 active U.S. DO seniors resulted in a ratio of PGY-1 positions per active U.S. DO senior of 4.97. Collectively, 12,912 active IMG applicants (both U.S. IMGs and non-U.S. IMGs) account for nearly a third (30.3 percent) of all active applicants, with a ratio of PGY-1 positions per active IMG applicant of 2.81.

- Primary care specialties offered record-high numbers of positions with high position fill rates, although fill rates decreased this year.
  - In 2022, a total of 6,693 U.S. MD seniors, 3,676 U.S. DO seniors, 2,134 U.S. IMGs and 3,242 non-U.S. IMGs matched to categorical positions in Family Medicine, Internal Medicine, and Pediatrics.
  - Though the number of positions offered for Internal Medicine (Categorical) has fluctuated, 9,380 positions were available in 2022, the highest number on record, and 8,915 were filled (95.0 percent; 0.7 percentage points fewer than 2021). U.S. MD seniors filled 37.2 percent, 1.8 percentage points fewer than last year; U.S. DO seniors filled 17.1 percent, an increase of 0.7 percentage points over last year. U.S. IMGs filled 12.1 percent, 1.2 percentage points fewer than last year. Non-U.S. IMGs filled 26 percent, an increase of 1.5 percentage points over last year.
  - In 2022, Family Medicine offered 4,916 positions, 4,451 of which were filled (90.5 percent; 5.2 percentage points fewer than 2021). U.S. MD seniors (1,541) filled 31.3 percent of the positions; however, a record number of U.S. DO seniors (1,494) matched, accounting for 30.4 percent of the available positions in the specialty. U.S. IMGs (777) filled 15.8 percent of the positions while non-U.S. IMGs (457) filled 9.3 percent.
  - Pediatrics (Categorical) has gained positions every year since 2005 and offered 2,942 positions in 2022. The overall fill rate was 97.2 percent (1.4 percentage points fewer than 2021), with 56.5 percent filled by U.S. MD seniors, 19.7 percent filled by U.S. DO seniors, and 19.5 percent filled by IMGs.

- The number of Emergency Medicine positions has grown every year since the specialty joined the Match in 1983. This year, 2,921 positions were offered of which 2,702 were filled. The position fill rate fell by 7 percentage points, with 54.5 percent of positions filled by U.S. MD seniors, 25.8 percent filled by U.S. DO seniors, and 7.6 percent filled by IMGs.

- In 2022, 12,836 applicants were eligible to participate in SOAP, 1,279 fewer than in 2021, representing a considerable decrease. Of the 2,262 positions placed in SOAP, 2,111 positions filled, 338 more than 2021.

We hope you find the data contained in the following pages useful as you reflect on the 2022 Match and prepare for future Matches.

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Table 1

Table 1 summarizes the 2022 Main Residency Match and shows the numbers of participating programs, offered positions, and unfilled programs. It also provides ranking and matching data for U.S. MD seniors (Table 1A) and U.S. DO seniors (Table 1B).

Using Anesthesiology PGY-1 as an example on Table 1A:

- The first three columns ("No. of Programs," "Positions Offered," and "Unfilled Programs") show that 165 programs offered 1,509 Anesthesiology PGY-1 positions and that 1 of those programs was unfilled after the matching algorithm had been processed.

- The numbers of U.S. MD senior applicants and total applicants are provided in the next two columns under "No. of Applicants." In 2022, 1,489 U.S. MD seniors ranked at least one Anesthesiology program, and 2,691 applicants in total ranked Anesthesiology. Note that the figures do not mean that Anesthesiology was the preferred choice of those applicants.

- The next two columns (under "No. of Matches") show that 1,054 of the 1,509 PGY-1 positions offered in Anesthesiology were filled by U.S. MD seniors, with 1,508 filled by all applicants.

- The fill rates (calculated as positions filled divided by positions offered) can be found in the two columns under "% Filled." Of the 1,509 PGY-1 positions offered in Anesthesiology, 69.8 percent were filled by U.S. MD seniors and 99.9 percent were filled overall.

- The "Ranked Positions" columns show that, collectively, U.S. MD seniors ranked the positions offered by those Anesthesiology programs 15,846 times and the total number of ranks by all applicants was 22,181.

The 2022 Match offered 39,205 positions, 1,099 more than 2021; of those, 36,277 were PGY-1 positions, 1,083 more than last year.

Table 1A Match Summary for MD Seniors, 2022

Specialty	No. of Programs	Positions Offered	Unfilled Programs	No. of Applicants*		No. of Matches*		% Filled		Ranked Positions	
				MD Seniors	Total	MD Seniors	Total	MD Seniors	Total	MD Seniors	Total
PGY-1 Positions											
Anesthesiology	165	1,509	1	1,489	2,691	1,054	1,508	69.8	99.9	15,846	22,181
Child Neurology	75	166	14	118	231	102	150	61.4	90.4	1,588	2,198
Dermatology	14	30	1	240	302	24	28	80.0	93.3	342	440
Emergency Medicine	277	2,921	69	1,695	3,081	1,593	2,702	54.5	92.5	24,562	38,174
Emergency Med-Anesthesiology	1	2	0	3	6	1	2	50.0	100.0	3	6
Emergency Med-Family Med	3	7	0	17	38	4	7	57.1	100.0	23	52
Family Medicine	745	4,916	176	1,789	7,425	1,541	4,451	31.3	90.5	22,939	63,480
Family Med-Preventive Med	2	2	0	9	22	0	2	0.0	100.0	9	23
Internal Medicine (Categorical)	641	9,380	91	4,120	13,844	3,491	8,915	37.2	95.0	52,100	113,873
Medicine-Anesthesiology	2	3	0	15	20	2	3	66.7	100.0	15	20
Medicine-Dermatology	5	8	0	34	42	7	8	87.5	100.0	63	76
Medicine-Emergency Med	12	31	0	72	120	22	31	71.0	100.0	347	489
Medicine-Medical Genetics	5	5	2	9	17	3	3	60.0	60.0	18	28
Medicine-Pediatrics	78	392	0	403	587	332	392	84.7	100.0	4,666	5,468
Medicine-Preliminary (PGY-1 Only)	353	1,774	52	3,644	5,804	1,261	1,624	71.1	91.5	56,793	70,290
Medicine-Preventive Med	4	8	0	31	108	5	8	62.5	100.0	33	116
Medicine-Primary	86	429	3	851	2,382	248	424	57.8	98.8	3,168	5,241
Medicine-Psychiatry	12	24	0	63	95	20	24	83.3	100.0	258	317
Interventional Radiology (Integrated)	24	45	0	174	246	37	45	82.2	100.0	703	885
Neurodevelopmental Disabilities	4	5	0	18	27	3	5	60.0	100.0	42	56
Neurological Surgery	115	240	0	275	391	202	240	84.2	100.0	4,361	4,955
Neurology	139	772	7	593	1,463	393	761	50.9	98.6	6,110	10,576
Obstetrics-Gynecology	288	1,503	3	1,358	2,161	1,106	1,499	73.6	99.7	15,778	21,035
OB/GYN-Preliminary (PGY-1 Only)	15	18	6	99	169	4	9	22.2	50.0	141	236
Orthopedic Surgery	210	875	0	1,086	1,470	705	875	80.6	100.0	10,613	12,588
Osteo Neuromusculoskeletal Med	5	16	2	0	23	0	13	0.0	81.3	0	53
Otolaryngology	134	361	0	463	574	316	361	87.5	100.0	5,276	5,855
Pathology	168	631	10	248	994	231	619	36.6	98.1	2,924	8,135
Pediatrics (Categorical)	235	2,942	28	1,871	3,824	1,661	2,861	56.5	97.2	25,389	39,475
Pediatrics-Anesthesiology	5	6	0	16	20	6	6	100.0	100.0	34	46
Pediatrics-Emergency Med	4	9	0	25	34	6	9	66.7	100.0	65	85
Pediatrics-Medical Genetics	23	30	2	23	50	18	28	60.0	93.3	177	261
Pediatrics-P M & R	3	3	0	12	14	3	3	100.0	100.0	26	30
Pediatrics-Preliminary	18	23	2	88	135	16	21	69.6	91.3	499	575
Pediatrics-Primary	14	74	1	289	646	31	73	41.9	98.6	453	876
Peds/Psych/Child Psych	8	21	0	51	62	20	21	95.2	100.0	186	201
Physical Medicine & Rehab	43	180	0	317	701	104	180	57.8	100.0	1,544	2,842
Plastic Surgery (Integrated)	86	194	0	281	351	173	194	89.2	100.0	2,924	3,137
Psychiatry	352	2,047	11	1,437	2,908	1,253	2,030	61.2	99.2	16,232	24,942
Psychiatry-Family Medicine	6	10	0	44	59	10	10	100.0	100.0	109	131
Psychiatry-Neurology	4	4	1	16	25	2	3	50.0	75.0	29	44
Radiation Oncology	5	10	1	82	108	7	9	70.0	90.0	114	161
Radiology-Diagnostic	34	132	0	716	1,156	73	132	55.3	100.0	1,719	2,780
Surgery (Categorical)	342	1,622	3	1,467	3,071	1,059	1,619	65.3	99.8	17,477	25,462
Surgery-Preliminary (PGY-1 Only)	251	1,150	142	1,008	2,077	304	632	26.4	55.0	6,905	10,799
Thoracic Surgery	35	47	0	76	111	41	47	87.2	100.0	804	949
Transitional (PGY-1 Only)	195	1,616	44	2,729	4,472	920	1,404	56.9	86.9	33,476	47,071
Vascular Surgery	68	84	0	100	168	72	84	85.7	100.0	1,895	2,190
Total PGY-1	**5,313**	**36,277**	**672**	**29,564**	**64,325**	**18,486**	**34,075**	**51.0**	**93.9**	**338,778**	**548,903**

Table 1A Match Summary for MD Seniors, 2022 (Continued)

Specialty	No. of Programs	Positions Offered	Unfilled Programs	No. of Applicants*		No. of Matches*		% Filled		Ranked Positions	
				MD Seniors	Total	MD Seniors	Total	MD Seniors	Total	MD Seniors	Total
PGY- 2 Positions											
Anesthesiology	58	346	0	1,094	1,812	232	346	67.1	100.0	5,792	7,881
Child Neurology	4	7	0	32	56	2	7	28.6	100.0	33	61
Dermatology	138	492	2	613	851	408	489	82.9	99.4	4,562	5,439
Interventional Radiology (Integrated)	66	123	0	199	300	99	123	80.5	100.0	1,775	2,150
Neurodevelopmental Disabilities	2	3	0	11	17	3	3	100.0	100.0	21	28
Neurology	42	233	1	465	928	165	232	70.8	99.6	2,218	3,337
Nuclear Medicine	1	1	1	0	0	0	0	0.0	0.0	0	0
Osteo Neuromusculoskeletal Med	1	2	0	0	8	0	2	0.0	100.0	0	8
Physical Medicine & Rehab	69	338	1	325	771	172	336	50.9	99.4	2,854	5,217
Radiation Oncology	83	166	25	111	189	97	134	58.4	80.7	1,807	2,514
Radiology-Diagnostic	172	997	1	1,105	1,850	713	996	71.5	99.9	13,228	17,858
Radiology-Nuclear Med	3	3	0	18	42	2	3	66.7	100.0	24	54
Total PGY- 2	**639**	**2,711**	**31**	**3,973**	**6,824**	**1,893**	**2,671**	**69.8**	**98.5**	**32,314**	**44,547**
Physician (R) Positions**											
Anesthesiology	55	114	4	0	312	0	108	0.0	94.7	0	995
Child Neurology	16	15	7	0	11	0	8	0.0	53.3	0	48
Dermatology	17	22	1	0	68	0	21	0.0	95.5	0	107
Interventional Radiology (Integrated)	1	1	0	0	2	0	1	0.0	100.0	0	2
Neurodevelopmental Disabilities	1	1	0	0	1	0	1	0.0	100.0	0	1
Neurology	8	9	0	0	33	0	9	0.0	100.0	0	48
Osteo Neuromusculoskeletal Med	1	6	1	0	8	0	4	0.0	66.7	0	8
Physical Medicine & Rehab	10	14	1	0	66	0	13	0.0	92.9	0	132
Radiation Oncology	7	9	3	0	17	0	6	0.0	66.7	0	36
Radiology-Diagnostic	19	26	0	0	123	0	26	0.0	100.0	0	248
Total Physician (R)	**135**	**217**	**17**	**0**	**641**	**0**	**197**	**0.0**	**90.8**	**0**	**1,625**
GRAND TOTAL	**6,087**	**39,205**	**720**	**33,537**	**71,790**	**20,379**	**36,943**	**52.0**	**94.2**	**371,092**	**595,075**

* Applicants can rank multiple specialties. In 2022, 2,347 applicants matched to both PGY-1 and PGY-2 positions; of those applicants, 1,819 were U.S. MD seniors.

** Physician (R) positions are PGY-2 positions starting in the year of the Match that are reserved for applicants who have had prior graduate medical education. Physician positions are not available to senior medical students. In previous *Results and Data Books*, the numbers of R positions were small and they were included in the categorical position counts. In 2014, NRMP began listing R positions separately.

Table 1B Match Summary for DO Seniors, 2022

Specialty	No. of Programs	Positions Offered	Unfilled Programs	No. of Applicants* DO Seniors	No. of Applicants* Total	No. of Matches* DO Seniors	No. of Matches* Total	% Filled DO Seniors	% Filled Total	Ranked Positions DO Seniors	Ranked Positions Total
PGY- 1 Positions											
Anesthesiology	165	1,509	1	505	2,691	263	1,508	17.4	99.9	3,575	22,181
Child Neurology	75	166	14	29	231	15	150	9.0	90.4	284	2,198
Dermatology	14	30	1	40	302	3	28	10.0	93.3	55	440
Emergency Medicine	277	2,921	69	850	3,081	753	2,702	25.8	92.5	10,186	38,174
Emergency Med-Anesthesiology	1	2	0	2	6	1	2	50.0	100.0	2	6
Emergency Med-Family Med	3	7	0	13	38	1	7	14.3	100.0	18	52
Family Medicine	745	4,916	176	2,013	7,425	1,494	4,451	30.4	90.5	23,642	63,480
Family Med-Preventive Med	2	2	0	6	22	1	2	50.0	100.0	6	23
Internal Medicine (Categorical)	641	9,380	91	2,030	13,844	1,602	8,915	17.1	95.0	22,603	113,873
Medicine-Anesthesiology	2	3	0	1	20	0	3	0.0	100.0	1	20
Medicine-Dermatology	5	8	0	3	42	1	8	12.5	100.0	4	76
Medicine-Emergency Med	12	31	0	31	120	9	31	29.0	100.0	108	489
Medicine-Medical Genetics	5	5	2	2	17	0	3	0.0	60.0	2	28
Medicine-Pediatrics	78	392	0	69	587	39	392	9.9	100.0	545	5,468
Medicine-Preliminary (PGY-1 Only)	353	1,774	52	891	5,804	151	1,624	8.5	91.5	8,110	70,290
Medicine-Preventive Med	4	8	0	6	108	0	8	0.0	100.0	6	116
Medicine-Primary	86	429	3	231	2,382	33	424	7.7	98.8	365	5,241
Medicine-Psychiatry	12	24	0	11	95	3	24	12.5	100.0	30	317
Interventional Radiology (Integrated)	24	45	0	47	246	3	45	6.7	100.0	127	885
Neurodevelopmental Disabilities	4	5	0	2	27	2	5	40.0	100.0	5	56
Neurological Surgery	115	240	0	24	391	9	240	3.8	100.0	154	4,955
Neurology	139	772	7	187	1,463	132	761	17.1	98.6	1,780	10,576
Obstetrics-Gynecology	288	1,503	3	396	2,161	242	1,499	16.1	99.7	3,523	21,035
OB/GYN-Preliminary (PGY-1 Only)	15	18	6	20	169	1	9	5.6	50.0	30	236
Orthopedic Surgery	210	875	0	205	1,470	111	875	12.7	100.0	1,210	12,588
Osteo Neuromusculoskeletal Med	5	16	2	15	23	10	13	62.5	81.3	34	53
Otolaryngology	134	361	0	41	574	21	361	5.8	100.0	238	5,855
Pathology	168	631	10	89	994	76	619	12.0	98.1	1,118	8,135
Pediatrics (Categorical)	235	2,942	28	682	3,824	580	2,861	19.7	97.2	7,853	39,475
Pediatrics-Anesthesiology	5	6	0	1	20	0	6	0.0	100.0	3	46
Pediatrics-Emergency Med	4	9	0	8	34	3	9	33.3	100.0	18	85
Pediatrics-Medical Genetics	23	30	2	1	50	1	28	3.3	93.3	5	261
Pediatrics-P M & R	3	3	0	2	14	0	3	0.0	100.0	4	30
Pediatrics-Preliminary	18	23	2	16	135	3	21	13.0	91.3	25	575
Pediatrics-Primary	14	74	1	82	646	9	73	12.2	98.6	106	876
Peds/Psych/Child Psych	8	21	0	10	62	1	21	4.8	100.0	14	201
Physical Medicine & Rehab	43	180	0	275	701	55	180	30.6	100.0	1,102	2,842
Plastic Surgery (Integrated)	86	194	0	10	351	0	194	0.0	100.0	25	3,137
Psychiatry	352	2,047	11	494	2,908	387	2,030	18.9	99.2	4,517	24,942
Psychiatry-Family Medicine	6	10	0	9	59	0	10	0.0	100.0	16	131
Psychiatry-Neurology	4	4	1	4	25	1	3	25.0	75.0	9	44
Radiation Oncology	5	10	1	5	108	1	9	10.0	90.0	8	161
Radiology-Diagnostic	34	132	0	240	1,156	41	132	31.1	100.0	690	2,780
Surgery (Categorical)	342	1,622	3	397	3,071	212	1,619	13.1	99.8	3,355	25,462
Surgery-Preliminary (PGY-1 Only)	251	1,150	142	248	2,077	56	632	4.9	55.0	990	10,799
Thoracic Surgery	35	47	0	4	111	1	47	2.1	100.0	13	949
Transitional (PGY-1 Only)	195	1,616	44	983	4,472	338	1,404	20.9	86.9	11,221	47,071
Vascular Surgery	68	84	0	16	168	1	84	1.2	100.0	75	2,190
Total PGY- 1	**5,313**	**36,277**	**672**	**11,246**	**64,325**	**6,666**	**34,075**	**18.4**	**93.9**	**107,810**	**548,903**

Table 1B Match Summary for DO Seniors, 2022 (Continued)

Specialty	No. of Programs	Positions Offered	Unfilled Programs	No. of Applicants* DO Seniors	No. of Applicants* Total	No. of Matches* DO Seniors	No. of Matches* Total	% Filled DO Seniors	% Filled Total	Ranked Positions DO Seniors	Ranked Positions Total
PGY- 2 Positions											
Anesthesiology	58	346	0	305	1,812	53	346	15.3	100.0	971	7,881
Child Neurology	4	7	0	11	56	3	7	42.9	100.0	13	61
Dermatology	138	492	2	85	851	38	489	7.7	99.4	383	5,439
Interventional Radiology (Integrated)	66	123	0	54	300	18	123	14.6	100.0	257	2,150
Neurodevelopmental Disabilities	2	3	0	2	17	0	3	0.0	100.0	3	28
Neurology	42	233	1	123	928	23	232	9.9	99.6	409	3,337
Nuclear Medicine	1	1	1	0	0	0	0	0.0	0.0	0	0
Osteo Neuromusculoskeletal Med	1	2	0	5	8	2	2	100.0	100.0	5	8
Physical Medicine & Rehab	69	338	1	290	771	127	336	37.6	99.4	1,886	5,217
Radiation Oncology	83	166	25	10	189	7	134	4.2	80.7	136	2,514
Radiology-Diagnostic	172	997	1	293	1,850	132	996	13.2	99.9	2,316	17,858
Radiology-Nuclear Med	3	3	0	1	42	1	3	33.3	100.0	1	54
Total PGY- 2	**639**	**2,711**	**31**	**1,179**	**6,824**	**404**	**2,671**	**14.9**	**98.5**	**6,380**	**44,547**
Physician (R) Positions**											
Anesthesiology	55	114	4	0	312	0	108	0.0	94.7	0	995
Child Neurology	16	15	7	0	11	0	8	0.0	53.3	0	48
Dermatology	17	22	1	0	68	0	21	0.0	95.5	0	107
Interventional Radiology (Integrated)	1	1	0	0	2	0	1	0.0	100.0	0	2
Neurodevelopmental Disabilities	1	1	0	0	1	0	1	0.0	100.0	0	1
Neurology	8	9	0	0	33	0	9	0.0	100.0	0	48
Osteo Neuromusculoskeletal Med	1	6	1	0	8	0	4	0.0	66.7	0	8
Physical Medicine & Rehab	10	14	1	0	66	0	13	0.0	92.9	0	132
Radiation Oncology	7	9	3	0	17	0	6	0.0	66.7	0	36
Radiology-Diagnostic	19	26	0	0	123	0	26	0.0	100.0	0	248
Total Physician (R)	**135**	**217**	**17**	**0**	**641**	**0**	**197**	**0.0**	**90.8**	**0**	**1,625**
GRAND TOTAL	**6,087**	**39,205**	**720**	**12,425**	**71,790**	**7,070**	**36,943**	**18.0**	**94.2**	**114,190**	**595,075**

* Applicants can rank multiple specialties. In 2022, 2,347 applicants matched to both PGY-1 and PGY-2 positions; Of those applicants, 369 were U.S. DO seniors.

** Physician (R) positions are PGY-2 positions starting in the year of the Match that are reserved for applicants who have had prior graduate medical education. Physician positions are not available to senior medical students. In previous *Results and Data Books*, the numbers of R positions were small and they were included in the categorical position counts. In 2014, NRMP began listing R positions separately.

Table 2

Table 2 shows the number of matches per specialty by applicant type. There was considerable variation in the numbers between applicant types. The data are described in more detail in Tables 10-12.

For example, the top five specialties to which U.S. MD seniors matched were:

- Internal Medicine (Categorical) (3,739)
- Pediatrics (Categorical) (1,692)
- Emergency Medicine (1,593)
- Family Medicine (1,541)
- Anesthesiology (1,286)

For U.S. MD graduates, the top five specialties were:

- Internal Medicine (Categorical) (164)
- Anesthesiology (159)
- Surgery (Categorical) (156)
- Family Medicine (Categorical) (87)
- Emergency Medicine (75)

For U.S. DO seniors, the top five specialties were:

- Internal Medicine (Categorical) (1,635)
- Family Medicine (1,494)
- Emergency Medicine (753)
- Pediatrics (Categorical) (589)
- Psychiatry (387)

For U.S. DO graduates, the top five specialties were:

- Family Medicine (94)
- Internal Medicine (Categorical) (86)
- Emergency Medicine (59)
- Surgery (Categorical) (30)
- Anesthesiology (40)

For U.S. citizen students and graduates of international medical schools ("U.S. IMG"), the top five specialties were:

- Internal Medicine (Categorical) (1,162)
- Family Medicine (777)
- Pediatrics (Categorical) (231)
- Psychiatry (188)
- Emergency Medicine (176)

For non-U.S. citizen students and graduates of international medical schools ("Non-U.S. IMG"), the top five specialties were:

- Internal Medicine (Categorical) (2,545)
- Family Medicine (457)
- Pediatrics (Categorical) (375)
- Pathology (212)
- Neurology (200)

Note: PGY-1 only tracks were not included in the above list.

Table 2 Matches by Specialty and Applicant Type, 2022

Specialty	Number of Positions	Number Filled	MD Senior	MD Grad	DO Senior	DO Grad	Others	U.S. IMG	Non-U.S. IMG	Number Unfilled
PGY- 1 Positions										
Anesthesiology	1,509	1,508	1,054	53	263	20	0	57	61	1
Child Neurology	166	150	102	1	15	1	1	8	22	16
Dermatology	30	28	24	0	3	0	0	0	1	2
Emergency Medicine	2,921	2,702	1,593	75	753	59	1	176	45	219
Emergency Med-Anesthesiology	2	2	1	0	1	0	0	0	0	0
Emergency Med-Family Med	7	7	4	0	1	0	0	1	1	0
Family Medicine	4,916	4,451	1,541	87	1,494	94	1	777	457	465
Family Med-Preventive Med	2	2	0	0	1	0	0	1	0	0
Internal Medicine (Categorical)	9,380	8,915	3,491	164	1,602	85	5	1,133	2,435	465
Medicine-Anesthesiology	3	3	2	0	0	0	0	0	1	0
Medicine-Dermatology	8	8	7	0	1	0	0	0	0	0
Medicine-Emergency Med	31	31	22	0	9	0	0	0	0	0
Medicine-Medical Genetics	5	3	3	0	0	0	0	0	0	2
Medicine-Pediatrics	392	392	332	2	39	0	0	9	10	0
Medicine-Preliminary (PGY-1 Only)	1,774	1,624	1,261	15	151	6	0	63	128	150
Medicine-Preventive Med	8	8	5	0	0	0	0	1	2	0
Medicine-Primary	429	424	248	3	33	1	0	29	110	5
Medicine-Psychiatry	24	24	20	0	3	0	0	1	0	0
Interventional Radiology (Integrated)	45	45	37	1	3	1	0	1	2	0
Neurodevelopmental Disabilities	5	5	3	0	2	0	0	0	0	0
Neurological Surgery	240	240	202	11	9	0	0	2	16	0
Neurology	772	761	393	6	132	3	0	64	163	11
Obstetrics-Gynecology	1,503	1,499	1,106	56	242	12	1	42	40	4
OB/GYN-Preliminary (PGY-1 Only)	18	9	4	1	1	0	0	1	2	9
Orthopedic Surgery	875	875	705	36	111	4	0	8	11	0
Osteo Neuromusculoskeletal Med	16	13	0	0	10	3	0	0	0	3
Otolaryngology	361	361	316	19	21	1	0	2	2	0
Pathology	631	619	231	29	76	9	0	62	212	12
Pediatrics (Categorical)	2,942	2,861	1,661	36	580	10	0	224	350	81
Pediatrics-Anesthesiology	6	6	6	0	0	0	0	0	0	0
Pediatrics-Emergency Med	9	9	6	0	3	0	0	0	0	0
Pediatrics-Medical Genetics	30	28	18	0	1	0	0	3	6	2
Pediatrics-P M & R	3	3	3	0	0	0	0	0	0	0
Pediatrics-Preliminary	23	21	16	0	3	0	0	0	2	2
Pediatrics-Primary	74	73	31	1	9	0	0	7	25	1
Peds/Psych/Child Psych	21	21	20	0	1	0	0	0	0	0
Physical Medicine & Rehab	180	180	104	4	55	1	0	8	8	0
Plastic Surgery (Integrated)	194	194	173	9	0	1	0	4	7	0
Psychiatry	2,047	2,030	1,253	45	387	24	0	188	133	17
Psychiatry-Family Medicine	10	10	10	0	0	0	0	0	0	0
Psychiatry-Neurology	4	3	2	0	1	0	0	0	0	1
Radiation Oncology	10	9	7	0	1	0	0	0	1	1
Radiology-Diagnostic	132	132	73	3	41	2	0	3	10	0
Surgery (Categorical)	1,622	1,619	1,059	156	212	30	1	80	81	3
Surgery-Preliminary (PGY-1 Only)	1,150	632	304	26	56	10	1	68	167	518
Thoracic Surgery	47	47	41	0	1	0	0	2	3	0
Transitional (PGY-1 Only)	1,616	1,404	920	17	338	5	0	73	51	212
Vascular Surgery	84	84	72	3	1	1	0	1	6	0
Total PGY-1	**36,277**	**34,075**	**18,486**	**859**	**6,666**	**383**	**11**	**3,099**	**4,571**	**2,202**

Table 2 Matches by Specialty and Applicant Type, 2022 (Continued)

Specialty	Number of Positions	Number Filled	MD Senior	MD Grad	DO Senior	DO Grad	Others	U.S. IMG	Non-U.S. IMG	Number Unfilled
PGY- 2 Positions										
Anesthesiology	346	346	232	23	53	7	0	23	8	0
Child Neurology	7	7	2	1	3	1	0	0	0	0
Dermatology	492	489	408	27	38	5	0	5	6	3
Interventional Radiology (Integrated)	123	123	99	3	18	0	0	1	2	0
Neurodevelopmental Disabilities	3	3	3	0	0	0	0	0	0	0
Neurology	233	232	165	1	23	0	0	9	34	1
Nuclear Medicine	1	0	0	0	0	0	0	0	0	1
Osteo Neuromusculoskeletal Med	2	2	0	0	2	0	0	0	0	0
Physical Medicine & Rehab	338	336	172	7	127	15	0	8	7	2
Radiation Oncology	166	134	97	8	7	0	0	9	13	32
Radiology-Diagnostic	997	996	713	53	132	7	0	32	59	1
Radiology-Nuclear Med	3	3	2	0	1	0	0	0	0	0
Total PGY-2	**2,711**	**2,671**	**1,893**	**123**	**404**	**35**	**0**	**87**	**129**	**40**
Physician (R) Positions										
Anesthesiology	114	108	0	83	0	13	0	7	5	6
Child Neurology	15	8	0	3	0	2	0	1	2	7
Dermatology	22	21	0	10	0	6	0	4	1	1
Interventional Radiology (Integrated)	1	1	0	1	0	0	0	0	0	0
Neurodevelopmental Disabilities	1	1	0	0	0	0	0	1	0	0
Neurology	9	9	0	4	0	2	0	0	3	0
Osteo Neuromusculoskeletal Med	6	4	0	0	0	3	0	1	0	2
Physical Medicine & Rehab	14	13	0	5	0	6	0	1	1	1
Radiation Oncology	9	6	0	3	0	1	0	2	0	3
Radiology-Diagnostic	26	26	0	19	0	5	0	0	2	0
Total Physician (R)	**217**	**197**	**0**	**128**	**0**	**38**	**0**	**17**	**14**	**20**
GRAND TOTAL	**39,205**	**36,943**	**20,379**	**1,110**	**7,070**	**456**	**11**	**3,203**	**4,714**	**2,262**

Table 3

Table 3 shows the numbers of positions offered by specialty between 2018 and 2022. The 2022 Match offered 36,277 PGY-1 positions, an increase of 6,045 (20.0 percent) over 2018. The combined increase of PGY-1 and PGY-2 positions was 6,078 (18.5 percent) over 2018.

In 2022, the number of positions in Internal Medicine (Categorical), Family Medicine, and Pediatrics was 17,741, 3,338 (23.2 percent) more than in 2018.

Specialties that have increased or decreased in matched applicants by at least 10 percent and 10 positions in the Match between 2018 and 2022 are highlighted in Table 3 with arrows.

Table 3 Positions Offered in the Matching Program, 2018 - 2022

Specialty	2022		2021		2020		2019		2018	
	No.	%	No.	%	No.	%	No.	%	No.	%
PGY-1 Positions										
▲ Anesthesiology	1,509	4.2	1,460	4.1	1,370	4.0	1,337	4.2	1,253	4.1
▲ Child Neurology	166	0.5	159	0.5	159	0.5	145	0.5	134	0.4
Dermatology	30	0.1	30	0.1	31	0.1	30	0.1	25	0.1
▲ Emergency Medicine	2,921	8.1	2,840	8.1	2,665	7.8	2,488	7.7	2,278	7.5
Emergency Med-Anesthesiology	2	0.0	2	0.0	0	0.0	1	0.0	2	0.0
Emergency Med-Family Med	7	0.0	7	0.0	6	0.0	4	0.0	4	0.0
▲ Family Medicine	4,916	13.6	4,823	13.7	4,662	13.6	4,107	12.8	3,629	12.0
Family Medicine-ONMM	0	0.0	0	0.0	2	0.0	1	0.0	4	0.0
Family Med-Preventive Med	2	0.0	2	0.0	3	0.0	4	0.0	3	0.0
▲ Internal Medicine (Categorical)	9,380	25.9	9,024	25.6	8,697	25.4	8,116	25.2	7,542	24.9
Medicine-Anesthesiology	3	0.0	4	0.0	3	0.0	5	0.0	6	0.0
Medicine-Dermatology	8	0.0	8	0.0	6	0.0	7	0.0	6	0.0
Medicine-Emergency Med	31	0.1	31	0.1	30	0.1	26	0.1	26	0.1
Medicine-Family Medicine	0	0.0	0	0.0	0	0.0	0	0.0	2	0.0
Medicine-Medical Genetics	5	0.0	4	0.0	4	0.0	3	0.0	1	0.0
Medicine-Pediatrics	392	1.1	385	1.1	390	1.1	390	1.2	382	1.3
Medicine-Preliminary (PGY-1 Only)	1,774	4.9	1,833	5.2	1,911	5.6	1,944	6.0	1,883	6.2
Medicine-Preventive Med	8	0.0	5	0.0	7	0.0	6	0.0	6	0.0
▲ Medicine-Primary	429	1.2	441	1.3	430	1.3	396	1.2	374	1.2
Medicine-Psychiatry	24	0.1	24	0.1	23	0.1	23	0.1	24	0.1
▲ Interventional Radiology (Integrated)	45	0.1	41	0.1	38	0.1	37	0.1	35	0.1
Neurodevelopmental Disabilities	5	0.0	6	0.0	4	0.0	4	0.0	4	0.0
Neurological Surgery	240	0.7	234	0.7	232	0.7	232	0.7	225	0.7
▲ Neurology	772	2.1	715	2.0	682	2.0	617	1.9	552	1.8
▲ Obstetrics-Gynecology	1,503	4.1	1,460	4.1	1,443	4.2	1,395	4.3	1,336	4.4
OB/GYN-Preliminary (PGY-1 Only)	18	0.0	18	0.1	18	0.1	18	0.1	21	0.1
▲ Orthopedic Surgery	875	2.4	868	2.5	849	2.5	755	2.3	742	2.5
▲ Osteo Neuromusculoskeletal Med	16	0.0	12	0.0	10	0.0	2	0.0	2	0.0
▲ Otolaryngology	361	1.0	350	1.0	350	1.0	328	1.0	315	1.0
Pathology	631	1.7	611	1.7	603	1.8	601	1.9	601	2.0
Pediatrics (Categorical)	2,942	8.1	2,901	8.2	2,864	8.4	2,847	8.8	2,768	9.2
Pediatrics-Anesthesiology	6	0.0	8	0.0	7	0.0	7	0.0	7	0.0
Pediatrics-Emergency Med	9	0.0	8	0.0	8	0.0	8	0.0	8	0.0
▲ Pediatrics-Medical Genetics	30	0.1	27	0.1	22	0.1	21	0.1	20	0.1
Pediatrics-P M & R	3	0.0	2	0.0	4	0.0	4	0.0	3	0.0
Pediatrics-Preliminary	23	0.1	24	0.1	19	0.1	24	0.1	19	0.1
▼ Pediatrics-Primary	74	0.2	75	0.2	92	0.3	90	0.3	90	0.3
Peds/Psych/Child Psych	21	0.1	21	0.1	22	0.1	21	0.1	21	0.1
▲ Physical Medicine & Rehab	180	0.5	157	0.4	151	0.4	138	0.4	133	0.4
▲ Plastic Surgery (Integrated)	194	0.5	187	0.5	180	0.5	172	0.5	168	0.6
Preventive Medicine	0	0.0	0	0.0	1	0.0	1	0.0	1	0.0
▲ Psychiatry	2,047	5.6	1,907	5.4	1,858	5.4	1,740	5.4	1,556	5.1
Psychiatry-Family Medicine	10	0.0	12	0.0	12	0.0	12	0.0	12	0.0
Psychiatry-Neurology	4	0.0	4	0.0	2	0.0	4	0.0	4	0.0
Radiation Oncology	10	0.0	15	0.0	14	0.0	15	0.0	16	0.1
Radiology-Diagnostic	132	0.4	122	0.3	123	0.4	123	0.4	125	0.4
▲ Surgery (Categorical)	1,622	4.5	1,569	4.5	1,536	4.5	1,432	4.4	1,319	4.4
▼ Surgery-Preliminary (PGY-1 Only)	1,150	3.2	1,136	3.2	1,174	3.4	1,158	3.6	1,363	4.5
▲ Thoracic Surgery	47	0.1	46	0.1	38	0.1	37	0.1	36	0.1
▲ Transitional (PGY-1 Only)	1,616	4.5	1,497	4.3	1,436	4.2	1,252	3.9	1,086	3.6
▲ Vascular Surgery	84	0.2	79	0.2	75	0.2	66	0.2	60	0.2
TOTAL - PGY1	**36,277**	**100**	**35,194**	**100**	**34,266**	**100**	**32,194**	**100**	**30,232**	**100**

Table 3 Positions Offered in the Matching Program, 2018 - 2022 (Continued)

Specialty	2022		2021		2020		2019		2018	
	No.	%	No.	%	No.	%	No.	%	No.	%
PGY-2 Positions										
▼ Anesthesiology	346	12.8	339	12.6	398	14.5	428	15.5	447	16.7
Child Neurology	7	0.3	8	0.3	9	0.3	11	0.4	8	0.3
▲ Dermatology	492	18.1	477	17.7	478	17.4	447	16.2	426	15.9
▲ Interventional Radiology (Integrated)	123	4.5	121	4.5	118	4.3	113	4.1	98	3.7
Neurodevelopmental Disabilities	3	0.1	4	0.1	3	0.1	5	0.2	4	0.1
▼ Neurology	233	8.6	254	9.4	244	8.9	281	10.2	287	10.7
Nuclear Medicine	1	0.0	1	0.0	1	0.0	0	0.0	3	0.1
Osteo Neuromusculoskeletal Med	2	0.1	7	0.3	7	0.3	4	0.1	0	0.0
▲ Physical Medicine & Rehab	338	12.5	327	12.1	316	11.5	308	11.2	281	10.5
Radiation Oncology	166	6.1	173	6.4	175	6.4	192	7.0	177	6.6
Radiology-Diagnostic	997	36.8	986	36.5	990	36.1	965	35.0	944	35.3
Radiology-Nuclear Med	3	0.1	2	0.1	3	0.1	2	0.1	3	0.1
TOTAL - PGY2	**2,711**	**100**	**2,699**	**100**	**2,742**	**100**	**2,756**	**100**	**2,678**	**100**
Physician (R) Positions										
▼ Anesthesiology	114	52.5	94	44.1	116	46.8	97	41.3	140	54.5
▼ Child Neurology	15	6.9	20	9.4	25	10.1	34	14.5	26	10.1
Dermatology	22	10.1	20	9.4	29	11.7	27	11.5	21	8.2
Interventional Radiology (Integrated)	1	0.5	2	0.9	0	0.0	1	0.4	3	1.2
Neurodevelopmental Disabilities	1	0.5	2	0.9	3	1.2	4	1.7	7	2.7
▼ Neurology	9	4.1	21	9.9	20	8.1	20	8.5	20	7.8
Nuclear Medicine	0	0.0	0	0.0	0	0.0	0	0.0	2	0.8
Osteo Neuromusculoskeletal Med	6	2.8	2	0.9	6	2.4	1	0.4	0	0.0
Physical Medicine & Rehab	14	6.5	15	7.0	13	5.2	18	7.7	7	2.7
Radiation Oncology	9	4.1	5	2.3	3	1.2	4	1.7	1	0.4
Radiology-Diagnostic	26	12.0	31	14.6	33	13.3	29	12.3	30	11.7
Radiology-Nuclear Med	0	0.0	1	0.5	0	0.0	0	0.0	0	0.0
TOTAL - Physician (R)	**217**	**100**	**213**	**100**	**248**	**100**	**235**	**100**	**257**	**100**
GRAND TOTAL	**39,205**	**100**	**38,106**	**100**	**37,256**	**100**	**35,185**	**100**	**33,167**	**100**

▲▼ Denotes increase/decrease in matched applicants of more than 10 percent and 10 positions between 2018 and 2022.

Table 4

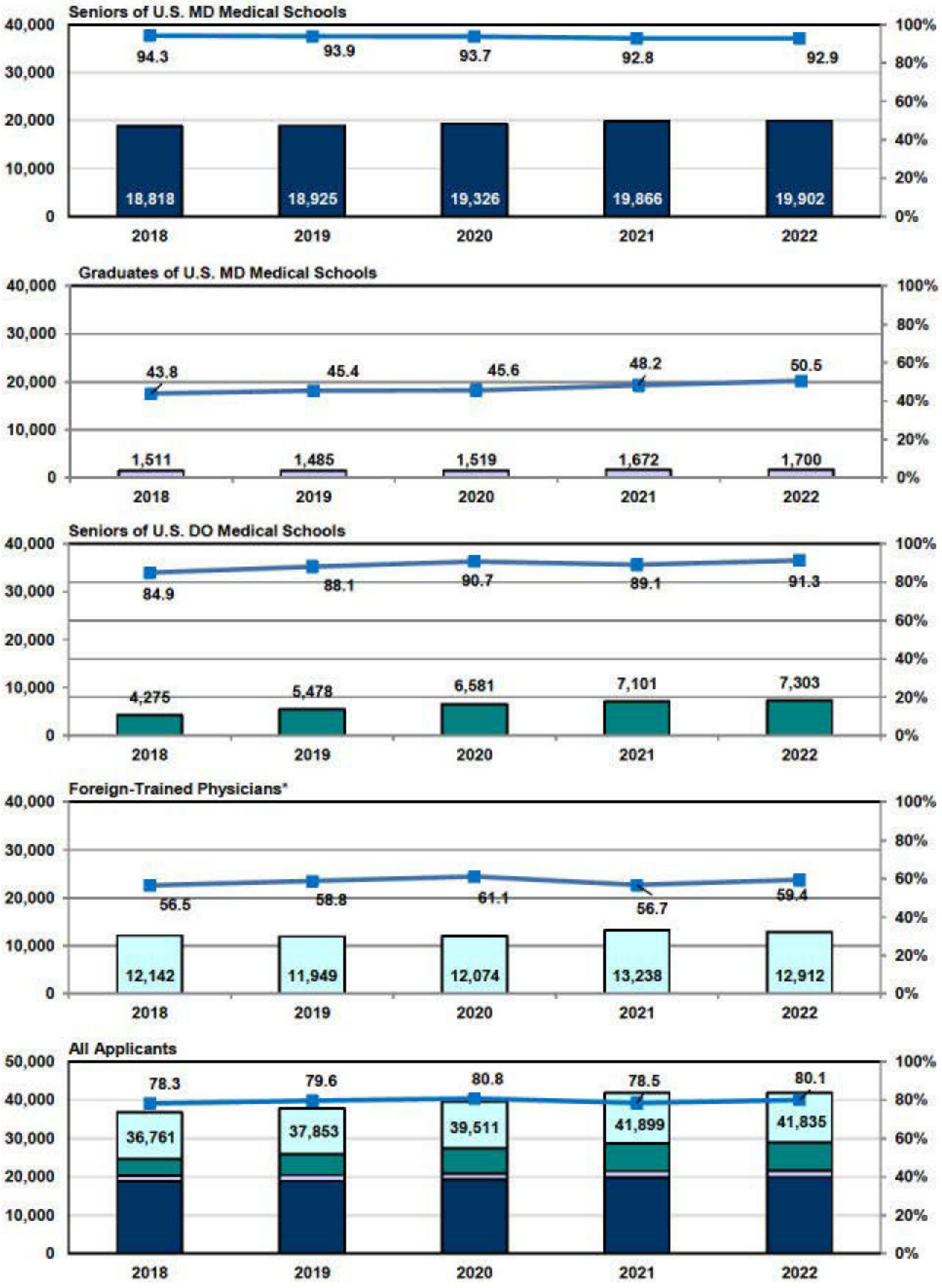
Many applicants in addition to U.S. MD seniors seek residency positions through the NRMP. Trend data for different applicant groups are shown in Figure 2 and Table 4. The arrows in Table 4 indicate increases in the numbers of active applicants that were greater than the overall increase of 14.7 percent for all active applicants between 2018 and 2022.

In 2022, the number of active applicants was 42,549, 41 (0.10 percent) more than in 2021. The number of active U.S. DO seniors in 2022 was 7,303, 3,028 (70.8 percent) more than in 2018 (n=4,275). Growth in the numbers of U.S. DO seniors is the result of the transition to single accreditation completed in 2020 and the dissolution of the American Osteopathic Association (AOA) Match after the 2019 appointment year.

The number of applicants matched to PGY-1 positions grew across nearly all applicant groups. As examples, there were 18,486 U.S. MD seniors who obtained PGY-1 positions in the Match, an increase of 51 compared to 2021. There were 6,666 U.S. DO seniors who obtained PGY-1 positions in the Match, an increase of 339. In addition, there were 4,571 non-U.S. citizen students/graduates of international medical schools who obtained PGY-1 positions in the Match, an increase of 215. Gains also were noted for U.S. MD and DO graduates.

The overall 2022 PGY-1 match rate was 80.1 percent, 1.6 percentage points higher than 2021, the result of an increase in the number of overall positions. The PGY-1 match rate for U.S. MD seniors (92.9 percent) was 0.1 percentage point higher than 2021 and consistent with the historical average of 92-95 percent. The PGY-1 match rate for U.S. MD graduates (50.5 percent) is on par with the historical match rate of MD seniors and 2.3 percentage points higher than 2021. The PGY-1 match rate for U.S. DO seniors (91.3 percent) was 2.2 percentage points higher than 2021 while the PGY-1 match rate for U.S. DO graduates increased by 9.3 percentage points to 53.6 percent. The PGY-1 match rate for U.S. citizen students/graduates of international medical schools (61.4 percent) was 1.9 percentage points higher than 2021 while the PGY-1 match rate for non-U.S. citizen students/graduates of international medical schools was 58.1 percent, 3.3 percentage points higher than 2021.

Figure 2 Number of Active Applicants and Percent Matched to PGY-1 Positions, 2018- 2022



*Foreign-trained physicians includes both U.S. citizen and non-U.S. citizen graduates of international medical schools.

Table 4 Applicants in the Matching Program, 2018 - 2022

Applicant	2022 No.	2022 %	2021 No.	2021 %	2020 No.	2020 %	2019 No.	2019 %	2018 No.	2018 %
Seniors of U.S. MD Medical Schools										
Active Applicants*	19,902	100	19,866	100	19,326	100	18,925	100	18,818	100
Matched PGY-1	18,486	92.9	18,435	92.8	18,108	93.7	17,763	93.9	17,740	94.3
Unmatched PGY-1	1,416	7.1	1,431	7.2	1,218	6.3	1,162	6.1	1,078	5.7
Withdrew	513	2.5	526	2.6	376	1.9	414	2.1	428	2.2
No Rank List	138	0.7	83	0.4	79	0.4	78	0.4	66	0.3
Total	**20,553**	**100**	**20,475**	**100**	**19,781**	**100**	**19,417**	**100**	**19,312**	**100**
Graduates of U.S. MD Medical Schools										
Active Applicants*	1,700	100	1,672	100	1,519	100	1,485	100	1,511	100
Matched PGY-1	859	50.5	806	48.2	693	45.6	674	45.4	662	43.8
Unmatched PGY-1	841	49.5	866	51.8	826	54.4	811	54.6	849	56.2
Withdrew	118	5.9	107	5.4	79	4.4	93	5.2	85	4.8
No Rank List	175	8.8	197	10.0	187	10.5	201	11.3	192	10.7
Total	**1,993**	**100**	**1,976**	**100**	**1,785**	**100**	**1,779**	**100**	**1,788**	**100**
Seniors of U.S. DO Medical Schools										
▲ Active Applicants*	7,303	100	7,101	100	6,581	100	5,478	100	4,275	100
Matched PGY-1	6,666	91.3	6,327	89.1	5,968	90.7	4,825	88.1	3,630	84.9
Unmatched PGY-1	637	8.7	774	10.9	613	9.3	653	11.9	645	15.1
Withdrew	199	2.6	181	2.5	180	2.6	812	12.8	1,128	20.4
No Rank List	64	0.8	50	0.7	50	0.7	76	1.2	132	2.4
Total	**7,566**	**100**	**7,332**	**100**	**6,811**	**100**	**6,366**	**100**	**5,535**	**100**
Graduates of U.S. DO Medical Schools										
▲ Active Applicants*	714	100	609	100	573	100	523	100	342	100
Matched PGY-1	383	53.6	270	44.3	247	43.1	251	48.0	141	41.2
Unmatched PGY-1	331	46.4	339	55.7	326	56.9	272	52.0	201	58.8
Withdrew	53	6.3	27	3.6	39	5.5	108	14.9	99	19.1
No Rank List	69	8.3	115	15.3	102	14.3	93	12.8	78	15.0
Total	**836**	**100**	**751**	**100**	**714**	**100**	**724**	**100**	**519**	**100**
U.S. Citizen Students/Graduates of International Medical Schools										
Active Applicants*	5,048	100	5,295	100	5,167	100	5,080	100	5,075	100
Matched PGY-1	3,099	61.4	3,152	59.5	3,154	61.0	2,997	59.0	2,900	57.1
Unmatched PGY-1	1,949	38.6	2,143	40.5	2,013	39.0	2,083	41.0	2,175	42.9
Withdrew	549	8.3	711	9.6	570	8.3	540	7.7	569	8.1
No Rank List	1,011	15.3	1,411	19.0	1,156	16.8	1,355	19.4	1,342	19.2
Total	**6,608**	**100**	**7,417**	**100**	**6,893**	**100**	**6,975**	**100**	**6,986**	**100**
Non-U.S. Citizen Students/Graduates of International Medical Schools										
Active Applicants*	7,864	100	7,943	100	6,907	100	6,869	100	7,067	100
Matched PGY-1	4,571	58.1	4,356	54.8	4,222	61.1	4,028	58.6	3,962	56.1
Unmatched PGY-1	3,293	41.9	3,587	45.2	2,685	38.9	2,841	41.4	3,105	43.9
Withdrew	634	6.3	749	7.0	680	7.6	740	7.9	805	8.3
No Rank List	1,596	15.8	2,026	18.9	1,369	15.3	1,701	18.3	1,866	19.2
Total	**10,094**	**100**	**10,718**	**100**	**8,956**	**100**	**9,310**	**100**	**9,738**	**100**
Students/Graduates of Canadian Medical Schools and Fifth Pathway Programs										
Active Applicants*	18	100	22	100.0	11	100.0	16	100.0	15	100.0
Matched PGY-1	11	61.1	7	31.8	7	63.6	12	75.0	5	33.3
Unmatched PGY-1	7	38.9	15	68.2	4	36.4	4	25.0	10	66.7
Withdrew	2	8.0	2	6.5	4	21.1	11	34.4	7	22.6
No Rank List	5	20.0	7	22.6	4	21.1	5	15.6	9	29.0
Total	**25**	**100**	**31**	**100.0**	**19**	**100.0**	**32**	**100.0**	**31**	**100.0**
All Applicants										
Active Applicants*	42,549	100	42,508	100	40,084	100	38,376	100	37,103	100
Matched PGY-1	34,075	80.1	33,353	78.5	32,399	80.8	30,550	79.6	29,040	78.3
Unmatched PGY-1	8,474	19.9	9,155	21.5	7,685	19.2	7,826	20.4	8,063	21.7
Withdrew	2,068	4.3	2,303	4.7	1,928	4.3	2,718	6.1	3,121	7.1
No Rank List	3,058	6.4	3,889	8.0	2,947	6.6	3,509	7.9	3,685	8.4
Total	**47,675**	**100**	**48,700**	**100**	**44,959**	**100**	**44,603**	**100**	**43,909**	**100**

▲ Denotes that the percentage increase in active applicants for this group was greater than the overall increase of 14.7 percent for all active applicants between 2018 and 2022.

* Applicants who submitted a certified rank order list of programs

Note: Match rates are based on all active applicants regardless of their ranking behavior. Therefore, applicants who matched to PGY-1 positions are counted as matched even if they ranked and did not match to a PGY-2 position. Applicants who ranked only advanced and physician (R) programs are counted as unmatched in this table because they did not match to a PGY-1 position.

Table 5

Table 5 shows the ratios of PGY-1 positions to active applicants. The same data are shown graphically in Figure 3. The red line in Figure 3 represents the point at which there are equal numbers of applicants and positions: above the red line represents more positions than total active applicants, below the line more total active applicants than positions. Active applicants are defined as those who certify rank order lists of programs.

- In 2022, the ratio of PGY-1 positions per active U.S. MD senior was 1.82, a 0.05 increase from 2021. The ratio of PGY-1 positions per active U.S. DO senior was 4.97 comparerd to 4.96 in 2021 (not reflected in Table). Combined, the PGY-1 positions per active US senior was 1.33 in 2022 (not reflected in Table).

- Historically, the ratio of PGY-1 positions to total applicants had roughly followed the trend of U.S. MD seniors because prior to 2019, more than half of all applicants came from that group. In recent history, however, the two have increasingly diverged. In 2022, the ratio was 0.85 positions per total active applicant, 0.02 percentage points higher than last year.

Figure 3

Positions per All Active and Active MD Senior Applicants, 1976 - 2022

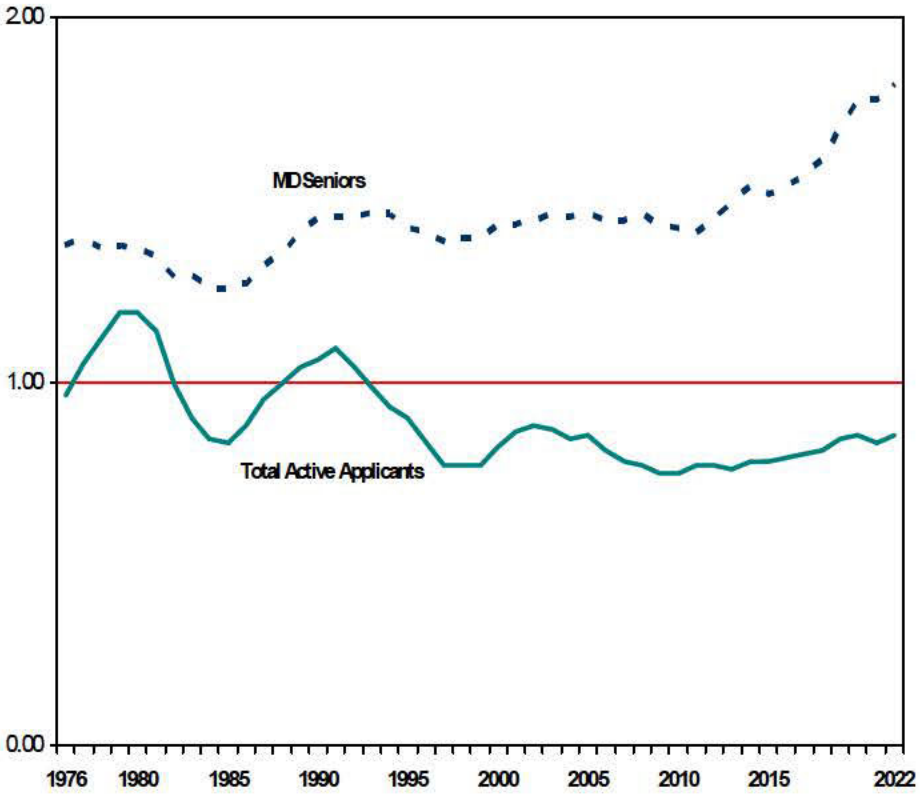


Table 5 Number of PGY-1 Positions per Active Applicant, 1976 - 2022

Year	Number of Positions	Active MD Seniors	Positions Per MD Senior	Active Total	Positions Per Active Applicant
1976	16,112	11,735	1.37	16,728	0.96
1977	16,574	11,898	1.39	15,854	1.05
1978	17,219	12,666	1.36	15,354	1.12
1979	17,824	13,036	1.37	14,985	1.19
1980	18,055	13,322	1.36	15,129	1.19
1981	18,331	13,705	1.34	16,104	1.14
1982	18,300	14,144	1.29	18,410	0.99
1983	17,952	13,969	1.29	20,044	0.90
1984	18,457	14,741	1.25	22,052	0.84
1985	18,535	14,849	1.25	22,386	0.83
1986	18,770	14,737	1.27	21,357	0.88
1987	19,047	14,466	1.32	20,054	0.95
1988	19,513	14,499	1.35	19,808	0.99
1989	19,955	14,117	1.41	19,207	1.04
1990	20,101	13,908	1.45	19,004	1.06
1991	20,192	13,943	1.45	18,450	1.09
1992	20,394	14,030	1.45	19,519	1.04
1993	20,598	14,094	1.46	20,916	0.98
1994	20,772	14,207	1.46	22,352	0.93
1995	20,751	14,621	1.42	22,936	0.90
1996	20,563	14,539	1.41	24,718	0.83
1997	20,209	14,614	1.38	26,323	0.77
1998	20,299	14,610	1.39	26,360	0.77
1999	20,453	14,607	1.40	26,462	0.77
2000	20,598	14,358	1.43	25,056	0.82
2001	20,642	14,455	1.43	23,981	0.86
2002	20,602	14,336	1.44	23,459	0.88
2003	20,908	14,332	1.46	23,965	0.87
2004	21,192	14,609	1.45	25,246	0.84
2005	21,454	14,719	1.46	25,348	0.85
2006	21,659	15,008	1.44	26,715	0.81
2007	21,845	15,206	1.44	27,944	0.78
2008	22,240	15,242	1.46	28,737	0.77
2009	22,427	15,638	1.43	29,888	0.75
2010	22,809 *	16,070	1.42*	30,543	0.75*
2011	23,418 *	16,559	1.41*	30,589	0.77*
2012	24,006 *	16,527	1.45*	31,355	0.77*
2013	26,138 *	17,487	1.49*	34,355	0.76*
2014	26,678 *	17,374	1.54*	34,270	0.78*
2015	27,293 *	18,025	1.51*	34,905	0.78*
2016	27,860 *	18,187	1.53*	35,476	0.79*
2017	28,849 *	18,539	1.56*	35,969	0.80*
2018	30,232 *	18,818	1.61*	37,103	0.81*
2019	32,194 *	18,925	1.70*	38,376	0.84*
2020	34,266 *	19,326	1.77*	40,084	0.85*
2021	35,194 *	19,866	1.77*	42,508	0.83*
2022	36,277 *	19,902	1.82*	42,549	0.85*

Note: Applicants who withdrew or did not rank programs are excluded.

* Physician (R) positions are excluded. R positions are PGY-2 positions starting in the year of the Match that are reserved for applicants who have had prior graduate medical education. Physician positions are not available to senior medical students. In previous *Results and Data Books*, the numbers of R positions were small, and they were included in the categorical position counts.

Table 6

Table 6 displays the match rates to PGY-1 positions for U.S. MD seniors, U.S. DO seniors, U.S. citizens trained in international medical schools (U.S. IMGs), non-U.S. citizens trained in international medical schools (non-U.S. IMGs), and other applicants (Canadian medical school students/graduates, Fifth Pathway applicants, DO graduates and MD graduates) since 1992. The data are shown graphically in Figure 4. Match rate is defined in Table 6 and Figure 4 as the percentage of active applicants who matched to PGY-1 positions.

- 92.9 percent of U.S. MD seniors matched to PGY-1 positions in 2022, within the historical 92-95 percent rate.
- 91.3 percent of U.S. DO seniors matched to PGY-1 positions, 2.2 percentage points higher than 2021 and the highest since 1992.
- 61.4 percent of U.S. IMGs matched to PGY-1 positions, 1.9 percentage points higher than 2021 and the highest since 1992.
- 58.1 percent of non-U.S. citizen IMGs matched to PGY-1 positions, 3.3 percentage points higher than 2021.

Figure 4 PGY-1 Match Rates by Applicant Type, 1992 - 2022

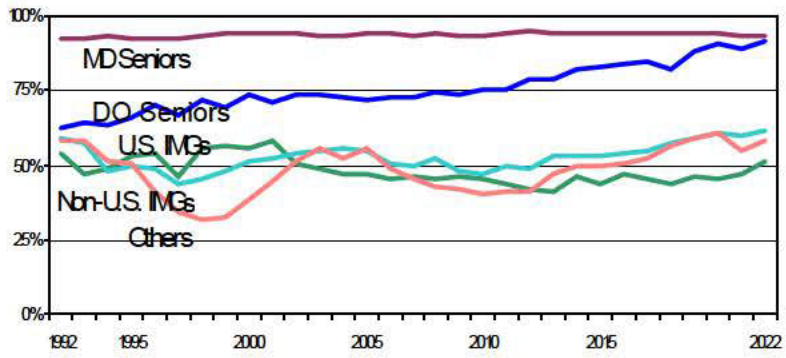


Table 6 PGY-1 Match Rates, 1992 - 2022

Year	Number of Positions	Total Active Applicants	Percent Matched					
			MD Seniors	DO Seniors	U.S. IMGs	Non-U.S. IMGs	Others	All Applicants
1992	20,394	19,519	92.4	62.1	58.7	58.0	53.5	83.3
1993	20,598	20,916	92.4	63.7	57.2	58.4	47.2	92.1
1994	20,772	22,352	93.0	63.5	47.5	50.9	48.6	77.9
1995	20,751	22,936	92.7	66.1	49.8	50.5	52.8	77.9
1996	20,563	24,718	92.1	70.4	48.5	40.9	53.7	72.8
1997	20,209	26,323	92.7	66.9	43.5	34.5	46.1	69.0
1998	20,299	26,360	93.5	71.7	45.5	31.4	55.4	69.0
1999	20,453	26,462	93.8	69.6	47.5	32.2	56.3	69.5
2000	20,598	25,056	93.9	73.1	51.4	38.5	55.8	73.4
2001	20,642	23,981	93.7	71.2	52.4	44.8	58.3	76.5
2002	20,602	23,459	94.1	73.3	53.8	51.3	50.2	78.6
2003	20,908	23,965	93.2	73.1	54.6	55.7	48.3	78.5
2004	21,192	25,246	92.9	72.7	55.4	52.4	47.4	76.8
2005	21,454	25,348	93.7	72.1	54.7	55.6	47.3	78.0
2006	21,659	26,715	93.7	72.8	50.6	48.9	45.3	75.1
2007	21,845	27,944	93.4	72.6	50.0	45.5	46.5	73.4
2008	22,240	28,737	94.2	74.2	51.9	42.4	45.3	72.9
2009	22,427	29,888	93.1	73.6	47.8	41.6	46.1	71.4
2010	22,809 *	30,543	93.3	75.0 *	47.3 *	39.8 *	45.0 *	71.2*
2011	23,418 *	30,589	94.1	75.4 *	50.0 *	40.9 *	43.7 *	73.2*
2012	24,006 *	31,355	95.1	78.8 *	49.1 *	40.6 *	41.9 *	73.1*
2013	26,138 *	34,355	93.7	78.5 *	52.8 *	47.0 *	40.7 *	73.5*
2014	26,678 *	34,270	94.4	82.1 *	53.0 *	49.5 *	46.0 *	75.0*
2015	27,293 *	34,905	93.9	82.7 *	53.1 *	49.4 *	43.4 *	75.2*
2016	27,860 *	35,476	93.8	83.8 *	53.9 *	50.5 *	47.3 *	75.6*
2017	28,849 *	35,969	94.3	85.0 *	54.8 *	52.4 *	44.9 *	77.0*
2018	30,232 *	37,103	94.3	81.7 *	57.1 *	56.1 *	43.3 *	78.3*
2019	32,194 *	38,376	93.9	88.1 *	59.0 *	58.6 *	46.3 *	79.6*
2020	34,266 *	40,084	93.7	90.7 *	61.0 *	61.1 *	45.0 *	80.8*
2021	35,194 *	42,508	92.8	89.1 *	59.5 *	54.8 *	47.0 *	78.5*
2022	36,277 *	42,549	92.9	91.3 *	61.4 *	58.1 *	51.5 *	80.1*

* Match rates were calculated after running the Match algorithm and do not include SOAP data. Physician (R) positions are excluded. R positions are PGY-2 positions starting in the year of the Match that are reserved for applicants who have had prior graduate medical education. Physician positions are not available to senior medical students. In previous *Results and Data Books*, the numbers of R positions were small, and they were included in the categorical position counts.

Tables 7 and 8; Figure 5

Table 7 displays the numbers of positions offered by specialty, as well as the numbers filled by U.S. MD seniors (Table 7A), U.S. DO seniors (Table 7B), and an aggregate of all applicants (including U.S. MD seniors and U.S. DO seniors respectively) from 2018 through 2022. The data in Table 7A and 7B are shown graphically in Figure 5 for specialties that offered at least 100 positions. Table 8 displays the same information for U.S. MD seniors in percentages.

- In 2022, 36,943 matches were made to PGY-1 and PGY-2 (advanced and physician) positions, an all-time high and an increase of 764 (2.1 percent) over 2021.
- In 2022, primary care specialties offered record-high numbers of positions and had high position fill rates.
  - Though the numbers of positions for Internal Medicine (Categorical) have fluctuated, 9,809 positions offered in 2022 is the highest number on record. The position fill rate for the specialty was 95.0 percent. U.S. MD seniors filled 37.2 percent while U.S. DO seniors filled 17.1 percent of total positions offered.
  - Family Medicine has experienced position increases every year since 2009. In 2022, Family Medicine offered 4,916 positions and filled 4,451 (90.5 percent). U.S. MD seniors filled 31.3 percent of all positions and a record number (1,494) of U.S. DO seniors matched, accounting for 30.4 percent of applicants who matched in the specialty.
  - Pediatrics (Categorical) has gained positions every year since 2005 and offered a record-high 3,016 positions in 2022. The overall fill rate was 97.2 percent, with 56.5 percent being filled by U.S. MD seniors and 19.7 percent filled by U.S. DO seniors.
- The number of Psychiatry positions has grown every year since 2008, and the 2,047 positions offered in 2022 represent the highest on record. The 99.2 percent fill rate is also among the highest on record.
- Emergency Medicine has gained positions every year since the specialty joined the Match in 1983, and offered 2,921 positions in 2022 (81 positions and 2.8 percentage points fewer than 2021). The total position fill rate was 92.5 percent (7 percentage points fewer than 2021), with 54.5 percent being filled by U.S. MD seniors and 25.8 percent by U.S. DO seniors.

Other trends of note are:

- Top ten specialties with at least 10 positions in the Match filled by U.S. MD seniors:
  (Listing based on percentages filled: using Thoracic Surgery as an example, there were 47 positions, 41 of which were filled by U.S. MD seniors, for a percentage filled rate of 87.2 percent.)
  Psychiatry-Family Medicine
  Peds/Psych/Child Psych
  Plastic Surgery (Integrated)
  Otolaryngology
  Thoracic Surgery
  Vascular Surgery
  Medicine-Pediatrics
  Neurological Surgery
  Medicine-Psychiatry
  Dermatology

- Top ten specialties with at least 10 positions in the Match filled by U.S. DO seniors:
  (Listing based on percentages filled, the same method applied for U.S. MD seniors.)
  Physical Medicine & Rehab
  Family Medicine
  Medicine-Emergency Med
  Emergency Medicine
  Transitional (PGY-1 Only)
  Pediatrics (Categorical)
  Psychiatry
  Internal Medicine (Categorical)
  Anesthesiology
  Obstetrics-Gynecology

Table 7A Positions Offered and Number Filled by MD Seniors and All Applicants, 2018 - 2022

Specialty	2022			2021			2020			2019			2018		
	Offered	Filled #MD	Filled #Tot	Offered	Filled #MD	Filled #Tot	Offered	Filled #MD	Filled #Tot	Offered	Filled #MD	Filled #Tot	Offered	Filled #MD	Filled #Tot
PGY-1 Positions															
▲Anesthesiology	1,509	1,054	1,508	1,460	1,024	1,457	1,370	936	1,369	1,337	907	1,316	1,253	861	1,226
Child Neurology	166	102	150	159	100	147	159	111	151	145	102	133	134	101	129
Dermatology	30	24	28	30	25	30	31	23	31	30	23	28	25	22	23
Emergency Medicine	2,921	1,593	2,702	2,840	1,765	2,826	2,665	1,713	2,652	2,488	1,617	2,458	2,278	1,606	2,265
Emergency Med-Anesthesiology	2	1	2	2	2	2	0	0	0	1	0	1	2	2	2
Emergency Med-Family Med	7	4	7	7	5	7	6	2	6	4	1	4	4	3	4
Family Medicine	4,916	1,541	4,451	4,823	1,606	4,472	4,662	1,543	4,313	4,107	1,601	3,827	3,629	1,628	3,510
Family Medicine-ONMM	0	0	0	0	0	0	2	0	2	1	0	1	4	0	4
Family Med-Preventive Med	2	0	2	2	1	2	3	2	2	4	3	4	3	3	3
nternal Medicine (Categorical)	9,380	3,491	8,915	9,024	3,523	8,632	8,697	3,496	8,324	8,116	3,366	7,892	7,542	3,195	7,363
Medicine-Anesthesiology	3	2	3	4	4	4	3	3	3	5	4	4	6	6	6
Medicine-Dermatology	8	7	8	8	7	7	6	5	5	7	6	7	6	5	5
Medicine-Emergency Med	31	22	31	31	19	31	30	19	30	26	20	26	26	22	26
Medicine-Family Medicine	0	0	0	0	0	0	0	0	0	0	0	0	2	2	2
Medicine-Medical Genetics	5	3	3	4	3	4	4	2	3	3	1	1	1	1	1
Medicine-Pediatrics	392	332	392	385	313	385	390	316	381	390	315	383	382	306	377
Medicine-Preliminary (PGY-1 Only)	1,774	1,261	1,624	1,833	1,210	1,639	1,911	1,313	1,759	1,944	1,356	1,796	1,883	1,370	1,762
Medicine-Preventive Med	8	5	8	5	2	5	7	4	7	6	2	6	6	4	6
Medicine-Primary	429	248	424	441	251	437	430	247	423	396	239	386	374	229	372
Medicine-Psychiatry	24	20	24	24	22	24	23	18	23	23	18	23	24	20	24
Interventional Radiology (Integrated)	45	37	45	41	30	38	38	25	37	37	30	37	35	34	35
Neurodevelopmental Disabilities	5	3	5	6	3	6	4	3	4	4	3	4	4	3	4
Neurological Surgery	240	202	240	234	198	234	232	203	232	232	213	231	225	203	225
▲Neurology	772	393	761	715	358	702	682	317	665	617	284	594	552	280	539
Obstetrics-Gynecology	1,503	1,106	1,499	1,460	1,088	1,457	1,443	1,089	1,440	1,395	1,049	1,392	1,336	1,051	1,330
OB/GYN-Preliminary (PGY-1 Only)	18	4	9	18	6	12	18	3	9	18	4	9	21	6	11
Orthopedic Surgery	875	705	875	868	699	866	849	686	844	755	693	752	742	691	738
Osteo Neuromusculoskeletal Med	16	0	13	12	0	3	10	0	8	2	0	0	2	0	2
▲Otolaryngology	361	316	361	350	310	350	350	310	348	328	308	328	315	284	303
Pathology	631	231	619	611	198	589	603	204	587	601	201	569	601	220	568
Pediatrics (Categorical)	2,942	1,661	2,861	2,901	1,749	2,860	2,864	1,731	2,812	2,847	1,715	2,778	2,768	1,746	2,711
Pediatrics-Anesthesiology	6	6	6	8	8	8	7	7	7	7	6	7	7	6	7
Pediatrics-Emergency Med	9	6	9	8	7	8	8	5	8	8	6	8	8	4	8
Pediatrics-Medical Genetics	30	18	28	27	19	25	22	13	20	21	14	16	20	14	18
Pediatrics-P M & R	3	3	3	2	2	2	4	2	4	4	2	3	3	3	3
Pediatrics-Preliminary	23	16	21	24	16	22	19	9	12	24	12	19	19	10	14
Pediatrics-Primary	74	31	73	75	39	74	92	36	90	90	36	89	90	36	86
Peds/Psych/Child Psych	21	20	21	21	19	21	22	20	22	21	20	21	21	17	20
▲Physical Medicine & Rehab	180	104	180	157	88	156	151	81	151	138	69	138	133	76	133
▲Plastic Surgery (Integrated)	194	173	194	187	167	187	180	165	180	172	158	172	168	156	167
Preventive Medicine	0	0	0	0	0	0	1	0	1	1	0	1	1	0	1
▲Psychiatry	2,047	1,253	2,030	1,907	1,205	1,904	1,858	1,138	1,838	1,740	1,054	1,720	1,556	982	1,540
Psychiatry-Family Medicine	10	10	10	12	11	12	12	10	12	12	12	12	12	12	12
Psychiatry-Neurology	4	2	3	4	1	4	2	2	2	4	3	3	4	3	3
Radiation Oncology	10	7	9	15	7	12	14	8	11	15	13	14	16	15	15
Radiology-Diagnostic	132	73	132	122	71	118	123	50	116	123	73	122	125	77	125
Surgery (Categorical)	1,622	1,059	1,619	1,569	1,029	1,564	1,536	1,033	1,531	1,432	1,053	1,432	1,319	1,005	1,314
▼Surgery-Preliminary (PGY-1 Only)	1,150	304	632	1,136	272	612	1,174	290	583	1,158	277	581	1,363	567	888
▲Thoracic Surgery	47	41	47	46	43	45	38	32	38	37	34	37	36	31	36
▲Transitional (PGY-1 Only)	1,616	920	1,404	1,497	845	1,272	1,436	822	1,230	1,252	788	1,101	1,086	772	1,016
▲Vascular Surgery	84	72	84	79	65	79	75	61	73	66	52	64	60	50	58
TOTAL - PGY-1	**36,277**	**18,486**	**34,075**	**35,194**	**18,435**	**33,353**	**34,266**	**18,108**	**32,399**	**32,194**	**17,763**	**30,550**	**30,232**	**17,740**	**29,040**

Table 7A Positions Offered and Number Filled by MD Seniors and All Applicants, 2018 - 2022 (Continued)

Specialty	2022			2021			2020			2019			2018		
	Offered	Filled #MD	Filled #Tot	Offered	Filled #MD	Filled #Tot	Offered	Filled #MD	Filled #Tot	Offered	Filled #MD	Filled #Tot	Offered	Filled #MD	Filled #Tot
PGY-2 Positions															
Anesthesiology	346	232	346	339	211	339	398	265	396	428	246	420	447	246	442
Child Neurology	7	2	7	8	1	6	9	1	6	11	1	9	8	3	7
▲ Dermatology	492	408	489	477	382	471	478	368	469	447	370	444	426	348	420
Interventional Radiology (Integrated)	123	99	123	121	97	117	118	94	111	113	101	113	98	93	98
Neurodevelopmental Disabilities	3	3	3	4	1	2	3	1	1	5	2	3	4	2	2
▼ Neurology	233	165	232	254	167	253	244	148	240	281	175	266	287	190	283
Nuclear Medicine	1	0	0	1	0	0	1	0	0	0	0	0	3	0	3
Osteo Neuromusculoskeletal Med	2	0	2	7	0	3	7	0	2	4	0	3	0	0	0
Physical Medicine & Rehab	338	172	336	327	167	325	316	164	312	308	151	305	281	166	281
▼ Radiation Oncology	166	97	134	173	94	138	175	114	143	192	147	163	177	162	172
Radiology-Diagnostic	997	713	996	986	670	979	990	660	967	965	665	950	944	683	939
Radiology-Nuclear Med	3	2	3	2	1	2	3	1	2	2	1	2	3	1	3
TOTAL - PGY-2	**2,711**	**1,893**	**2,671**	**2,699**	**1,791**	**2,635**	**2,742**	**1,816**	**2,649**	**2,756**	**1,859**	**2,678**	**2,678**	**1,894**	**2,650**
Physician (R) Positions															
Anesthesiology	114	0	108	94	0	93	116	0	108	97	0	91	140	0	120
Child Neurology	15	0	8	20	0	14	25	0	12	34	0	12	26	0	12
Dermatology	22	0	21	20	0	20	29	0	29	27	0	25	21	0	20
Interventional Radiology (Integrated)	1	0	1	2	0	2	0	0	0	1	0	1	3	0	3
Neurodevelopmental Disabilities	1	0	1	2	0	2	3	0	1	4	0	1	7	0	2
Neurology	9	0	9	21	0	20	20	0	16	20	0	14	20	0	18
Nuclear Medicine	0	0	0	0	0	0	0	0	0	0	0	0	2	0	1
Osteo Neuromusculoskeletal Med	6	0	4	2	0	1	6	0	1	1	0	0	0	0	0
Physical Medicine & Rehab	14	0	13	15	0	12	13	0	13	18	0	16	7	0	7
Radiation Oncology	9	0	6	5	0	3	3	0	2	4	0	2	1	0	1
Radiology-Diagnostic	26	0	26	31	0	23	33	0	28	29	0	27	30	0	25
Radiology-Nuclear Med	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0
TOTAL - Physician (R)	**217**	**0**	**197**	**213**	**0**	**191**	**248**	**0**	**210**	**235**	**0**	**189**	**257**	**0**	**209**
GRAND TOTAL	**39,205**	**20,379**	**36,943**	**38,106**	**20,226**	**36,179**	**37,256**	**19,924**	**35,258**	**35,185**	**19,622**	**33,417**	**33,167**	**19,634**	**31,899**

▲▼ Denotes increase/decrease in number of positions filled by MD seniors of more than 10 percent and 10 positions between 2018 and 2022.

Table 7B Positions Offered and Number Filled by DO Seniors and All Applicants, 2018 - 2022

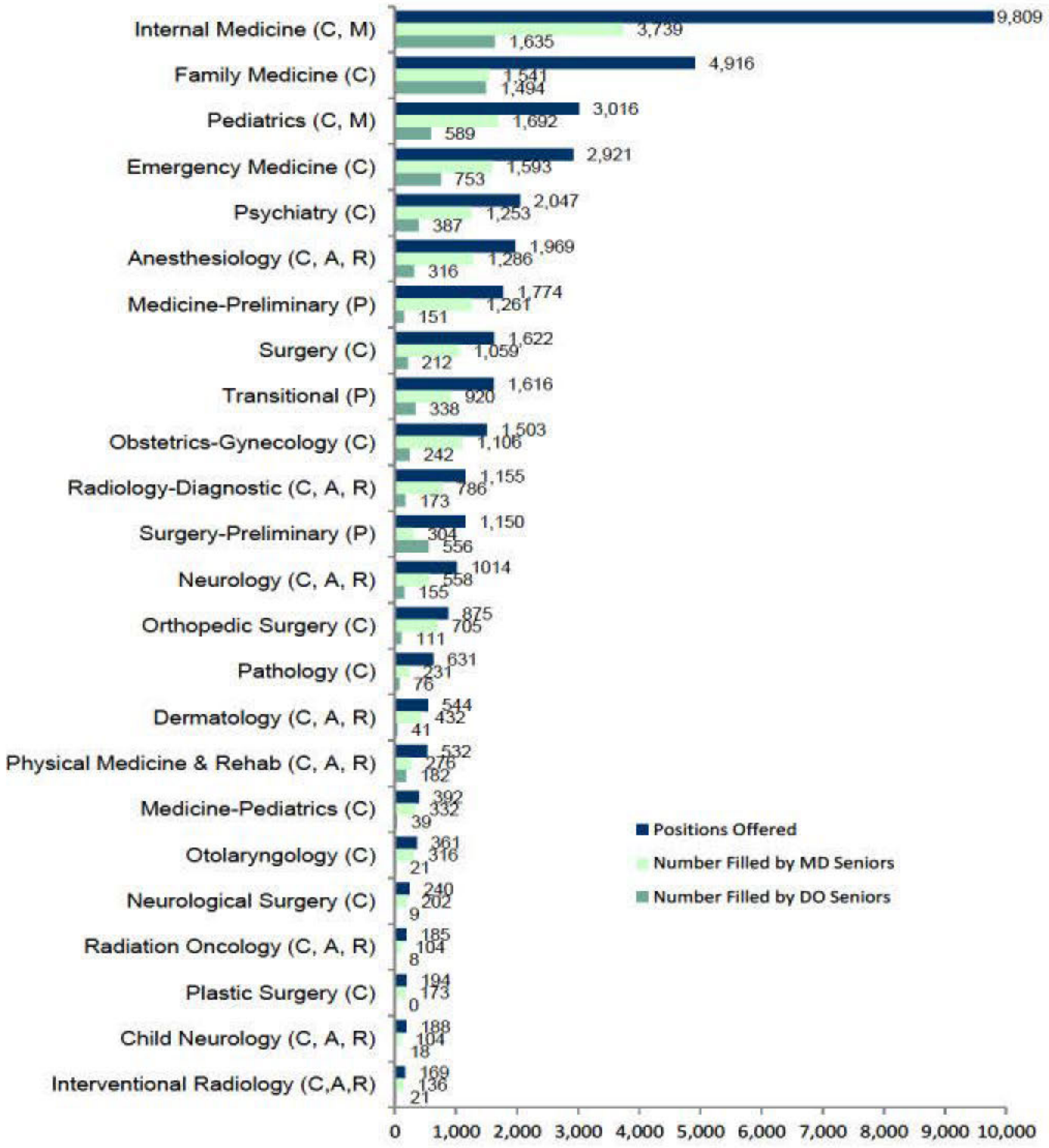
Specialty	2022			2021			2020			2019			2018		
	Offered	Filled #DO	Filled #Tot	Offered	Filled #DO	Filled #Tot	Offered	Filled #DO	Filled #Tot	Offered	Filled #DO	Filled #Tot	Offered	Filled #DO	Filled #Tot
PGY-1 Positions															
▲Anesthesiology	1,509	263	1,508	1,460	268	1,457	1,370	262	1,369	1,337	243	1,316	1,253	203	1,226
Child Neurology	166	15	150	159	18	147	159	20	151	145	6	133	134	11	129
Dermatology	30	3	28	30	5	30	31	6	31	30	3	28	25	0	23
▲Emergency Medicine	2,921	753	2,702	2,840	790	2,826	2,665	683	2,652	2,488	618	2,458	2,278	457	2,265
Emergency Med-Anesthesiology	2	1	2	2	0	2	0	0	0	1	0	1	2	0	2
Emergency Med-Family Med	7	1	7	7	2	7	6	3	6	4	1	4	4	1	4
▲Family Medicine	4,916	1,494	4,451	4,823	1,440	4,472	4,662	1,392	4,313	4,107	937	3,827	3,629	671	3,510
Family Medicine-ONMM	0	0	0	0	0	0	2	2	2	1	1	1	4	4	4
Family Med-Preventive Med	2	1	2	2	0	2	3	0	2	4	1	4	3	0	3
▲Internal Medicine (Categorical)	9,380	1,602	8,915	9,024	1,482	8,632	8,697	1,389	8,324	8,116	1,140	7,892	7,542	839	7,363
Medicine-Anesthesiology	3	0	3	4	0	4	3	0	3	5	0	4	6	0	6
Medicine-Dermatology	8	1	8	8	0	7	6	0	5	7	0	7	6	0	5
Medicine-Emergency Med	31	9	31	31	10	31	30	9	30	26	4	26	26	3	26
Medicine-Family Medicine	0	0	0	0	0	0	0	0	0	0	0	0	2	0	2
Medicine-Medical Genetics	5	0	3	4	0	4	4	0	3	3	0	1	1	0	1
Medicine-Pediatrics	392	39	392	385	47	385	390	36	381	390	31	383	382	47	377
Medicine-Preliminary (PGY-1 Only)	1,774	151	1,624	1,833	177	1,639	1,911	162	1,759	1,944	163	1,796	1,883	158	1,762
Medicine-Preventive Med	8	0	8	5	0	5	7	0	7	6	0	6	6	0	6
Medicine-Primary	429	33	424	441	41	437	430	41	423	396	33	386	374	31	372
Medicine-Psychiatry	24	3	24	24	1	24	23	0	23	23	5	23	24	2	24
Interventional Radiology (Integrated)	45	3	45	41	3	38	38	5	37	37	4	37	35	1	35
Neurodevelopmental Disabilities	5	2	5	6	2	6	4	0	4	4	0	4	4	1	4
Neurological Surgery	240	9	240	234	6	234	232	3	232	232	4	231	225	3	225
▲Neurology	772	132	761	715	107	702	682	103	665	617	96	594	552	60	539
▲Obstetrics-Gynecology	1,503	242	1,499	1,460	225	1,457	1,443	221	1,440	1,395	221	1,392	1,336	152	1,330
OB/GYN-Preliminary (PGY-1 Only)	18	1	9	18	1	12	18	1	9	18	1	9	21	0	11
▲Orthopedic Surgery	875	111	875	868	107	866	849	112	844	755	13	752	742	4	738
Osteo Neuromusculoskeletal Med	16	10	13	12	2	3	10	8	8	2	0	0	2	2	2
▲Otolaryngology	361	21	361	350	16	350	350	17	348	328	13	328	315	3	303
▲Pathology	631	76	619	611	55	589	603	67	587	601	49	569	601	54	568
▲Pediatrics (Categorical)	2,942	580	2,861	2,901	519	2,860	2,864	483	2,812	2,847	477	2,778	2,768	399	2,711
Pediatrics-Anesthesiology	6	0	6	8	0	8	7	0	7	7	0	7	7	0	7
Pediatrics-Emergency Med	9	3	9	8	1	8	8	1	8	8	2	8	8	2	8
Pediatrics-Medical Genetics	30	1	28	27	2	25	22	3	20	21	2	16	20	2	18
Pediatrics-P M & R	3	0	3	2	0	2	4	2	4	4	1	3	3	0	3
Pediatrics-Preliminary	23	3	21	24	1	22	19	0	12	24	1	19	19	0	14
Pediatrics-Primary	74	9	73	75	3	74	92	11	90	90	9	89	90	3	86
Peds/Psych/Child Psych	21	1	21	21	1	21	22	1	22	21	1	21	21	3	20
▲Physical Medicine & Rehab	180	55	180	157	49	156	151	60	151	138	49	138	133	44	133
Plastic Surgery (Integrated)	194	0	194	187	2	187	180	0	180	172	1	172	168	2	167
Preventive Medicine	0	0	0	0	0	0	1	0	1	1	0	1	1	0	1
▲Psychiatry	2,047	387	2,030	1,907	332	1,904	1,858	335	1,838	1,740	315	1,720	1,556	241	1,540
Psychiatry-Family Medicine	10	0	10	12	1	12	12	2	12	12	0	12	12	0	12
Psychiatry-Neurology	4	1	3	4	2	4	2	0	2	4	0	3	4	0	3
Radiation Oncology	10	1	9	15	0	12	14	1	11	15	0	14	16	0	15
▲Radiology-Diagnostic	132	41	132	122	28	118	123	28	116	123	24	122	125	24	125
▲Surgery (Categorical)	1,622	212	1,619	1,569	228	1,564	1,536	202	1,531	1,432	124	1,432	1,319	70	1,314
▲Surgery-Preliminary (PGY-1 Only)	1,150	56	632	1,136	47	612	1,174	31	583	1,158	36	581	1,363	43	888
Thoracic Surgery	47	1	47	46	1	45	38	1	38	37	0	37	36	0	36
▲Transitional (PGY-1 Only)	1,616	338	1,404	1,497	302	1,272	1,436	260	1,230	1,252	191	1,101	1,086	92	1,016
Vascular Surgery	84	1	84	79	3	79	75	5	73	66	5	64	60	1	58
TOTAL - PGY-1	**36,277**	**6,666**	**34,075**	**35,194**	**6,327**	**33,353**	**34,266**	**5,968**	**32,399**	**32,194**	**4,825**	**30,550**	**30,232**	**3,633**	**29,040**

Table 7B Positions Offered and Number Filled by DO Seniors and All Applicants, 2018 - 2022 (Continued)

Specialty	2022			2021			2020			2019			2018		
		Filled			Filled			Filled			Filled			Filled	
	Offered	#DO	#Tot	Offered	#DO	#Tot	Offered	#DO	#Tot	Offered	#DO	#Tot	Offered	#DO	#Tot
PGY-2 Positions															
Anesthesiology	346	53	346	339	69	339	398	65	396	428	86	420	447	68	442
Child Neurology	7	3	7	8	1	6	9	1	6	11	0	9	8	0	7
Dermatology	492	38	489	477	31	471	478	35	469	447	28	444	426	12	420
Interventional Radiology (Integrated)	123	18	123	121	12	117	118	10	111	113	8	113	98	3	98
Neurodevelopmental Disabilities	3	0	3	4	0	2	3	0	1	5	0	3	4	0	2
Neurology	233	23	232	254	27	253	244	23	240	281	17	266	287	30	283
Nuclear Medicine	1	0	0	1	0	0	1	0	0	0	0	0	3	0	3
Osteo Neuromusculoskeletal Med	2	2	2	7	2	3	7	2	2	4	3	3	2	0	0
Physical Medicine & Rehab	338	127	336	327	121	325	316	120	312	308	115	305	281	77	281
Radiation Oncology	166	7	134	173	10	138	175	4	143	192	2	163	177	3	172
Radiology-Diagnostic	997	132	996	986	143	979	990	135	967	965	130	950	944	106	939
Radiology-Nuclear Med	3	1	3	2	0	2	3	0	2	2	0	2	3	0	3
TOTAL - PGY-2	**2,711**	**404**	**2,671**	**2,699**	**416**	**2,635**	**2,742**	**395**	**2,649**	**2,756**	**389**	**2,678**	**2,680**	**299**	**2,650**
Physician (R) Positions															
Anesthesiology	114	0	108	94	0	93	116	0	108	97	0	91	140	0	120
Child Neurology	15	0	8	20	0	14	25	0	12	34	0	12	26	0	12
Dermatology	22	0	21	20	0	20	29	0	29	27	0	25	21	0	20
Interventional Radiology (Integrated)	1	0	1	2	0	2	0	0	0	1	0	1	3	0	3
Neurodevelopmental Disabilities	1	0	1	2	0	2	3	0	1	4	0	1	7	0	2
Neurology	9	0	9	21	0	20	20	0	16	20	0	14	20	0	18
Nuclear Medicine	0	0	0	0	0	0	0	0	0	0	0	0	2	0	1
Osteo Neuromusculoskeletal Med	6	0	4	2	0	1	6	0	1	1	0	0	0	0	0
Physical Medicine & Rehab	14	0	13	15	0	12	13	0	13	18	0	16	7	0	7
Radiation Oncology	9	0	6	5	0	3	3	0	2	4	0	2	1	0	1
Radiology-Diagnostic	26	0	26	31	0	23	33	0	28	29	0	27	30	0	25
Radiology-Nuclear Med	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0
TOTAL - Physician (R)	**217**	**0**	**197**	**213**	**0**	**191**	**248**	**0**	**210**	**235**	**0**	**189**	**257**	**0**	**209**
GRAND TOTAL	**39,205**	**7,070**	**36,943**	**38,106**	**6,743**	**36,179**	**37,256**	**6,363**	**35,258**	**35,185**	**5,214**	**33,417**	**33,169**	**3,932**	**31,899**

Denotes increase/decrease in number of positions filled by DO seniors of more than 10 percent and 10 positions between 2018 and 2022.

Figure 5 Number of Positions Offered and Filled for Selected Specialties, * 2022



* Specialties offering at least 100 positions.

A: Advanced positions
C: Categorical positions
M: Primary care categorical positions
P: Preliminary positions
R: Physician positions

Table 8 Positions Offered and Percent Filled by MD Seniors and All Applicants, 2018 - 2022

Specialty	2022			2021			2020			2019			2018		
		Filled			Filled			Filled			Filled			Filled	
	Offered	%MD	%Tot	Offered	%MD	%Tot	Offered	%MD	%Tot	Offered	%MD	%Tot	Offered	%MD	%Tot
PGY-1 Positions															
Anesthesiology	1,509	69.8	99.9	1,460	70.1	99.8	1,370	68.3	99.9	1,337	67.8	98.4	1,253	68.7	97.8
Child Neurology	166	61.4	90.4	159	62.9	92.5	159	69.8	95.0	145	70.3	91.7	134	75.4	96.3
Dermatology	30	80.0	93.3	30	83.3	100.0	31	74.2	100.0	30	76.7	93.3	25	88.0	92.0
Emergency Medicine	2,921	54.5	92.5	2,840	62.1	99.5	2,665	64.3	99.5	2,488	65.0	98.8	2,278	70.5	99.4
Emergency Med-Anesthesiology	2	50.0	100.0	2	100.0	100.0	0	0.0	0.0	1	0.0	100.0	2	100.0	100.0
Emergency Med-Family Med	7	57.1	100.0	7	71.4	100.0	6	33.3	100.0	4	25.0	100.0	4	75.0	100.0
Family Medicine	4,916	31.3	90.5	4,823	33.3	92.7	4,662	33.1	92.5	4,107	39.0	93.2	3,629	44.9	96.7
Family Medicine-ONMM	0	0.0	0.0	0	0.0	0.0	2	0.0	100.0	1	0.0	100.0	4	0.0	100.0
Family Med-Preventive Med	2	0.0	100.0	2	50.0	100.0	3	66.7	66.7	4	75.0	100.0	3	100.0	100.0
Internal Medicine (Categorical)	9,380	37.2	95.0	9,024	39.0	95.7	8,697	40.2	95.7	8,116	41.5	97.2	7,542	42.4	97.6
Medicine-Anesthesiology	3	66.7	100.0	4	100.0	100.0	3	100.0	100.0	5	80.0	80.0	6	100.0	100.0
Medicine-Dermatology	8	87.5	100.0	8	87.5	87.5	6	83.3	83.3	7	85.7	100.0	6	83.3	83.3
Medicine-Emergency Med	31	71.0	100.0	31	61.3	100.0	30	63.3	100.0	26	76.9	100.0	26	84.6	100.0
Medicine-Family Medicine	0	0.0	0.0	0	0.0	0.0	0	0.0	0.0	0	0.0	0.0	2	100.0	100.0
Medicine-Medical Genetics	5	60.0	60.0	4	75.0	100.0	4	50.0	75.0	3	33.3	33.3	1	100.0	100.0
Medicine-Pediatrics	392	84.7	100.0	385	81.3	100.0	390	81.0	97.7	390	80.8	98.2	382	80.1	98.7
Medicine-Preliminary (PGY-1 Only)	1,774	71.1	91.5	1,833	66.0	89.4	1,911	68.7	92.0	1,944	69.8	92.4	1,883	72.8	93.6
Medicine-Preventive Med	8	62.5	100.0	5	40.0	100.0	7	57.1	100.0	6	33.3	100.0	6	66.7	100.0
Medicine-Primary	429	57.8	98.8	441	56.9	99.1	430	57.4	98.4	396	60.4	97.5	374	61.2	99.5
Medicine-Psychiatry	24	83.3	100.0	24	91.7	100.0	23	78.3	100.0	23	78.3	100.0	24	83.3	100.0
Interventional Radiology (Integrated)	45	82.2	100.0	41	73.2	92.7	38	65.8	97.4	37	81.1	100.0	35	97.1	100.0
Neurodevelopmental Disabilities	5	60.0	100.0	6	50.0	100.0	4	75.0	100.0	4	75.0	100.0	4	75.0	100.0
Neurological Surgery	240	84.2	100.0	234	84.6	100.0	232	87.5	100.0	232	91.8	99.6	225	90.2	100.0
Neurology	772	50.9	98.6	715	50.1	98.2	682	46.5	97.5	617	46.0	96.3	552	50.7	97.6
Obstetrics-Gynecology	1,503	73.6	99.7	1,460	74.5	99.8	1,443	75.5	99.8	1,395	75.2	99.8	1,336	78.7	99.6
OB/GYN-Preliminary (PGY-1 Only)	18	22.2	50.0	18	33.3	66.7	18	16.7	50.0	18	22.2	50.0	21	28.6	52.4
Orthopedic Surgery	875	80.6	100.0	868	80.5	99.8	849	80.8	99.4	755	91.8	99.6	742	93.1	99.5
Osteo Neuromusculoskeletal Med	16	0.0	81.3	12	0.0	25.0	10	0.0	80.0	2	0.0	0.0	2	0.0	100.0
Otolaryngology	361	87.5	100.0	350	88.6	100.0	350	88.6	99.4	328	93.9	100.0	315	90.2	96.2
Pathology	631	36.6	98.1	611	32.4	96.4	603	33.8	97.3	601	33.4	94.7	601	36.6	94.5
Pediatrics (Categorical)	2,942	56.5	97.2	2,901	60.3	98.6	2,864	60.4	98.2	2,847	60.2	97.6	2,768	63.1	97.9
Pediatrics-Anesthesiology	6	100.0	100.0	8	100.0	100.0	7	100.0	100.0	7	85.7	100.0	7	85.7	100.0
Pediatrics-Emergency Med	9	66.7	100.0	8	87.5	100.0	8	62.5	100.0	8	75.0	100.0	8	50.0	100.0
Pediatrics-Medical Genetics	30	60.0	93.3	27	70.4	92.6	22	59.1	90.9	21	66.7	76.2	20	70.0	90.0
Pediatrics-P M & R	3	100.0	100.0	2	100.0	100.0	4	50.0	100.0	4	50.0	75.0	3	100.0	100.0
Pediatrics-Preliminary	23	69.6	91.3	24	66.7	91.7	19	47.4	63.2	24	50.0	79.2	19	52.6	73.7
Pediatrics-Primary	74	41.9	98.6	75	52.0	98.7	92	39.1	97.8	90	40.0	98.9	90	40.0	95.6
Peds/Psych/Child Psych	21	95.2	100.0	21	90.5	100.0	22	90.9	100.0	21	95.2	100.0	21	81.0	95.2
Physical Medicine & Rehab	180	57.8	100.0	157	56.1	99.4	151	53.6	100.0	138	50.0	100.0	133	57.1	100.0
Plastic Surgery (Integrated)	194	89.2	100.0	187	89.3	100.0	180	91.7	100.0	172	91.9	100.0	168	92.9	99.4
Preventive Medicine	0	0.0	0.0	0	0.0	0.0	1	0.0	100.0	1	0.0	100.0	1	0.0	100.0
Psychiatry	2,047	61.2	99.2	1,907	63.2	99.8	1,858	61.2	98.9	1,740	60.6	98.9	1,556	63.1	99.0
Psychiatry-Family Medicine	10	100.0	100.0	12	91.7	100.0	12	83.3	100.0	12	100.0	100.0	12	100.0	100.0
Psychiatry-Neurology	4	50.0	75.0	4	25.0	100.0	2	100.0	100.0	4	75.0	75.0	4	75.0	75.0
Radiation Oncology	10	70.0	90.0	15	46.7	80.0	14	57.1	78.6	15	86.7	93.3	16	93.8	93.8
Radiology-Diagnostic	132	55.3	100.0	122	58.2	96.7	123	40.7	94.3	123*	59.3	99.2*	125	61.6	100.0
Surgery (Categorical)	1,622	65.3	99.8	1,569	65.6	99.7	1,536	67.3	99.7	1,432	73.5	100.0	1,319	76.2	99.6
Surgery-Preliminary (PGY-1 Only)	1,150	26.4	55.0	1,136	23.9	53.9	1,174	24.7	49.7	1,158	23.9	50.2	1,363	41.6	65.2
Thoracic Surgery	47	87.2	100.0	46	93.5	97.8	38	84.2	100.0	37	91.9	100.0	36	86.1	100.0
Transitional (PGY-1 Only)	1,616	56.9	86.9	1,497	56.4	85.0	1,436	57.2	85.7	1,252	62.9	87.9	1,086	71.1	93.6
Vascular Surgery	84	85.7	100.0	79	82.3	100.0	75	81.3	97.3	66	78.8	97.0	60	83.3	96.7
TOTAL - PGY-1	**36,277**	**51.0**	**93.9**	**35,194**	**52.4**	**94.8**	**34,266**	**52.8**	**94.6**	**32,194**	**55.2**	**94.9**	**30,232**	**58.7**	**96.1**

Table 8 Positions Offered and Percent Filled by MD Seniors and All Applicants, 2018 - 2022 (Continued)

Specialty	2022			2021			2020			2019			2018		
		Filled			Filled			Filled			Filled			Filled	
	Offered	%MD	%Tot	Offered	%MD	%Tot	Offered	%MD	%Tot	Offered	%MD	%Tot	Offered	%MD	%Tot
PGY-2 Positions															
Anesthesiology	346	67.1	100.0	339	62.2	100.0	398	66.6	99.5	428	57.5	98.1	447	55.0	98.9
Child Neurology	7	28.6	100.0	8	12.5	75.0	9	11.1	66.7	11	9.1	81.8	8	37.5	87.5
Dermatology	492	82.9	99.4	477	80.1	98.7	478	77.0	98.1	447	82.8	99.3	426	81.7	98.6
Interventional Radiology (Integrated)	123	80.5	100.0	121	80.2	96.7	118	79.7	94.1	113	89.4	100.0	98	94.9	100.0
Neurodevelopmental Disabilities	3	100.0	100.0	4	25.0	50.0	3	33.3	33.3	5	40.0	60.0	4	50.0	50.0
Neurology	233	70.8	99.6	254	65.7	99.6	244	60.7	98.4	281	62.3	94.7	287	66.2	98.6
Nuclear Medicine	1	0.0	0.0	1	0.0	0.0	1	0.0	0.0	0	0.0	0.0	3	0.0	100.0
Osteo Neuromusculoskeletal Med	2	0.0	100.0	7	0.0	42.9	7	0.0	28.6	4	0.0	75.0	0	0.0	0.0
Physical Medicine & Rehab	338	50.9	99.4	327	51.1	99.4	316	51.9	98.7	308	49.0	99.0	281	59.1	100.0
Radiation Oncology	166	58.4	80.7	173	54.3	79.8	175	65.1	81.7	192	76.6	84.9	177	91.5	97.2
Radiology-Diagnostic	997	71.5	99.9	986	68.0	99.3	990	66.7	97.7	965	68.9	98.4	944	72.4	99.5
Radiology-Nuclear Med	3	66.7	100.0	2	50.0	100.0	3	33.3	66.7	2	50.0	100.0	3	33.3	100.0
TOTAL - PGY-2	**2,711**	**69.8**	**98.5**	**2,699**	**66.4**	**97.6**	**2,742**	**66.2**	**96.6**	**2,756**	**67.5**	**97.2**	**2,678**	**70.7**	**99.0**
Physician (R) Positions*															
Anesthesiology	114	0.0	94.7	94	0.0	98.9	116	0.0	93.1	97	0.0	93.8	140	0.0	85.7
Child Neurology	15	0.0	53.3	20	0.0	70.0	25	0.0	48.0	34	0.0	35.3	26	0.0	46.2
Dermatology	22	0.0	95.5	20	0.0	100.0	29	0.0	100.0	27	0.0	92.6	21	0.0	95.2
Interventional Radiology (Integrated)	1	0.0	100.0	2	0.0	100.0	0	0.0	0.0	1	0.0	100.0	3	0.0	100.0
Neurodevelopmental Disabilities	1	0.0	100.0	2	0.0	100.0	3	0.0	33.3	4	0.0	25.0	7	0.0	28.6
Neurology	9	0.0	100.0	21	0.0	95.2	20	0.0	80.0	20	0.0	70.0	20	0.0	90.0
Nuclear Medicine	0	0.0	0.0	0	0.0	0.0	0	0.0	0.0	0	0.0	0.0	2	0.0	50.0
Osteo Neuromusculoskeletal Med	6	0.0	66.7	2	0.0	50.0	6	0.0	16.7	1	0.0	0.0	0	0.0	0.0
Physical Medicine & Rehab	14	0.0	92.9	15	0.0	80.0	13	0.0	100.0	18	0.0	88.9	7	0.0	100.0
Radiation Oncology	9	0.0	66.7	5	0.0	60.0	3	0.0	66.7	4	0.0	50.0	1	0.0	100.0
Radiology-Diagnostic	26	0.0	100.0	31	0.0	74.2	33	0.0	84.8	29	0.0	93.1	30	0.0	83.3
Radiology-Nuclear Med	0	0.0	0.0	1	0.0	100.0	0	0.0	0.0	0	0.0	0.0	0	0.0	0.0
TOTAL - Physician (R)	**217**	**0.0**	**90.8**	**213**	**0.0**	**89.7**	**248**	**0.0**	**84.7**	**235**	**0.0**	**80.4**	**257**	**0.0**	**81.3**
GRAND TOTAL	**39,205**	**52.0**	**94.2**	**38,106**	**53.1**	**94.9**	**37,256**	**53.5**	**94.6**	**35,185**	**55.8**	**95.0**	**33,167**	**59.2**	**96.2**

* Physician (R) positions are PGY-2 positions starting in the year of the Match that are reserved for applicants who have had prior graduate medical education. Physician positions are not available to senior medical students. In previous *Results and Data Books*, the numbers of R positions were small, and they were included in the categorical position counts. In 2014, NRMP began listing R positions separately.

Tables 9-12

Tables 9 through 12 display the numbers of PGY-1 matches in each specialty and their proportions among all specialties for four different applicant groups: all applicants (Table 9), U.S. MD seniors (Table 10), U.S. DO seniors (Table 11), and foreign-trained physicians (Table 12). Foreign-trained physicians are U.S. citizen and non-U.S. citizen students and graduates of international medical schools, excluding Canadian and Fifth Pathway applicants. Specialties that placed at least 10 positions in the Match and showed an increase or decrease in the numbers of matched applicants of greater than 10 percent between 2018 and 2022 are highlighted with arrows.

Between 2018 and 2022, the proportions of matched applicants among all PGY-1 specialties were relatively stable for all applicant groups with some notable trends:

The proportions of U.S. MD seniors matching in Psychiatry (6.8 percent), Anesthesiology (5.7 percent), and Neurology (2.1 percent) have increased modestly but consistently over the past five years (Table 10). In contrast, the proportions of U.S. MD seniors matching in Pediatrics (Categorical) (9.0 percent), Emergency Medicine (8.6 percent) and Family Medicine (8.3 percent) have generally declined over the same period. The proportion of U.S. MD seniors matching in Preliminary Surgery (1.6 percent) was half of that reported in 2018, a likely result, in part, of the fact that U.S. MD seniors who match to Urology no longer use the Main Residency Match to obtain their Preliminary Surgery training.

As a result of the transition to a single accreditation system, the number of U.S. DO seniors in the Match has grown considerably, and every year more U.S. DO seniors match in most specialties (see Table 11). In 2022, the total number of matched U.S. DO seniors was 6,664; compared to 2021, the number matched increased by 337 (5.3 percent). Between 2018 and 2022, the match rate for U.S. DO seniors in Internal Medicine has consistently remained high, fluctuating between 23.1 percent and 24.0 percent. In 2022, the number of U.S. DO seniors in Family Medicine programs was 1,494, 823 (122.7 percent) more than 2018.

Historically, positions obtained by foreign-trained physicians (IMGs) have been concentrated in a few specialties. In 2022, 70.1 percent of matched IMGs obtained positions in Internal Medicine (categorical), Family Medicine, and Pediatrics (categorical) (Table 12).

Table 9 All Applicants Matched to PGY-1 Positions by Specialty, 2018 - 2022

	2022		2021		2020		2019		2018	
Specialty	No.	%	No.	%	No.	%	No.	%	No.	%
▲ Anesthesiology	1,508	4.4	1,457	4.4	1,369	4.2	1,316	4.3	1,226	4.2
▲ Child Neurology	150	0.4	147	0.4	151	0.5	133	0.4	129	0.4
Dermatology	28	0.1	30	0.1	31	0.1	28	0.1	23	0.1
▲ Emergency Medicine	2,702	7.9	2,826	8.5	2,652	8.2	2,458	8.0	2,265	7.8
Emergency Med-Anesthesiology	2	0.0	2	0.0	0	0.0	1	0.0	2	0.0
Emergency Med-Family Med	7	0.0	7	0.0	6	0.0	4	0.0	4	0.0
▲ Family Medicine	4,451	13.1	4,472	13.4	4,313	13.3	3,827	12.5	3,510	12.1
Family Medicine-ONMM	0	0.0	0	0.0	2	0.0	1	0.0	4	0.0
Family Med-Preventive Med	2	0.0	2	0.0	2	0.0	4	0.0	3	0.0
▲ Internal Medicine (Categorical)	8,915	26.2	8,632	25.9	8,324	25.7	7,892	25.8	7,363	25.4
Medicine-Anesthesiology	3	0.0	4	0.0	3	0.0	4	0.0	6	0.0
Medicine-Dermatology	8	0.0	7	0.0	5	0.0	7	0.0	5	0.0
Medicine-Emergency Med	31	0.1	31	0.1	30	0.1	26	0.1	26	0.1
Medicine-Family Medicine	0	0.0	0	0.0	0	0.0	0	0.0	2	0.0
Medicine-Medical Genetics	3	0.0	4	0.0	3	0.0	1	0.0	1	0.0
Medicine-Pediatrics	392	1.2	385	1.2	381	1.2	383	1.3	377	1.3
Medicine-Preliminary (PGY-1 Only)	1,624	4.8	1,639	4.9	1,759	5.4	1,796	5.9	1,762	6.1
Medicine-Preventive Med	8	0.0	5	0.0	7	0.0	6	0.0	6	0.0
▲ Medicine-Primary	424	1.2	437	1.3	423	1.3	386	1.3	372	1.3
Medicine-Psychiatry	24	0.1	24	0.1	23	0.1	23	0.1	24	0.1
▲ nterventional Radiology (Integrated)	45	0.1	38	0.1	37	0.1	37	0.1	35	0.1
Neurodevelopmental Disabilities	5	0.0	6	0.0	4	0.0	4	0.0	4	0.0
Neurological Surgery	240	0.7	234	0.7	232	0.7	231	0.8	225	0.8
▲ Neurology	761	2.2	702	2.1	665	2.1	594	1.9	539	1.9
▲ Obstetrics-Gynecology	1,499	4.4	1,457	4.4	1,440	4.4	1,392	4.6	1,330	4.6
OB/GYN-Preliminary (PGY-1 Only)	9	0.0	12	0.0	9	0.0	9	0.0	11	0.0
▲ Orthopedic Surgery	875	2.6	866	2.6	844	2.6	752	2.5	738	2.5
▲ Osteo Neuromusculoskeletal Med	13	0.0	3	0.0	8	0.0	0	0.0	2	0.0
▲ Otolaryngology	361	1.1	350	1.0	348	1.1	328	1.1	303	1.0
Pathology	619	1.8	589	1.8	587	1.8	569	1.9	568	2.0
Pediatrics (Categorical)	2,861	8.4	2,860	8.6	2,812	8.7	2,778	9.1	2,711	9.3
Pediatrics-Anesthesiology	6	0.0	8	0.0	7	0.0	7	0.0	7	0.0
Pediatrics-Emergency Med	9	0.0	8	0.0	8	0.0	8	0.0	8	0.0
▲ Pediatrics-Medical Genetics	28	0.1	25	0.1	20	0.1	16	0.1	18	0.1
Pediatrics-P M & R	3	0.0	2	0.0	4	0.0	3	0.0	3	0.0
Pediatrics-Preliminary	21	0.1	22	0.1	12	0.0	19	0.1	14	0.0
▼ Pediatrics-Primary	73	0.2	74	0.2	90	0.3	89	0.3	86	0.3
Peds/Psych/Child Psych	21	0.1	21	0.1	22	0.1	21	0.1	20	0.1
▲ Physical Medicine & Rehab	180	0.5	156	0.5	151	0.5	138	0.5	133	0.5
▲ Plastic Surgery (Integrated)	194	0.6	187	0.6	180	0.6	172	0.6	167	0.6
Preventive Medicine	0	0.0	0	0.0	1	0.0	1	0.0	1	0.0
▲ Psychiatry	2,030	6.0	1,904	5.7	1,838	5.7	1,720	5.6	1,540	5.3
Psychiatry-Family Medicine	10	0.0	12	0.0	12	0.0	12	0.0	12	0.0
Psychiatry-Neurology	3	0.0	4	0.0	2	0.0	3	0.0	3	0.0
Radiation Oncology	9	0.0	12	0.0	11	0.0	14	0.0	15	0.1
Radiology-Diagnostic	132	0.4	118	0.4	116	0.4	122	0.4	125	0.4
▲ Surgery (Categorical)	1,619	4.8	1,564	4.7	1,531	4.7	1,432	4.7	1,314	4.5
▼ Surgery-Preliminary (PGY-1 Only)	632	1.9	612	1.8	583	1.8	581	1.9	888	3.1
▲ Thoracic Surgery	47	0.1	45	0.1	38	0.1	37	0.1	36	0.1
▲ Transitional (PGY-1 Only)	1,404	4.1	1,272	3.8	1,230	3.8	1,101	3.6	1,016	3.5
▲ Vascular Surgery	84	0.2	79	0.2	73	0.2	64	0.2	58	0.2
TOTAL - PGY-1	**34,075**	**100**	**33,353**	**100**	**32,399**	**100**	**30,550**	**100**	**29,040**	**100**

▲▼Denotes increase/decrease in number of filled positions of more than 10 percent and 10 positions between 2018 and 2022.

Table 10 U.S. MD Seniors Matched to PGY-1 Positions by Specialty, 2018 - 2022

	Specialty	2022		2021		2020		2019		2018	
		No.	%	No.	%	No.	%	No.	%	No.	%
▲	Anesthesiology	1,054	5.7	1,024	5.6	936	5.2	907	5.1	861	4.9
	Child Neurology	102	0.6	100	0.5	111	0.6	102	0.6	101	0.6
	Dermatology	24	0.1	25	0.1	23	0.1	23	0.1	22	0.1
	Emergency Medicine	1,593	8.6	1,765	9.6	1,713	9.5	1,617	9.1	1,606	9.1
	Emergency Med-Anesthesiology	1	0.0	2	0.0	0	0.0	0	0.0	2	0.0
	Emergency Med-Family Med	4	0.0	5	0.0	2	0.0	1	0.0	3	0.0
	Family Medicine	1,541	8.3	1,606	8.7	1,543	8.5	1,601	9.0	1,628	9.2
	Family Med-Preventive Med	0	0.0	1	0.0	2	0.0	3	0.0	3	0.0
	Internal Medicine (Categorical)	3,491	18.9	3,523	19.1	3,496	19.3	3,366	18.9	3,195	18.0
	Medicine-Anesthesiology	2	0.0	4	0.0	3	0.0	4	0.0	6	0.0
	Medicine-Dermatology	7	0.0	7	0.0	5	0.0	6	0.0	5	0.0
	Medicine-Emergency Med	22	0.1	19	0.1	19	0.1	20	0.1	22	0.1
	Medicine-Family Medicine	0	0.0	0	0.0	0	0.0	0	0.0	2	0.0
	Medicine-Medical Genetics	3	0.0	3	0.0	2	0.0	1	0.0	1	0.0
	Medicine-Pediatrics	332	1.8	313	1.7	316	1.7	315	1.8	306	1.7
	Medicine-Preliminary (PGY-1 Only)	1,261	6.8	1,210	6.6	1,313	7.3	1,356	7.6	1,370	7.7
	Medicine-Preventive Med	5	0.0	2	0.0	4	0.0	2	0.0	4	0.0
	Medicine-Primary	248	1.3	251	1.4	247	1.4	239	1.3	229	1.3
	Medicine-Psychiatry	20	0.1	22	0.1	18	0.1	18	0.1	20	0.1
	Interventional Radiology (Integrated)	37	0.2	30	0.2	25	0.1	30	0.2	34	0.2
	Neurodevelopmental Disabilities	3	0.0	3	0.0	3	0.0	3	0.0	3	0.0
	Neurological Surgery	202	1.1	198	1.1	203	1.1	213	1.2	203	1.1
▲	Neurology	393	2.1	358	1.9	317	1.8	284	1.6	280	1.6
	Obstetrics-Gynecology	1,106	6.0	1,088	5.9	1,089	6.0	1,049	5.9	1,051	5.9
	OB/GYN-Preliminary (PGY-1 Only)	4	0.0	6	0.0	3	0.0	4	0.0	6	0.0
	Orthopedic Surgery	705	3.8	699	3.8	686	3.8	693	3.9	691	3.9
▲	Otolaryngology	316	1.7	310	1.7	310	1.7	308	1.7	284	1.6
	Pathology	231	1.2	198	1.1	204	1.1	201	1.1	220	1.2
	Pediatrics (Categorical)	1,661	9.0	1,749	9.5	1,731	9.6	1,715	9.7	1,746	9.8
	Pediatrics-Anesthesiology	6	0.0	8	0.0	7	0.0	6	0.0	6	0.0
	Pediatrics-Emergency Med	6	0.0	7	0.0	5	0.0	6	0.0	4	0.0
	Pediatrics-Medical Genetics	18	0.1	19	0.1	13	0.1	14	0.1	14	0.1
	Pediatrics-P M & R	3	0.0	2	0.0	2	0.0	2	0.0	3	0.0
	Pediatrics-Preliminary	16	0.1	16	0.1	9	0.0	12	0.1	10	0.1
	Pediatrics-Primary	31	0.2	39	0.2	36	0.2	36	0.2	36	0.2
	Peds/Psych/Child Psych	20	0.1	19	0.1	20	0.1	20	0.1	17	0.1
▲	Physical Medicine & Rehab	104	0.6	88	0.5	81	0.4	69	0.4	76	0.4
▲	Plastic Surgery (Integrated)	173	0.9	167	0.9	165	0.9	158	0.9	156	0.9
▲	Psychiatry	1,253	6.8	1,205	6.5	1,138	6.3	1,054	5.9	982	5.5
	Psychiatry-Family Medicine	10	0.1	11	0.1	10	0.1	12	0.1	12	0.1
	Psychiatry-Neurology	2	0.0	1	0.0	2	0.0	3	0.0	3	0.0
	Radiation Oncology	7	0.0	7	0.0	8	0.0	13	0.1	15	0.1
	Radiology-Diagnostic	73	0.4	71	0.4	50	0.3	73	0.4	77	0.4
	Surgery (Categorical)	1,059	5.7	1,029	5.6	1,033	5.7	1,053	5.9	1,005	5.7
▼	Surgery-Preliminary (PGY-1 Only)	304	1.6	272	1.5	290	1.6	277	1.6	567	3.2
▲	Thoracic Surgery	41	0.2	43	0.2	32	0.2	34	0.2	31	0.2
▲	Transitional (PGY-1 Only)	920	5.0	845	4.6	822	4.5	788	4.4	772	4.4
▲	Vascular Surgery	72	0.4	65	0.4	61	0.3	52	0.3	50	0.3
	TOTAL - PGY-1	**18,486**	**100**	**18,435**	**100**	**18,108**	**100**	**17,763**	**100**	**17,740**	**100**

▲▼ Denotes increase/decrease in matched U.S. MD seniors of more than 10 percent and 10 positions between 2018 and 2022.

Table 11 U.S. DO Seniors Matched to PGY-1 Positions by Specialty, 2018 - 2022

Specialty	2022		2021		2020		2019		2018	
	No.	%	No.	%	No.	%	No.	%	No.	%
▲ Anesthesiology	263	3.9	268	4.2	262	4.4	243	5.0	203	5.6
Child Neurology	15	0.2	18	0.3	20	0.3	6	0.1	11	0.3
Dermatology	3	0.0	5	0.1	6	0.1	3	0.1	0	0.0
▲ Emergency Medicine	753	11.3	790	12.5	683	11.4	618	12.8	457	12.6
Emergency Med-Family Med	1	0.0	2	0.0	3	0.1	1	0.0	1	0.0
▲ Family Medicine	1,494	22.4	1,440	22.8	1,392	23.3	937	19.4	671	18.5
Family Medicine-ONMM	0	0.0	0	0.0	2	0.0	1	0.0	4	0.1
Family Med-Preventive Med	1	0.0	0	0.0	0	0.0	1	0.0	0	0.0
▲ Internal Medicine (Categorical)	1,602	24.0	1,482	23.4	1,389	23.3	1,140	23.6	839	23.1
Medicine-Emergency Med	9	0.1	10	0.2	9	0.2	4	0.1	3	0.1
Medicine-Pediatrics	39	0.6	47	0.7	36	0.6	31	0.6	47	1.3
Medicine-Preliminary (PGY-1 Only)	151	2.3	177	2.8	162	2.7	163	3.4	158	4.4
Medicine-Primary	33	0.5	41	0.6	41	0.7	33	0.7	31	0.9
Medicine-Psychiatry	3	0.0	1	0.0	0	0.0	5	0.1	2	0.1
Interventional Radiology (Integrated)	3	0.0	3	0.0	5	0.1	4	0.1	1	0.0
Neurodevelopmental Disabilities	2	0.0	2	0.0	0	0.0	0	0.0	1	0.0
Neurological Surgery	9	0.1	6	0.1	3	0.1	4	0.1	3	0.1
▲ Neurology	132	2.0	107	1.7	103	1.7	96	2.0	60	1.7
▲ Obstetrics-Gynecology	242	3.6	225	3.6	221	3.7	221	4.6	152	4.2
OB/GYN-Preliminary (PGY-1 Only)	1	0.0	1	0.0	1	0.0	1	0.0	0	0.0
▲ Orthopedic Surgery	111	1.7	107	1.7	112	1.9	13	0.3	4	0.1
Osteo Neuromusculoskeletal Med	10	0.2	2	0.0	8	0.1	0	0.0	2	0.1
▲ Otolaryngology	21	0.3	16	0.3	17	0.3	13	0.3	3	0.1
▲ Pathology	76	1.1	55	0.9	67	1.1	49	1.0	54	1.5
▲ Pediatrics (Categorical)	580	8.7	519	8.2	483	8.1	477	9.9	399	11.0
Pediatrics-Anesthesiology	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Pediatrics-Emergency Med	3	0.0	1	0.0	1	0.0	2	0.0	2	0.1
Pediatrics-Medical Genetics	1	0.0	2	0.0	3	0.1	2	0.0	2	0.1
Pediatrics-P M & R	0	0.0	0	0.0	2	0.0	1	0.0	0	0.0
Pediatrics-Preliminary	3	0.0	1	0.0	0	0.0	1	0.0	0	0.0
Pediatrics-Primary	9	0.1	3	0.0	11	0.2	9	0.2	3	0.1
Peds/Psych/Child Psych	1	0.0	1	0.0	1	0.0	1	0.0	3	0.1
▲ Physical Medicine & Rehab	55	0.8	49	0.8	60	1.0	49	1.0	41	1.1
Plastic Surgery (Integrated)	0	0.0	2	0.0	0	0.0	1	0.0	2	0.1
▲ Psychiatry	387	5.8	332	5.2	335	5.6	315	6.5	241	6.6
Psychiatry-Family Medicine	0	0.0	1	0.0	2	0.0	0	0.0	0	0.0
Psychiatry-Neurology	1	0.0	2	0.0	0	0.0	0	0.0	0	0.0
Radiation Oncology	1	0.0	0	0.0	1	0.0	0	0.0	0	0.0
▲ Radiology-Diagnostic	41	0.6	28	0.4	28	0.5	24	0.5	24	0.7
▲ Surgery (Categorical)	212	3.2	228	3.6	202	3.4	124	2.6	70	1.9
▲ Surgery-Preliminary (PGY-1 Only)	56	0.8	47	0.7	31	0.5	36	0.7	43	1.2
Thoracic Surgery	1	0.0	1	0.0	1	0.0	0	0.0	0	0.0
▲ Transitional (PGY-1 Only)	338	5.1	302	4.8	260	4.4	191	4.0	92	2.5
Vascular Surgery	1	0.0	3	0.0	5	0.1	5	0.1	1	0.0
TOTAL - PGY-1	**6,664**	**100**	**6,327**	**100**	**5,968**	**100**	**4,825**	**100**	**3,630**	**100**

▲▼ Denotes increase/decrease in matched DO seniors of more than 10 percent and 10 positions between 2018 and 2022.

Table 12 Foreign-Trained Physicians* Matched to PGY-1 Positions by Specialty, 2018 - 2022

	Specialty	2022		2021		2020		2019		2018	
		No.	%	No.	%	No.	%	No.	%	No.	%
	Anesthesiology	118	1.5	116	1.5	136	1.8	139	2.0	126	1.8
▲	Child Neurology	30	0.4	28	0.4	17	0.2	22	0.3	17	0.2
	Dermatology	1	0.0	0	0.0	2	0.0	2	0.0	1	0.0
▲	Emergency Medicine	221	2.9	178	2.4	185	2.5	139	2.0	109	1.6
	Emergency Med-Anesthesiology	0	0.0	0	0.0	0	0.0	1	0.0	0	0.0
	Emergency Med-Family Med	2	0.0	0	0.0	1	0.0	2	0.0	0	0.0
▲	Family Medicine	1,234	16.1	1224	16.3	1,192	16.2	1,113	15.8	1,065	15.5
	Family Med-Preventive Med	1	0.0	1	0.0	0	0.0	0	0.0	0	0.0
▲	Internal Medicine (Categorical)	3,568	46.5	3416	45.5	3,239	43.9	3,203	45.6	3,183	46.4
	Medicine-Emergency Med	0	0.0	2	0.0	0	0.0	2	0.0	1	0.0
	Medicine-Medical Genetics	0	0.0	1	0.0	0	0.0	0	0.0	0	0.0
	Medicine-Pediatrics	19	0.2	23	0.3	24	0.3	33	0.5	22	0.3
▼	Medicine-Preliminary (PGY-1 Only)	191	2.5	230	3.1	263	3.6	254	3.6	217	3.2
	Medicine-Preventive Med	3	0.0	3	0.0	3	0.0	4	0.1	2	0.0
▲	Medicine-Primary	139	1.8	138	1.8	126	1.7	107	1.5	105	1.5
	Medicine-Psychiatry	1	0.0	1	0.0	4	0.1	0	0.0	2	0.0
	Interventional Radiology (Integrated)	3	0.0	3	0.0	6	0.1	0	0.0	0	0.0
	Neurodevelopmental Disabilities	0	0.0	1	0.0	1	0.0	1	0.0	0	0.0
	Neurological Surgery	18	0.2	17	0.2	18	0.2	8	0.1	10	0.1
▲	Neurology	227	3.0	226	3.0	238	3.2	205	2.9	189	2.8
▼	Obstetrics-Gynecology	82	1.1	88	1.2	94	1.3	84	1.2	104	1.5
	OB/GYN-Preliminary (PGY-1 Only)	3	0.0	5	0.1	5	0.1	3	0.0	5	0.1
	Orthopedic Surgery	19	0.2	8	0.1	12	0.2	10	0.1	13	0.2
	Otolaryngology	4	0.1	6	0.1	5	0.1	7	0.1	10	0.1
	Pathology	274	3.6	301	4.0	286	3.9	280	4.0	257	3.7
	Pediatrics (Categorical)	574	7.5	552	7.4	562	7.6	527	7.5	533	7.8
	Pediatrics-Anesthesiology	0	0.0	0	0.0	0	0.0	0	0.0	1	0.0
	Pediatrics-Emergency Med	0	0.0	0	0.0	2	0.0	0	0.0	1	0.0
	Pediatrics-Medical Genetics	9	0.1	4	0.1	4	0.1	0	0.0	2	0.0
	Pediatrics-Preliminary	2	0.0	5	0.1	3	0.0	4	0.1	3	0.0
▼	Pediatrics-Primary	32	0.4	32	0.4	43	0.6	44	0.6	46	0.7
	Peds/Psych/Child Psych	0	0.0	1	0.0	1	0.0	0	0.0	0	0.0
	Physical Medicine & Rehab	16	0.2	15	0.2	9	0.1	14	0.2	12	0.2
	Plastic Surgery (Integrated)	11	0.1	8	0.1	9	0.1	4	0.1	4	0.1
	Preventive Medicine	0	0.0	0	0.0	1	0.0	1	0.0	1	0.0
▲	Psychiatry	321	4.2	309	4.1	293	4.0	279	4.0	264	3.8
	Psychiatry-Family Medicine	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
	Psychiatry-Neurology	0	0.0	1	0.0	0	0.0	0	0.0	0	0.0
	Radiation Oncology	1	0.0	5	0.1	2	0.0	1	0.0	0	0.0
	Radiology-Diagnostic	13	0.2	16	0.2	34	0.5	22	0.3	20	0.3
▲	Surgery (Categorical)	161	2.1	156	2.1	178	2.4	152	2.2	140	2.0
	Surgery-Preliminary (PGY-1 Only)	235	3.1	269	3.6	242	3.3	248	3.5	255	3.7
	Thoracic Surgery	5	0.1	1	0.0	4	0.1	2	0.0	4	0.1
	Transitional (PGY-1 Only)	124	1.6	109	1.5	128	1.7	102	1.5	134	2.0
	Vascular Surgery	7	0.1	9	0.1	4	0.1	6	0.1	4	0.1
	TOTAL - PGY-1	**7,669**	**100**	**7508**	**100**	**7,376**	**100**	**7,025**	**100**	**6,862**	**100**

▲▼ Denotes increase/decrease in matched foreign-trained physicians of more than 10 percent and 10 positions between 2018 and 2022.

* Foreign-trained physicians include both U.S. citizen and non-U.S. citizen graduates of international medical schools.

Table 13

Table 13A and 13B display the numbers of applicants who ranked each specialty as their only choice, first choice, or not first choice: Only choice includes applicants who ranked that specialty first on their rank order lists (ROLs) and ranked no other specialties. First choice includes applicants who ranked that specialty first and ranked at least one other specialty. Not first choice includes applicants who ranked another specialty first but also included that specialty on their ROL. Preferred choice is defined as first choice ignoring any subsequent choices (only choice and first choice combined). Data on U.S. MD and DO seniors are listed in Table 13A and the same categories are listed in Table 13B for U.S. IMGs and non-U.S. IMGs.

Transitional Year programs are excluded from the counts because they are not considered a preference for a specific specialty. PGY-1 and PGY-2 (including physician R) programs are combined. Internal Medicine and Pediatrics include categorical and primary positions. Preliminary programs are separated from categorical programs for Internal Medicine, Obstetrics and Gynecology, Pediatrics, and General Surgery.

Table 13A and 13B also show the ratio of the number of positions in a specialty to the number of applicants choosing a specialty as their preferred choice.

Using Anesthesiology on Table 13A as an example:

- Combining categorical, advanced, and physician positions, Anesthesiology offered 1,969 positions in total.

- A total of 1,492 U.S. MD seniors ranked at least one Anesthesiology program (sum of 954 “only choice,” 461 “first choice,” and 77 “not first choice”). Anesthesiology was the “preferred choice” for 1,415 U.S. seniors (sum of 954 “only choice” and 461 “first choice”). With 1,969 positions offered, the ratio of positions to U.S. MD senior applicants who ranked Anesthesiology as the “preferred” choice was 1.4 to 1.

- Similarly, 511 U.S. DO senior applicants ranked at least one Anesthesiology program (sum of 175 “only choice,” 299 “first choice,” and 37 “not first choice”). Anesthesiology was the “preferred choice” for 474 U.S. DO seniors (sum of 175 “only choice” and 299 “first choice”). With 1,969 positions offered, the ratio of positions to U.S. DO senior applicants who ranked Anesthesiology as the “preferred” choice was 4.2 to 1.

- Lastly, for the 1,889 total applicants who preferred Anesthesiology (combining MD seniors and DO seniors), the ratio of positions per applicant was 1.0.

Table 13 A U.S. MD Seniors and U.S. DO Seniors Choices by Specialty, 2022

Specialty	U.S. MD Seniors					U.S. DO Seniors				Positions per All MD/DO Senior Applicants
		Preferred Choice			Positions per MD Senior	Preferred Choice			Positions per DO Senior	
	Total Positions	Only Choice	First Choice	Not First Choice		Only Choice	First Choice	Not First Choice		
Anesthesiology	1,969	954	461	77	1.4	175	299	37	4.2	1.0
Child Neurology	188	77	27	14	1.8	12	7	11	9.9	1.5
Dermatology	544	133	462	19	0.9	14	62	11	7.2	0.8
Emergency Medicine	2,921	1,470	124	101	1.8	630	144	76	3.8	1.2
Family Medicine	4,916	1,409	91	289	3.3	1,271	136	606	3.5	1.7
Internal Medicine	9,809	3,491	198	443	2.7	1,353	243	435	6.1	1.9
Internal Medicine (Prelim)	1,774	214	18	1,196	7.6	4	6	313	177.4	7.3
Internal Medicine/Emergency Medicine	31	0	36	36	0.9	0	14	17	2.2	0.6
Internal Medicine/Pediatrics	392	247	116	40	1.1	18	32	19	7.8	0.9
Internal Medicine/Psychiatry	24	1	34	28	0.7	0	3	8	8.0	0.6
Interventional Radiology	169	4	157	40	1.0	0	34	25	5.0	0.9
Neurological Surgery	240	240	32	3	0.9	9	12	3	11.4	0.8
Neurology	1,014	501	61	31	1.8	115	48	25	6.2	1.4
Obstetrics and Gynecology	1,503	1,123	192	43	1.1	250	121	25	4.1	0.9
Orthopaedic Surgery	875	939	129	18	0.8	147	50	8	4.4	0.7
Osteopathic Neuromusculoskeletal Medicine	24	0	0	0	0.0	3	7	6	2.4	2.4
Otolaryngology	361	375	80	8	0.8	7	28	6	10.3	0.7
Pathology-Anatomic and Clinical	631	215	15	18	2.7	75	6	8	7.8	2.0
Pediatrics	3,016	1,626	56	191	1.8	511	74	97	5.2	1.3
Pediatrics (Prelim)	23	0	0	20	0.0	0	0	3	0.0	0.0
Pediatrics/Medical Genetics	30	3	15	5	1.7	0	1	0	30.0	1.6
Pediatrics/Psychiatry/Child and Adolescent Psychiatry	21	0	33	18	0.6	0	3	7	7.0	0.6
Physical Medicine and Rehabilitation	532	202	108	26	1.7	137	138	35	1.9	0.9
Plastic Surgery	194	173	103	5	0.7	1	5	4	32.3	0.7
Psychiatry	2,047	1,183	146	108	1.5	299	136	59	4.7	1.2
Radiation Oncology	185	81	23	7	1.8	3	4	3	26.4	1.7
Radiology-Diagnostic	1,155	502	409	199	1.3	89	164	47	4.6	1.0
Surgery-General	1,622	889	317	261	1.3	202	123	72	5.0	1.1
Surgery-General (Prelim)	1,150	75	6	525	14.2	8	4	147	95.8	12.4
Thoracic Surgery	47	1	62	13	0.7	0	2	2	23.5	0.7
Vascular Surgery	84	50	45	5	0.9	2	11	3	6.5	0.8
TOTAL *	**39,205**	**16,234**	**3,667**	**4,924**		**5,353**	**1,949**	**2,644**		

Only choice includes applicants who ranked that specialty first on their rank order lists (ROLs) and ranked no other specialties. **First choice** includes applicants who ranked that specialty first and ranked at least one other specialty on their ROLs. **Not first choice** includes applicants who ranked another specialty first but also included that specialty on their ROLs. **Preferred choice** is defined as either only choice or first choice. Transitional Year programs were excluded from these counts because they are not considered a preference for a specific specialty.

Total Positions: includes all positions (categorical, advanced, primary care categorical, and physician) except preliminary positions offered in a specialty. Preliminary positions are reported separately.

Positions Per MD Senior: is the ratio of Total Positions to the number of MD seniors for whom that specialty was the first or only choice.
Positions Per DO Senior: is the ratio of Total Positions to the number of DO seniors for whom that specialty was the first or only choice.
Positions Per All Senior Applicants: is the ratio of Total Positions to the number of MD seniors and DO seniors for whom that specialty was the first or only choice.

Note: Specialties with fewer than 20 total positions are not displayed on this table.

* The **TOTAL** row includes all positions in all specialties.

Table 13 B U.S. IMG and Non-U.S. IMG Choices by Specialty, 2022

Specialty	Total Positions	Non- U.S. IMG Preferred Choice Only Choice	Non- U.S. IMG Preferred Choice First Choice	Non- U.S. IMG Not First Choice	Non- U.S. IMG Positions per Non-U.S. IMG	U.S. IMG Preferred Choice Only Choice	U.S. IMG Preferred Choice First Choice	U.S. IMG Not First Choice	U.S. IMG Positions per U.S. IMG	Positions per All IMG Applicants
Anesthesiology	1,969	96	90	26	10.6	77	106	30	10.8	5.3
Child Neurology	188	14	16	29	6.3	8	8	6	11.8	4.1
Dermatology	544	16	9	2	21.8	17	8	4	21.8	10.9
Emergency Medicine	2,921	34	29	18	46.4	113	102	40	13.6	10.5
Family Medicine	4,916	564	227	548	6.2	800	294	739	4.5	2.6
Internal Medicine	9,809	3,233	967	625	2.3	1,160	649	593	5.4	1.6
Internal Medicine (Prelim)	1,774	25	22	444	37.7	12	21	280	53.8	22.2
Internal Medicine/Emergency Medicine	31	0	2	1	15.5	0	3	4	10.3	6.2
Internal Medicine/Pediatrics	392	6	15	53	18.7	5	13	10	21.8	10.1
Internal Medicine/Psychiatry	24	1	2	8	8.0	1	2	5	8.0	4.0
Interventional Radiology	169	1	13	11	12.1	0	7	7	24.1	8.0
Neurological Surgery	240	28	14	1	5.7	6	3	2	26.7	4.7
Neurology	1,014	221	150	166	2.7	65	57	44	8.3	2.1
Obstetrics and Gynecology	1,503	59	60	21	12.6	54	71	22	12.0	6.2
Orthopaedic Surgery	875	17	3	0	43.8	19	12	1	28.2	17.2
Osteopathic Neuromusculoskeletal Medicine	24	0	0	0	0.0	1	0	0	24.0	24.0
Otolaryngology	361	7	5	0	30.1	2	2	1	90.3	22.6
Pathology-Anatomic and Clinical	631	305	30	80	1.9	100	34	43	4.7	1.3
Pediatrics	3,016	405	133	279	5.6	211	79	114	10.4	3.6
Pediatrics (Prelim)	23	0	3	9	7.7	0	0	2	0.0	7.7
Pediatrics/Medical Genetics	30	2	8	9	3.0	0	4	0	7.5	2.1
Pediatrics/Psychiatry/Child and Adolescent Psychiatry	21	0	0	0	0.0	0	1	0	21.0	21.0
Physical Medicine and Rehabilitation	532	16	17	13	16.1	18	25	14	12.4	7.0
Plastic Surgery	194	6	11	1	11.4	6	7	0	14.9	6.5
Psychiatry	2,047	223	58	70	7.3	245	145	81	5.2	3.1
Radiation Oncology	185	16	8	8	7.7	9	3	4	15.4	5.1
Radiology-Diagnostic	1,155	55	104	35	7.3	30	56	19	13.4	4.7
Surgery-General	1,622	110	181	121	5.6	96	148	81	6.6	3.0
Surgery-General (Prelim)	1,150	66	61	288	9.1	12	24	187	31.9	7.1
Thoracic Surgery	47	4	12	4	2.9	0	4	1	11.8	2.4
Vascular Surgery	84	5	15	6	4.2	0	5	5	16.8	3.4
TOTAL *	**39,205**	**5,570**	**2,292**	**3,117**		**3,117**	**1,929**	**2,587**		

Only choice includes applicants who ranked that specialty first on their rank order lists (ROLs) and ranked no other specialties. **First choice** includes applicants who ranked that specialty first and ranked at least one other specialty on their ROLs. **Not first choice** includes applicants who ranked another specialty first but also included that specialty on their ROLs. **Preferred choice** is defined as either only choice or first choice. Transitional Year programs were excluded from these counts because they are not considered a preference for a specific specialty.

Total Positions: includes all positions (categorical, advanced, primary care categorical, and physician) except preliminary positions offered in a specialty. Preliminary positions are reported separately.

Positions Per Non-U.S. IMG: is the ratio of Total Positions to the number of Non-U.S. IMG for whom that specialty was the first or only choice.
Positions Per U.S. IMG: is the ratio of Total Positions to the number of U.S. IMG for whom that specialty was the first or only choice.
Positions Per All IMG Applicants: is the ratio of Total Positions to the number of Non-U.S. IMG and U.S. IMG for whom that specialty was the first or only choice.

Note: Specialties with fewer than 20 total positions are not displayed on this table.

***** The **TOTAL** row includes all positions in all specialties.

Table 14

Tables 14A and 14B present data on applicants who ranked each specialty as their only choice in the 2022 Match. Table 14A, reflects outcomes for U.S. MD and DO seniors, and the same categories are presented in Table 14B for U.S. IMGs and non-U.S. IMGs. Prior to 2012, Table 14 and Figure 6 reported Match results by specialty groups that included the combined specialties. In this report, results are aggregated by specialty instead of specialty group. Preliminary positions are reported separately.

Internal Medicine, Family Medicine, and Pediatrics had large numbers of matched U.S. MD seniors and DO seniors. Overall, 3,038 (61.8 percent) of matched U.S. DO seniors who ranked only one specialty (n=4,914) matched to a primary care specialty compared to 6,437 (42.6 percent) of matched U.S. MD seniors who ranked only one specialty (n=15,123). In contrast, 75.4 percent (1,368 of 1,815) matched U.S. citizen IMGs who ranked only one specialty matched in primary care along with 79.1 percent (2,468 of 3,119) of non-U.S. citizen IMGs.

As seen in Figure 6, higher proportions of unmatched U.S. MD seniors and DO seniors have been observed in traditionally competitive specialties like Orthopedic Surgery, Neurological Surgery, Plastic Surgery, Otolaryngology, Dermatology, and General Surgery.

Table 14 A — Match Results for U.S. MD Seniors and U.S. DO Seniors Applicants Who Ranked Each Specialty as Their Only Choice, 2022

	Matched		Unmatched		Total		Percent Matched		Percent Unmatched	
Specialty	MD	DO	MD	DO	MD	DO	MD	DO	MD	DO
Anesthesiology	901	135	53	40	954	175	6.0	2.7	5.6	22.9
Child Neurology	77	12	0	0	77	12	0.5	0.2	0.0	0.0
Dermatology	106	10	27	4	133	14	0.7	0.2	20.3	28.6
Emergency Medicine	1,454	611	16	19	1,470	630	9.6	12.4	1.1	3.0
Family Medicine	1,386	1,228	23	43	1,409	1,271	9.2	25.0	1.6	3.4
Internal Medicine	3,443	1,305	48	48	3,491	1,353	22.8	26.6	1.4	3.5
Internal Medicine (Prelim)	210	4	4	0	214	4	1.4	0.1	1.9	0.0
Internal Medicine/Emergency Medicine	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Internal Medicine/Pediatrics	242	18	5	0	247	18	1.6	0.4	2.0	0.0
Internal Medicine/Psychiatry	0	0	1	0	1	0	0.0	0.0	100.0	0.0
Interventional Radiology	4	0	0	0	4	0	0.0	0.0	0.0	0.0
Neurological Surgery	196	5	44	4	240	9	1.3	0.1	18.3	44.4
Neurology	494	111	7	4	501	115	3.3	2.3	1.4	3.5
Obstetrics and Gynecology	975	179	148	71	1,123	250	6.4	3.6	13.2	28.4
Orthopaedic Surgery	658	91	281	56	939	147	4.4	1.9	29.9	38.1
Osteopathic Neuromusculoskeletal Medicine	0	3	0	0	0	3	0.0	0.1	0.0	0.0
Otolaryngology	275	7	100	0	375	7	1.8	0.1	26.7	0.0
Pathology-Anatomic and Clinical	210	70	5	5	215	75	1.4	1.4	2.3	6.7
Pediatrics	1,608	505	18	6	1,626	511	10.6	10.3	1.1	1.2
Pediatrics (Prelim)	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Pediatrics/Medical Genetics	3	0	0	0	3	0	0.0	0.0	0.0	0.0
Pediatrics/Psychiatry/Child and Adolescent Psychiatry	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Physical Medicine and Rehabilitation	180	111	22	26	202	137	1.2	2.3	10.9	19.0
Plastic Surgery	138	0	35	1	173	1	0.9	0.0	20.2	100.0
Psychiatry	1,105	275	78	24	1,183	299	7.3	5.6	6.6	8.0
Radiation Oncology	80	3	1	0	81	3	0.5	0.1	1.2	0.0
Radiology-Diagnostic	444	68	58	21	502	89	2.9	1.4	11.6	23.6
Surgery-General	775	146	114	56	889	202	5.1	3.0	12.8	27.7
Surgery-General (Prelim)	66	7	9	1	75	8	0.4	0.1	12.0	12.5
Thoracic Surgery	0	0	1	0	1	0	0.0	0.0	100.0	0.0
Vascular Surgery	45	0	5	2	50	2	0.3	0.0	10.0	100.0
TOTAL*	**15,123**	**4,914**	**1,111**	**439**	**16,234**	**5,353**	**100.0**	**100.0**	**6.8**	**8.2**

Note: Specialties with fewer than 20 total positions are not displayed on this table. Transitional Year is excluded.

* The **TOTAL** row includes all positions in all specialties.

Table 14 B

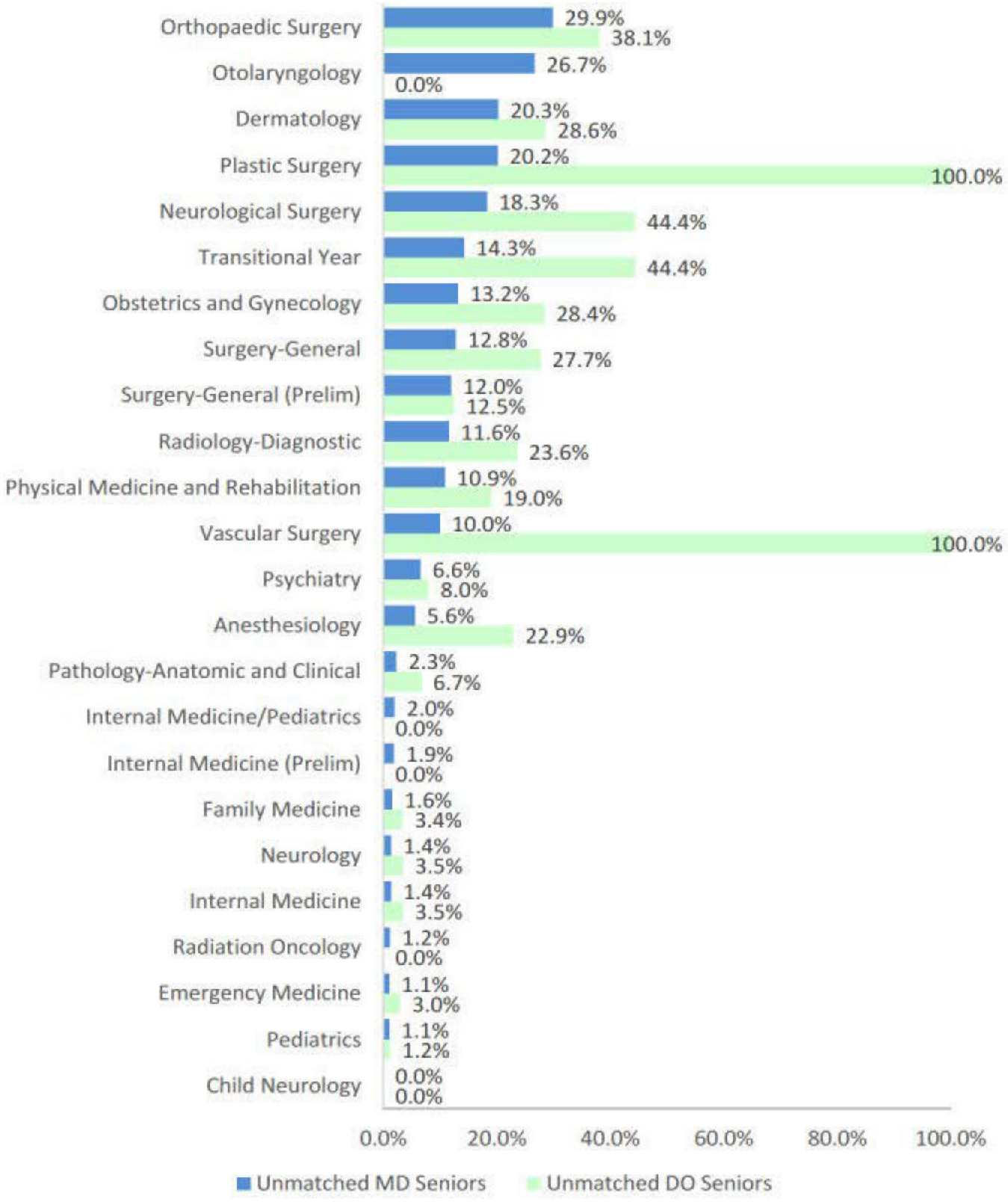
Match Results for U.S. IMG and Non-U.S. IMG Applicants Who Ranked Each Specialty as Their Only Choice, 2022

Specialty	Matched		Unmatched		Total		Percent Matched		Percent Unmatched	
	U.S.IMG	IMG	U.S. IMG	IMG	U.S. IMG	IMG	U.S. IMG	IMG	U.S. IMG	IMG
Anesthesiology	35	39	42	57	77	96	1.9	1.3	54.5	59.4
Child Neurology	5	7	3	7	8	14	0.3	0.2	37.5	50.0
Dermatology	7	7	10	9	17	16	0.4	0.2	58.8	56.3
Emergency Medicine	92	24	21	10	113	34	5.1	0.8	18.6	29.4
Family Medicine	478	265	322	299	800	564	26.3	8.5	40.3	53.0
Internal Medicine	726	1,955	434	1,278	1,160	3,233	40.0	62.7	37.4	39.5
Internal Medicine (Prelim)	4	11	8	14	12	25	0.2	0.4	66.7	56.0
Internal Medicine/Emergency Medicine	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Internal Medicine/Pediatrics	1	2	4	4	5	6	0.1	0.1	80.0	66.7
Internal Medicine/Psychiatry	0	0	1	1	1	1	0.0	0.0	100.0	100.0
Interventional Radiology	0	0	0	1	0	1	0.0	0.0	0.0	100.0
Neurological Surgery	2	13	4	15	6	28	0.1	0.4	66.7	53.6
Neurology	37	122	28	99	65	221	2.0	3.9	43.1	44.8
Obstetrics and Gynecology	19	18	35	41	54	59	1.0	0.6	64.8	69.5
Orthopaedic Surgery	6	11	13	6	19	17	0.3	0.4	68.4	35.3
Osteopathic Neuromusculoskeletal Medicine	1	0	0	0	1	0	0.1	0.0	0.0	0.0
Otolaryngology	1	1	1	6	2	7	0.1	0.0	50.0	85.7
Pathology-Anatomic and Clinical	48	185	52	120	100	305	2.6	5.9	52.0	39.3
Pediatrics	164	248	47	157	211	405	9.0	8.0	22.3	38.8
Pediatrics (Prelim)	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Pediatrics/Medical Genetics	0	1	0	1	0	2	0.0	0.0	0.0	50.0
Pediatrics/Psychiatry/Child and Adolescent Psychiatry	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Physical Medicine and Rehabilitation	5	6	13	10	18	16	0.3	0.2	72.2	62.5
Plastic Surgery	2	3	4	3	6	6	0.1	0.1	66.7	50.0
Psychiatry	112	101	133	122	245	223	6.2	3.2	54.3	54.7
Radiation Oncology	7	9	2	7	9	16	0.4	0.3	22.2	43.8
Radiology-Diagnostic	13	24	17	31	30	55	0.7	0.8	56.7	56.4
Surgery-General	33	32	63	78	96	110	1.8	1.0	65.6	70.9
Surgery-General (Prelim)	5	28	7	38	12	66	0.3	0.9	58.3	57.6
Thoracic Surgery	0	1	0	3	0	4	0.0	0.0	0.0	75.0
Vascular Surgery	0	1	0	4	0	5	0.0	0.0	0.0	80.0
TOTAL*	**1,815**	**3,119**	**1,302**	**2,451**	**3,117**	**5,570**	**100.0**	**100.0**	**41.8**	**44.0**

Note: Specialties with fewer than 20 total positions are not displayed on this table. Transitional Year is excluded.

***** The **TOTAL** row includes all positions in all specialties.

Figure 6 **Percentages of Unmatched MD Seniors and DO Seniors Who Ranked Each Specialty as Their Only Choice, 2022**



Note: Specialties with fewer than 20 matched applicants are excluded from this figure. Transitional Year is excluded.

Table 15 and Figure 7

Table 15 shows trends between 1997 and 2022 in the percentages of U.S. MD seniors and U.S. DO seniors who matched to their first, second, third, fourth, or lower than fourth program choice on their rank order lists. (See Table 6 for trends in overall match rates by applicant type based on total active applicants).

In 2022, 48.5 percent of matched U.S. MD seniors matched to their first-choice programs, 2.1 percentage points higher than in 2021. Among matched U.S. DO seniors, the percentage of first-choice matches was 47.7 percent, 5.3 percentage points higher than in 2021. Among all active U.S. MD senior applicants, 6.7 percent were unmatched; among all active U.S. DO senior applicants, 8.2 percent were unmatched.

Figure 7 shows the percentage of applicants matched to programs by rank choice using both matched applicants (top two figures) and all applicants (bottom two figures).

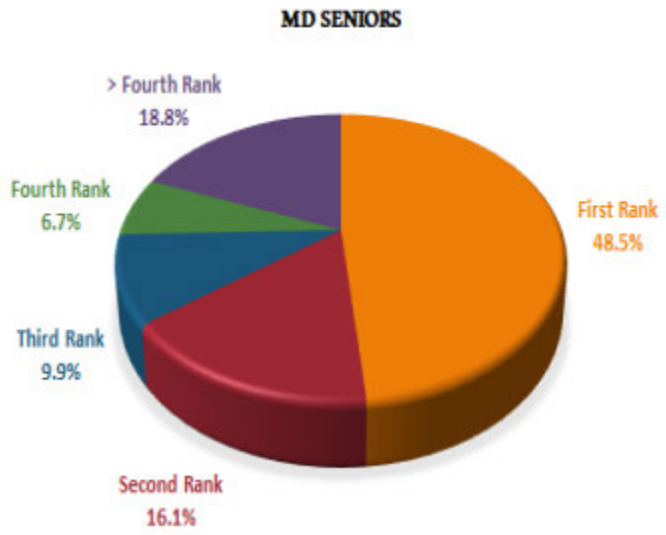
Table 15 Matches from MD and DO Seniors Applicants' Rank Order Lists, 1997 - 2022

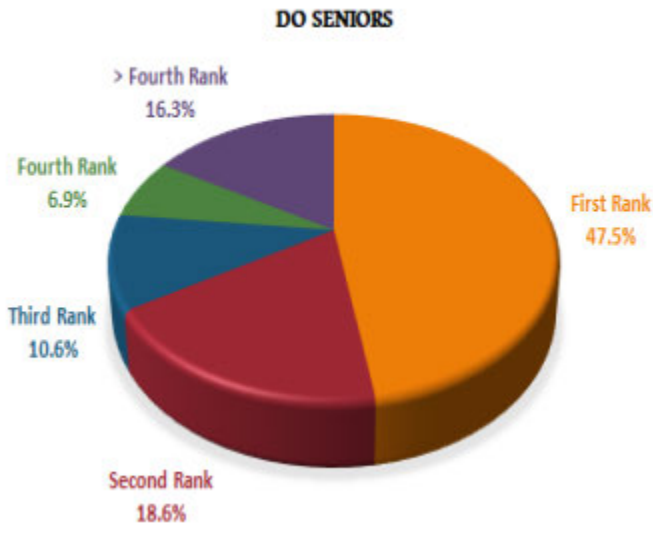
Year	First Rank No.	First Rank % of Matches	Second Rank No.	Second Rank % of Matches	Third Rank No.	Third Rank % of Matches	Fourth Rank No.	Fourth Rank % of Matches	> Fourth Rank No.	> Fourth Rank % of Matches	Unmatched No.	Unmatched %
MD Seniors												
1997	8,079	59.0	2,182	15.9	1,311	9.6	761	5.6	1,369	10.0	912	6.2
1998	8,028	58.0	2,283	16.5	1,332	9.6	802	5.8	1,398	10.1	767	5.2
1999	8,455	60.7	2,181	15.7	1,234	8.9	774	5.6	1,277	9.2	686	4.7
2000	8,542	62.4	2,102	15.3	1,187	8.7	656	4.8	1,209	8.8	662	4.6
2001	8,393	61.0	2,149	15.6	1,199	8.7	698	5.1	1,314	9.6	702	4.9
2002	8,370	61.0	2,130	15.5	1,289	9.4	687	5.0	1,249	9.1	611	4.3
2003	8,482	62.4	2,135	15.7	1,144	8.4	701	5.2	1,133	8.3	737	5.1
2004	8,510	61.9	2,138	15.6	1,188	8.6	659	4.8	1,243	9.0	871	6.0
2005	8,729	62.5	2,091	15.0	1,219	8.7	655	4.7	1,267	9.1	758	5.1
2006	8,551	60.1	2,198	15.5	1,286	9.0	734	5.2	1,451	10.2	788	5.3
2007	8,442	58.6	2,266	15.7	1,367	9.5	797	5.5	1,537	10.7	797	5.2
2008	8,692	59.9	2,280	15.7	1,300	9.0	738	5.1	1,505	10.4	727	4.8
2009	8,318	56.4	2,394	16.2	1,355	9.2	788	5.3	1,887	12.8	896	5.7
2010	8,462	56.0	2,468	16.3	1,471	9.7	852	5.6	1,869	12.4	948	5.9
2011	8,707	55.4	2,531	16.1	1,547	9.9	913	5.8	2,006	12.8	855	5.2
2012	8,946	56.5	2,467	15.6	1,500	9.5	904	5.7	2,015	12.7	695	4.2
2013	8,672	52.5	2,650	16.0	1,700	10.3	1,100	6.7	2,402	14.5	963	5.5
2014	8,970	54.2	2,691	16.3	1,710	10.3	1,001	6.1	2,163	13.1	839	4.8
2015	8,789	51.6	2,817	16.5	1,748	10.3	1,134	6.7	2,544	14.9	993	5.5
2016	9,110	53.0	2,830	16.5	1,673	9.7	1,023	5.9	2,561	14.9	990	5.4
2017	8,976	51.0	2,920	16.6	1,885	10.7	1,102	6.3	2,722	15.5	934	5.0
2018	9,128	51.1	2,831	15.9	1,832	10.3	1,184	6.6	2,877	16.1	966	5.1
2019	8,915	50.0	2,888	16.2	1,914	10.7	1,235	6.9	2,883	16.2	1,090	5.8
2020	8,955	49.2	2,979	16.4	1,820	10.0	1,237	6.8	3,198	17.6	1,137	5.9
2021	8,569	46.4	2,907	15.7	1,880	10.2	1,349	7.3	3,778	20.4	1,383	7.0
2022	8,999	48.5	2,993	16.1	1,833	9.9	1,250	6.7	3,485	18.8	1,342	6.7
DO Seniors												
1997	250	62.0	68	16.9	49	12.2	16	4.0	20	5.0	134	25.0
1998	281	57.3	99	20.2	39	8.0	26	5.3	45	9.2	114	18.9
1999	357	60.6	107	18.2	49	8.3	30	5.1	46	7.8	129	18.0
2000	438	59.0	127	17.1	69	9.3	48	6.5	60	8.1	130	14.9
2001	511	58.9	145	16.7	96	11.1	47	5.4	68	7.8	150	14.7
2002	512	55.2	183	19.7	102	11.0	56	6.0	75	8.1	152	14.1
2003	605	59.7	196	19.3	93	9.2	61	6.0	59	5.8	154	13.2
2004	647	57.6	231	20.6	113	10.1	56	5.0	77	6.9	187	14.3
2005	628	58.1	196	18.1	102	9.4	69	6.4	85	7.9	210	16.3
2006	586	56.2	209	20.1	110	10.6	65	6.2	72	6.9	209	16.7
2007	641	55.1	225	19.3	110	9.5	85	7.3	103	8.8	239	17.0
2008	752	54.3	283	20.4	148	10.7	81	5.9	120	8.7	274	16.5
2009	755	52.3	282	19.5	174	12.1	90	6.2	142	9.8	320	18.2
2010	718	48.5	310	21.0	174	11.8	98	6.6	179	12.1	312	17.4
2011	817	50.7	305	18.9	184	11.4	120	7.4	185	11.5	338	17.3
2012	888	49.4	385	21.4	216	12.0	111	6.2	198	11.0	325	15.3
2013	971	48.3	368	18.3	227	11.3	133	6.6	313	15.6	413	17.0
2014	1,021	47.6	439	20.5	267	12.5	131	6.1	285	13.3	338	13.6
2015	1,162	49.7	456	19.5	254	10.9	164	7.0	302	12.9	377	13.9
2016	1,174	48.9	461	19.2	294	12.2	186	7.7	288	12.0	360	13.0
2017	1,453	49.8	528	18.1	342	11.7	195	6.7	399	13.7	418	12.5
2018	1,780	48.2	672	18.2	451	12.2	244	6.6	549	14.9	579	13.5
2019	2,338	47.7	929	19.0	564	11.5	346	7.1	722	14.7	579	10.6
2020	2,869	47.8	1,059	17.6	677	11.3	442	7.4	958	16.0	576	8.8
2021	2,692	42.4	1,146	18.0	749	11.8	513	8.1	1,252	19.7	749	10.5
2022	3,195	47.7	1,237	18.5	711	10.6	464	6.9	1,094	16.3	602	8.2

Note: The above data has no implications about applicant or match quality. Ranking preferences are individualized decisions based on a variety of factors.

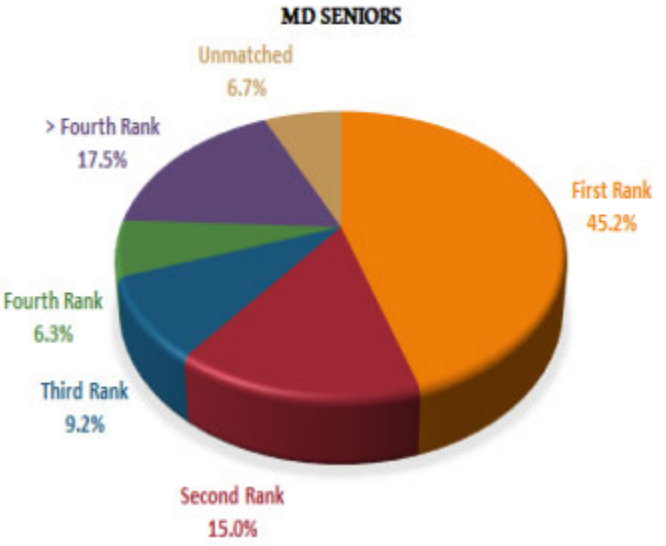
Figure 7 **Percent of Matches by Choice and Type of Applicant, 2022**

Matched Applicants





All Applicants



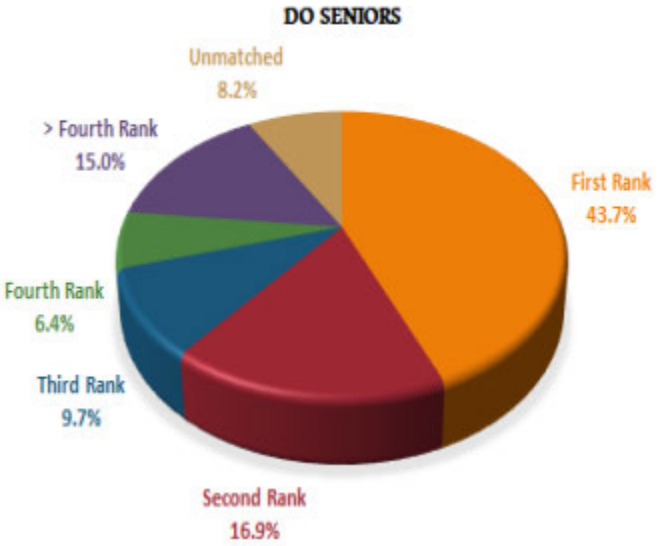


Table 16

The NRMP began offering the couples match in 1984. Any two individuals can identify themselves as a couple to the NRMP and submit rank order lists of identical length. The matching algorithm treats the two lists as a unit, matching the couple to the highest pair of program choices where both partners obtain a match.

Table 16 presents the number of couples in the Match and their match outcomes. In 2022, 2,444 individual applicants participated in the Match as a couple (2,444/2 = 1,222 couples).

Couples often rank the same program multiple times against a different program on the partner's list. They also have the option of one partner indicating a willingness to be unmatched at a specific rank on the rank order list if the other partner matches to the program paired to that rank. Table 16 shows the number of couples matched with that option in the One Matched column (100 in 2022).

Couples enjoy success, with match rates above 90 percent every year since 1984. In 2022, the match rate for couples was 93.7 percent, calculated by adding number of 'Both Matched' (n= 1,095 x 2 = 2,190) to number of 'One Matched' (n=100) and dividing by number of 'Individual' (n=2,444). Approximately 66 percent of couples are U.S. MD seniors.

Table 16 Number of Couples in the Match and Match Outcome, 1987 - 2022

Year	Couples	Individuals	Both Matched	One Matched	Neither Matched	Match Rate %
1987	347	694	316	14	17	93.1
1988	388	776	355	19	14	93.9
1989	421	842	384	21	16	93.7
1990	397	794	356	20	21	92.2
1991	377	754	349	17	11	94.8
1992	461	922	412	20	29	91.5
1993	427	854	384	27	16	93.1
1994	446	892	391	35	20	91.6
1995	499	998	433	33	33	90.1
1996	504	1,008	446	20	38	90.5
1997	535	1,070	479	29	27	92.2
1998	525	1,050	481	27	17	94.2
1999	536	1,072	496	27	13	95.1
2000	508	1,016	475	18	15	95.3
2001	561	1,122	518	25	18	94.6
2002	543	1,086	507	19	17	95.1
2003	570	1,140	529	22	19	94.7
2004	641	1,282	584	36	21	93.9
2005	606	1,212	552	39	15	94.3
2006	610	1,220	552	36	22	93.4
2007	621	1,242	553	36	32	91.9
2008	738	1,476	667	47	24	93.6
2009	788	1,576	706	55	27	93.1
2010	808	1,616	730	50	28	93.4
2011	809	1,618	739	53	17	94.6
2012	878	1,756	804	54	19	94.6
2013	935	1,870	868	44	23	95.2
2014	925	1,850	843	56	26	94.2
2015	1,035	2,070	950	62	23	94.8
2016	1,046	2,092	971	61	14	95.7
2017	1,125	2,250	1,040	66	19	95.4
2018	1,165	2,330	1,082	67	16	95.8
2019	1,076	2,152	993	59	24	95.0
2020	1,224	2,448	1,128	84	12	95.6
2021	1,224	2,448	1,089	108	27	93.4
2022	1,222	2,444	1,095	100	27	93.7

Figure 8 Number of Couples in the Match and Match Outcome, 1987-2022

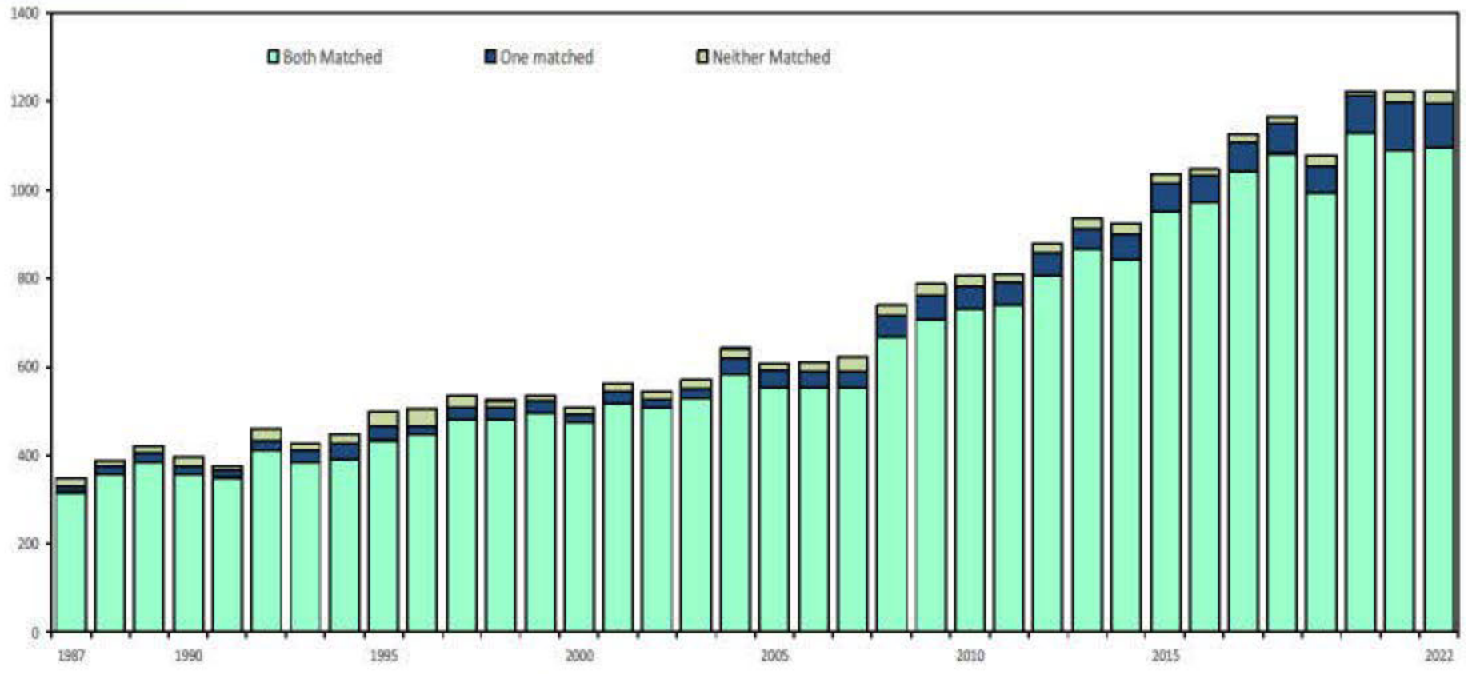


Table 17

Table 17 displays by specialty the average number of ranked applicants needed to fill each position within programs. Only programs that filled all positions are included in the calculations. Specialties with fewer than 5 programs that filled all positions were excluded to maintain their anonymity. Although this measure is affected by such factors as the number and geographic distribution of programs as well as the number of applicants ranked by the programs, it is a rough measure of specialty competitiveness. It may be more appropriate to interpret the data within each specialty across time and less appropriate to compare across specialties, especially for specialties with a large proportion of programs that do not fill.

Using Emergency Medicine as an example, on average programs that filled all positions ranked 8.8 applicants per available position in the 2022 Match. That figure represents an increase of 3.0 ranked applicants per filled position when compared with the 2021 average of 5.8.

Table 17 Average Number of Ranked Applicants Needed to Fill Each Position by Specialty, 2018 - 2022

Specialty	Average Number of Ranked Applicants Per Position Needed to Fill All Positions within Programs*				
	2022	2021	2020	2019	2018
PGY- 1					
Anesthesiology	5.7	5.6	6.5	7.0	7.7
Child Neurology	7.6	7.8	5.9	6.2	6.3
Dermatology	2.6	5.5	5.3	4.1	4.6
Emergency Medicine	8.8	5.8	6.0	6.8	6.4
Family Medicine	7.5	7.7	6.5	6.0	6.0
Internal Medicine (Categorical)	7.3	7.8	6.5	7.2	7.3
Medicine-Dermatology	2.3	--	--	2.5	--
Medicine-Emergency Med	4.8	2.9	4.0	4.3	5.0
Medicine-Pediatrics	6.1	5.4	6.4	6.6	6.1
Medicine-Preliminary (PGY-1 Only)	8.5	8.4	7.6	8.2	7.5
Medicine-Primary	9.9	9.2	8.2	6.7	9.4
Medicine-Psychiatry	3.8	5.2	3.1	3.6	3.7
Interventional Radiology (Integrated)	5.5	7.5	7.6	5.2	6.6
Neurological Surgery	5.2	5.6	4.1	4.8	5.2
Neurology	6.9	7.0	6.2	6.3	5.4
Obstetrics-Gynecology	4.0	4.5	4.3	4.1	4.4
OB/GYN-Preliminary (PGY-1 Only)	7.6	21.6	13.4	8.7	8.4
Orthopedic Surgery	3.8	4.6	4.5	5.8	5.7
Otolaryngology	4.8	4.5	4.7	4.3	6.9
Pathology	5.3	6.5	4.9	4.4	5.2
Pediatrics (Categorical)	9.0	8.8	8.2	8.3	7.9
Pediatrics-Anesthesiology	2.6	2.4	3.8	1.9	5.5
Pediatrics-Medical Genetics	5.6	3.8	3.8	3.7	4.2
Pediatrics-Preliminary	3.4	5.9	4.0	4.3	7.1
Pediatrics-Primary	6.0	8.2	8.3	5.6	6.5
Peds/Psych/Child Psych	3.6	3.7	3.6	3.3	4.1
Physical Medicine & Rehab	4.4	5.3	5.0	5.3	4.3
Plastic Surgery (Integrated)	4.5	4.3	4.3	5.6	5.4
Psychiatry	5.2	4.8	4.9	4.3	3.9
Psychiatry-Family Medicine	3.4	3.9	3.5	2.9	2.7
Radiation Oncology	--	13.3	6.1	3.4	6.1
Radiology-Diagnostic	6.0	8.1	7.1	8.3	6.0
Surgery (Categorical)	4.5	4.9	4.5	4.6	5.0
Surgery-Preliminary (PGY-1 Only)	5.3	5.3	4.5	4.7	3.0
Thoracic Surgery	3.8	3.8	2.5	2.8	3.2
Transitional (PGY-1 Only)	5.2	5.5	4.7	4.9	4.7
Vascular Surgery	4.8	4.2	4.2	5.9	5.9
PGY- 2					
Anesthesiology	17.4	20.6	18.8	21.9	20.7
Child Neurology	--	--	--	2.9	8.3
Dermatology	3.0	3.7	3.9	3.3	3.8
Interventional Radiology (Integrated)	6.9	6.8	7.3	5.7	4.6
Neurology	7.7	9.6	9.0	7.9	6.2
Physical Medicine & Rehab	5.8	6.2	6.1	6.8	5.4
Radiation Oncology	9.2	10.0	6.0	6.7	5.9
Radiology-Diagnostic	5.4	6.5	7.6	7.2	6.0
Physician (R)*					
Anesthesiology	3.0	1.8	2.4	2.1	2.5
Child Neurology	2.9	2.9	1.7	1.3	1.4
Dermatology	1.8	1.3	1.3	1.2	1.4
Neurology	1.2	1.7	1.6	2.5	1.4
Physical Medicine & Rehab	1.8	1.4	1.0	2.3	1.3
Radiology-Diagnostic	2.0	1.7	1.9	1.6	1.4

*Only those programs that filled all positions were included in the calculations. Specialties with fewer than 5 programs that filled all positions were excluded from this table to maintain anonymity.

Tables 18 and 19

In 2012, NRMP launched the Match Week Supplemental Offer and Acceptance Program® (SOAP®) to replace the "Scramble," streamlining the process for unmatched applicants and the directors of unfilled programs. During SOAP, eligible unmatched applicants use ERAS®, a service of the Association of American Medical Colleges (AAMC®), to apply to programs with unfilled positions. Programs interview applicants and create preference lists in the NRMP Registration, Ranking, and Results® (R3®) system, which offers positions to applicants in order of the program's preference through a series of offer rounds.

The universe of SOAP-eligible applicants is slightly different from that of unmatched active applicants. An applicant is eligible for SOAP if the applicant is 1) registered for the Main Residency Match, 2) eligible to enter graduate medical education on July 1 in the year of the Match, and 3) fully unmatched or partially matched (i.e., with only a preliminary or an advanced position) on Monday of Match week. Applicants do not have to submit rank order lists when the matching algorithm is processed to be eligible to participate in SOAP.

In 2022, 12,836 applicants were SOAP-eligible, 1,279 fewer than in 2021 (Table 19). In 2022, U.S. citizen and non-U.S. citizen IMGs together constituted more than two thirds (64.8 percent) of SOAP-eligible applicants. Compared with 2021, 673 fewer non-U.S. citizen IMGs and 586 fewer U.S. citizen IMGs were eligible for SOAP this year, driven largely by lower overall participation rates among these groups. The number of SOAP-eligible U.S. MD seniors was 159 more than in 2021 while the number of SOAP-eligible U.S. DO seniors was 73 fewer.

As is true for applicants, the universe of SOAP programs is also slightly different. Programs can elect not to submit a rank order list to be processed by the matching algorithm. Programs also can elect whether to participate in SOAP should they have unfilled positions after the matching algorithm is processed. In 2022, there were 46 programs that did not submit a rank order list, accounting for 96 unfilled positions. There were 766 programs with 2,358 unfilled positions. Additionally, there are unfilled programs that submit a rank order list but elect not to participate in SOAP to fill their unfilled positions. After removing the unfilled positions in programs that elected not to participate in SOAP, 2,262 positions were placed in SOAP, coincidentally, the same number of positions that remained after the algorithm was processed. 907 (40.1 percent) of the SOAP positions were PGY-1 only: 537 Preliminary Surgery, 140 Preliminary Medicine, 10 Preliminary Obstetrics and Gynecology, 2 Preliminary Pediatrics and 218 Transitional Year. Other specialties with large numbers of positions in SOAP were Family Medicine (468), Internal Medicine (451 categorical and 10 primary), and Pediatrics (80 categorical and 1 primary). There were 370 more SOAP positions offered in 2022 compared to 2021 and 383 more PGY-1 positions available.

During SOAP, offers are extended to applicants in rounds based upon the number of unfilled positions remaining in the program, and a position can be re-offered in a subsequent round if an offer from a prior round is rejected or expires. As presented in Figure 9, in 2022, a total of 3,555 offers were sent to applicants; of those, 2,111 were accepted, 1,353 were rejected, and 91 were left to expire. By the conclusion of SOAP, 93.3 percent (2,111 of 2,262) of the available positions in SOAP were filled, resulting in a 99.6 percent fill rate overall for all positions placed in the 2022 Match and SOAP. After SOAP's conclusion, 151 positions placed in SOAP remained unfilled.

As presented in Table 19, U.S. MD seniors accounted for 43.2 percent (911 of 2,111) of the total positions filled during SOAP. U.S. DO seniors accounted for 24.2 percent (511 of 2,111) of the total positions filled. International medical graduates, as a group, accounted for 22.4 percent (473 of 2,111) total positions filled during SOAP.

Table 18 Participating Programs and Positions Filled in SOAP, 2021 - 2022

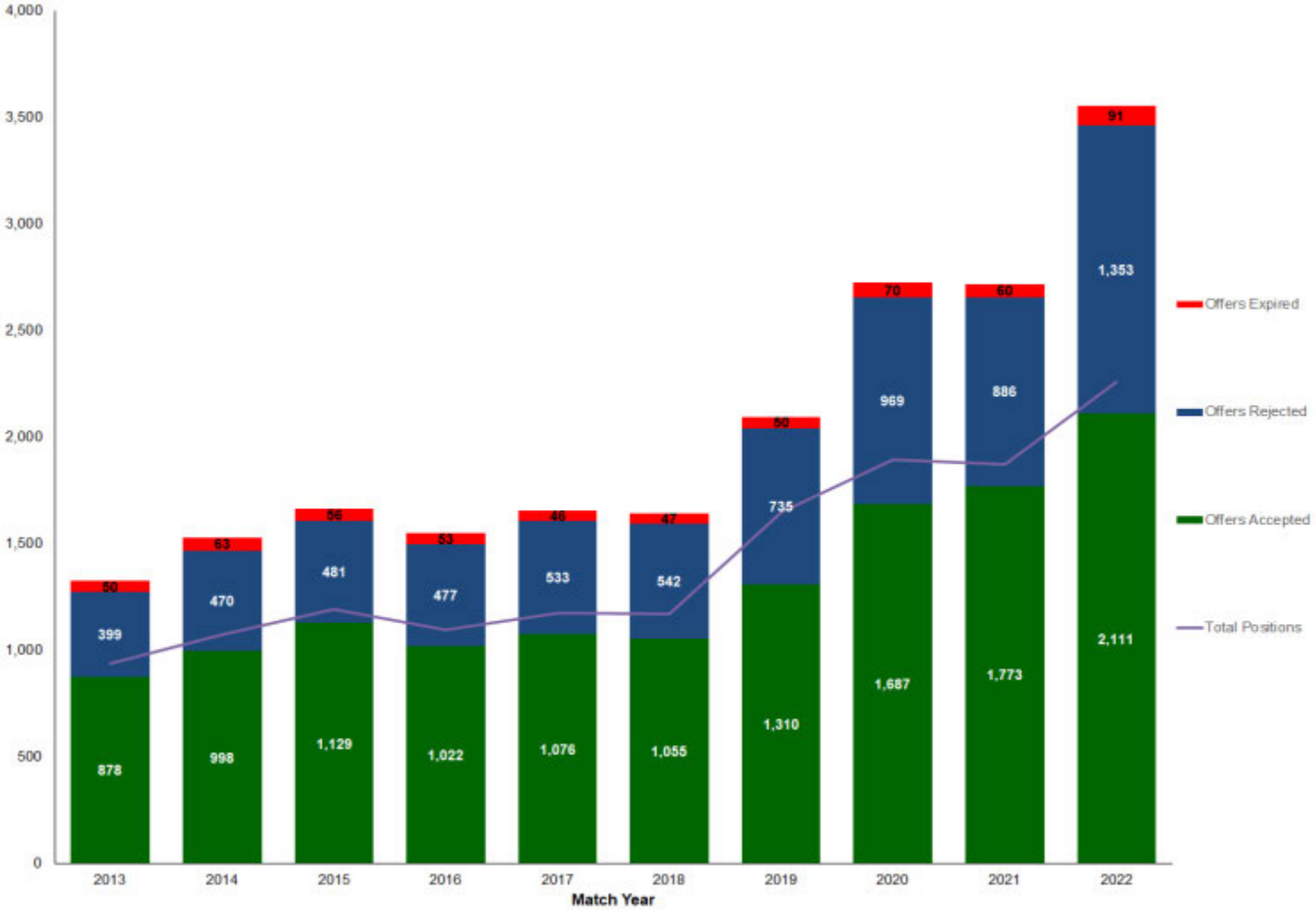
Specialty	2022 Participating Programs	2022 Available Positions	2022 Filled Programs	2022 Filled Positions	2021 Participating Programs	2021 Available Positions	2021 Filled Programs	2021 Filled Positions
PGY-1 Positions								
Anesthesiology					2	3	2	3
Child Neurology	12	14	11	13	9	10	8	9
Dermatology	1	2	1	2				
Emergency Medicine	67	217	57	202	4	7	3	6
Family Medicine	176	468	160	445	129	348	124	340
Internal Medicine (Categorical)	88	451	75	427	72	387	62	368
Medicine-Dermatology					1	1	1	1
Medicine-Preliminary (PGY-1 Only)	46	140	39	125	75	195	69	181
Medicine-Primary	3	10	2	9	1	4	1	4
Interventional Radiology (Integrated)					3	3	2	2
Neurology	7	11	7	11	7	13	7	13
Obstetrics-Gynecology	3	4	3	4	2	3	2	3
OB/GYN-Preliminary (PGY-1 Only)	7	10	7	10	5	7	5	7
Orthopedic Surgery					2	4	2	4
Osteo Neuromusculoskeletal Med	2	3	2	3	3	6	2	4
Pathology	8	10	6	8	12	18	11	17
Pediatrics (Categorical)	27	80	26	79	14	38	14	38
Pediatrics-Medical Genetics	1	1	1	1	1	1	1	1
Pediatrics-Preliminary	2	2	2	2				
Pediatrics-Primary	1	1	1	1	1	1	1	1
Physical Medicine & Rehab					1	1	1	1
Psychiatry	9	14	9	14	1	4	1	4
Radiation Oncology	1	1	1	1	1	3		2
Radiology-Diagnostic	1	1			1	4	1	4
Surgery (Categorical)	3	3	3	3	3	5	3	5
Surgery-Preliminary (PGY-1 Only)	145	537	132	518	144	519	130	493
Transitional (PGY-1 Only)	44	218	33	199	50	230	47	219
Total - PGY-1	**654**	**2,198**	**578**	**2,077**	**544**	**1,815**	**500**	**1,730**
PGY-2 Positions								
Child Neurology	1	1			2	2		
Dermatology	2	3	1	1	3	4	2	2
Interventional Radiology (Integrated)					3	4	3	4
Neurology					3	4	1	1
Osteo Neuromusculoskeletal Med					3	4	2	2
Physical Medicine & Rehab	1	2	1	2	1	2	1	2
Radiation Oncology	20	26	15	20	23	28	15	19
Radiology-Diagnostic	1	1	1	1	2	3		
Total - PGY-2	**25**	**33**	**18**	**24**	**40**	**51**	**24**	**30**
Physician (R) Positions*								
Anesthesiology	2	4	1	3	4	4	1	1
Child Neurology	8	8	1	1	6	6	1	1
Dermatology	3	3	1	1				
Neurology	5	5	2	2	3	3	1	1
Osteo Neuromusculoskeletal Med	1	2			1	1		
Physical Medicine & Rehab	2	6	1	1	2	3	2	3
Radiation Oncology	2	2	2	2	1	1	1	1
Radiology-Diagnostic	1	1			5	8	4	6
Total - Physician	**24**	**31**	**8**	**10**	**22**	**26**	**10**	**13**
Grand Total	**703**	**2,262**	**604**	**2,111**	**606**	**1,892**	**534**	**1,773**

* Physician (R) positions are PGY-2 positions starting in the year of the Match that are reserved for applicants who have had prior graduate medical education. Physician positions are not available to senior medical students. In *Results and Data Books* prior to 2014, the numbers of R positions were small and they were included in the categorical position counts. In this report, R positions are listed separately.

Table 19 SOAP Applicants Accepting Positions by Type, 2021 - 2022

Applicant Type	2022 Eligible Applicants	2022 Positions Accepted	2022 Unique Applicants Accepting Positions	2021 Eligible Applicants	2021 Positions Accepted	2021 Unique Applicants Accepting Positions
Seniors of U.S. MD Medical Schools	2,284	911	902	2,125	846	842
Graduates of U.S. MD Medical Schools	945	125	125	999	89	89
Seniors of U.S. DO Medical Schools	891	511	511	964	484	484
Graduates of U.S. DO Medical Schools	384	91	91	428	41	41
U.S. Citizen Students/Graduates of International Medical Schools	3,114	305	304	3,700	175	175
Non-U.S. Citizen Students/Graduates of International Medical Schools	5,203	168	168	5,876	138	138
Students/Graduates of Canadian Medical Schools and Fifth Pathway Progs	15	0	0	23	0	0
Total	**12,836**	**2,111**	**2,101**	**14,115**	**1,773**	**1,769**

Figure 9 Offers Extended in SOAP,* 2013-2022



*When an applicant accepts a position, the R3 system creates an automatic rejection of position offers for which the applicant no longer is eligible. A position may be offered in multiple rounds if it has not been accepted.

NRMP Program Results lists every hospital that participated in the Main Residency Match, along with the number of positions offered and filled for each of the institution's programs.

Sponsoring institutions are arranged alphabetically within state. The listing includes the institution name (abbreviated in some instances); the program code, which identifies each program; the quota (the number of positions offered by the program); and the number of applicants matched with that program.

There are three reasons why a program that ranked an adequate number of applicants did not fill its quota: (1) the applicants preferred other programs offering positions; (2) the applicants did not rank the program; or (3) the applicants had withdrawn from the Match.

There are also three reasons why applicants may not be matched with their most preferred program: (1) the program was filled with applicants it preferred; (2) the program did not rank the applicant; or (3) the program had withdrawn from the Match.

The following types of positions are offered through the NRMP:

- Categorical (C) positions are positions in programs that expect applicants who enter in their first post graduate year to complete the training required for certification in that specialty, provided their performance is satisfactory. Categorical programs in primary care Medicine and primary care Pediatrics are designated by (M) to distinguish them from regular Medicine and Pediatrics programs.

- Preliminary (P) positions are for one or two years of training needed as a prerequisite for entering advanced positions in specialty programs that require one or more years of broad clinical training. Internal Medicine, Surgery, and Transitional programs commonly offer preliminary positions.

- Advanced (A) positions beginning in 2023 are positions in specialty programs that begin after completion of one or more years of preliminary training. Applicants without prior graduate medical education can apply for those positions while also applying for preliminary positions that are compatible with their plans.

- Physician (R) positions are PGY-2 positions starting in the year of the Match that are reserved for physicians who have had prior graduate medical education. Physician positions are not available to U.S. senior medical students.

NRMP Program Code Structure

The NRMP program code is a **9-11 character** code based on the following criteria.

- The first four characters are the Institution Code.

- The fifth through the seventh characters represent the specialty code obtained from the first three digits of the program's ACGME Code and designates the specialty.

  Note: See ACGME Specialty Codes on the following page.

- The eighth character represents the program type:
  P - Preliminary program
  C - Categorical program
  M - Primary program
  A - Advanced program
  R - Physician program
  F - Fellowship program

- The ninth through eleven character represents the track:
  0 - first program/track in the specialty and program type at the institution
  1 - second program/track in the same specialty and program type at the same institution (i.e. 34th Street Clinic)
  2 - third program/track in the same specialty and program type at the same institution (i.e. Rural Clinic).

Examples:

Institution: **3099** - University at Buffalo SOM
ACGME Code: **120**-35-21-489 - Family Medicine
Program Type: **C** - Categorical

First Track: **0** - Buffalo General Hospital (Main Program)
Program Code: 3099120C0

Second Track: **1** -Erie County Medical Center
Program Code: 3099120C1

Third Track: **2** - Millard Fillmore Suburban Hospital
Program Code: 3099120C2

ACGME SPECIALTY CODES AND DESCRIPTIONS
5th, 6th, and 7th Characters of the NRMP Program Code

SPECIALTY CODE	SPECIALTY DESCRIPTION
040	Anesthesiology
080	Dermatology
110	Emergency Medicine
120	Family Medicine
140	Internal Medicine
160	Neurological Surgery
180	Neurology
185	Child Neurology (Neurology)
186	Neurodevelopmental Disabilities
200	Nuclear Medicine
220	Obstetrics and Gynecology
260	Orthopaedic Surgery
275	Osteopathic Neuromusculoskeletal Medicine
280	Otolaryngology
300	Pathology-Anatomic and Clinical
320	Pediatrics
340	Physical Medicine and Rehabilitation
362	Plastic Surgery (Integrated)
380	Preventive Medicine
400	Psychiatry
416	Interventional Radiology (Integrated)
420	Radiology-Diagnostic
430	Radiation Oncology
440	Surgery-General
451	Vascular Surgery
461	Thoracic Surgery
700	Internal Medicine/Pediatrics
705	Internal Medicine/Emergency Medicine
715	Internal Medicine/Psychiatry
720	Psychiatry/Family Medicine
725	Pediatrics/Emergency Medicine
726	Pediatrics/Anesthesiology
730	Pediatrics/Psychiatry/Child and Adolescent Psychiatry
735	Pediatrics/Physical Medicine and Rehabilitation
740	Internal Medicine/Family Medicine
742	Internal Medicine/Anesthesiology
751	Internal Medicine/Preventive Medicine
752	Family Medicine/Preventive Medicine
753	Family Medicine/Osteopathic Neuromusculoskeletal Medicine
755	Psychiatry/Neurology
765	Pediatrics/Medical Genetics
766	Internal Medicine/Medical Genetics
770	Diagnostic Radiology/Nuclear Medicine/Nuclear Radiology
785	Internal Medicine/Dermatology
795	Emergency Medicine/Family Medicine
796	Emergency Medicine/Anesthesiology
999	Transitional Year

ALABAMA

Baptist Outreach Services-AL

Montgomery	Code	Quota	Matched
Family Medicine	3082120C0	8	8

Brookwood Baptist Health-AL

Birmingham	Code	Quota	Matched
Internal Medicine	1903140C0	10	8
Med-Prelim/UAB PM&R	1903140P1	4	4
Pathology	1903300C0	2	1
Radiology-Diagnostic	1903420C0	4	4
General Surgery	1903440C0	5	5
Surgery-Preliminary	1903440P0	3	3
Transitional	1903999P0	13	13

Cahaba Medical Care-AL

Centreville	Code	Quota	Matched
Family Medicine/Rural	1590120C0	5	5
Family Medicine/Urban	1590120C1	7	7
Family Medicine/Frontier	1590120C2	4	4

East Alabama Med Ctr

Opelika	Code	Quota	Matched
Internal Medicine	2265140C0	10	10

Gadsden Regional Med Ctr-AL

Gadsden	Code	Quota	Matched
Family Medicine	2315120C0	6	6

Jack Hughston Memorial Hosp-AL

Phenix City	Code	Quota	Matched
Orthopaedic Surgery	2233260C0	3	3

North Alabama Med Ctr

Florence	Code	Quota	Matched
Internal Medicine	2239140C0	12	12

South Baldwin Reg Med Ctr-AL

Foley	Code	Quota	Matched
Family Medicine	2143120C0	11	11

Southeast Health-AL

Dothan	Code	Quota	Matched
Internal Medicine	2132140C0	16	16
Transitional	2132999P0	12	12

St Vincents East-AL

Birmingham	Code	Quota	Matched
Family Medicine	3060120C0	8	8

Thomas Hospital-AL

Fairhope	Code	Quota	Matched
Internal Medicine	2271140C0	14	7

U Alabama CCHS-Tuscaloosa

Tuscaloosa	Code	Quota	Matched
Family Medicine	2955120C0	16	16

U Alabama Med Ctr-Birmingham

Birmingham	Code	Quota	Matched
Anesthesiology	1007040C0	21	21
Anesthesiology/Research	1007040C1	0	0
Dermatology	1007080A0	5	5
Emergency Medicine	1007110C0	12	12
Internal Medicine	1007140C0	37	37
Int Med/ABIM Research Pathway	1007140C2	2	2
Neurological Surgery	1007160C0	3	3
Neurology	1007180C0	9	9
Child Neurology	1007185C0	2	2
Obstetrics-Gynecology	1007220C0	8	8
Orthopaedic Surgery	1007260C0	6	6
Otolaryngology	1007280C0	4	4
Pathology	1007300C0	7	7
Pediatrics	1007320C0	25	25
Phys Medicine & Rehab	1007340A0	4	4
Plastic Surgery (Integrated)	1007362C0	1	1
Psychiatry	1007400C0	8	8
Psychiatry/Research	1007400C1	2	2
Interventional Radiology (Integ)	1007416A0	2	2
Radiology-Diagnostic	1007420A0	9	9
Radiation Oncology	1007430A0	3	2
General Surgery	1007440C0	7	7
Gen Surg/Integ 4/3 CT Surgery	1007440C1	1	1
Surgery-Preliminary	1007440P2	1	1
Vascular Surgery	1007451C0	1	1
Medicine-Pediatrics	1007700C0	4	4
Pediatrics-Medical Genetics	1007765C0	1	1
Medicine-Medical Genetics	1007766C0	1	0

U Alabama SOM-Huntsville

Huntsville	Code	Quota	Matched
Family Medicine	2947120C0	12	12
Internal Medicine	2947140C0	9	9

U Alabama SOM-Montgomery

Montgomery	Code	Quota	Matched
Internal Medicine	1009140C0	5	5
Medicine-Preliminary	1009140P0	6	6

U South Alabama Hospitals

Mobile	Code	Quota	Matched
Emergency Medicine	1852110C0	6	6
Family Medicine	1852120C0	6	3
Internal Medicine	1852140C0	18	18
Medicine-Preliminary	1852140P0	6	5
Neurology	1852180C0	4	2
Neurology	1852180R0	1	1
Obstetrics-Gynecology	1852220C0	4	4
Orthopaedic Surgery	1852260C0	3	3
Pathology	1852300C0	3	3
Pediatrics	1852320C0	12	12
Psychiatry	1852400C0	5	5
Radiology-Diagnostic	1852420A0	4	4
Radiology-Diagnostic	1852420R0	1	1
General Surgery	1852440C0	6	6
Surgery-Preliminary	1852440P0	4	1
Medicine-Pediatrics	1852700C0	3	3

UAB Selma Fam Med Res-AL

Selma	Code	Quota	Matched
Family Medicine	3061120C0	6	6

ALASKA

Providence Hospital-AK

Anchorage	Code	Quota	Matched
Family Medicine	1313120C0	12	12

ARIZONA

Abrazo Health Network-AZ

Phoenix	Code	Quota	Matched
Emergency Medicine	2002110C0	6	6
Family Medicine	2002120C0	7	6
Internal Medicine	2002140C0	16	16
General Surgery	2002440C0	3	3
Transitional	2002999P0	13	13

Barrow Neurological Inst at SJHMC-AZ

Phoenix	Code	Quota	Matched
Neurological Surgery	1012160C0	4	4
Neurology	1012180C0	7	7

Creighton University-AZ

Phoenix	Code	Quota	Matched
Emergency Medicine/Phoenix	2154110C0	16	16
Family Medicine/Phoenix	2154120C0	8	8
Internal Medicine/St Josephs	2154140C0	26	26
Med-Prelim/St Josephs	2154140P0	7	5
Ob-Gyn/Phoenix Integ	2154220C0	8	8
Ob-Gyn/Phoenix Prelim	2154220P0	1	1
Psychiatry/Phoenix	2154400C0	6	6
Radiology-Diagnostic/St Josephs	2154420A0	8	8
General Surgery/Valleywise	2154440C2	8	8
Surg-Prelim/Valleywise	2154440P2	12	2

HonorHealth-AZ

Scottsdale	Code	Quota	Matched
Dermatology/Thompson Peak	1929080A0	2	2
Family Medicine/Osborn	1929120C0	8	8
Internal Med/Thompson Peak	1929140C0	6	6
Med-Prelim/PM&R	1929140P1	2	2
Med-Prelim/Dermatology	1929140P2	2	2
Phys Medicine & Rehab	1929340A0	2	2
General Surgery/Lincoln	1929440C0	4	4

Mayo Clinic School of Grad Med Educ-AZ

Scottsdale	Code	Quota	Matched
Anesthesiology	3200040A0	1	1
Anesthesiology	3200040C0	4	4
Anesthesiology	3200040R0	1	1
Dermatology	3200080C0	2	2
Internal Medicine	3200140C0	13	13
Medicine-Primary	3200140M0	0	0
Neurological Surgery	3200160C0	1	1
Neurology	3200180C0	5	5
Orthopaedic Surgery	3200260C0	3	3
Otolaryngology	3200280C0	2	2
Plastic Surgery (Integrated)	3200362C0	1	1
Radiology-Diagnostic	3200420A0	2	2
Radiology-Diagnostic	3200420C0	2	2
Radiation Oncology	3200430C0	1	0
General Surgery	3200440C0	4	4
Surgery-Preliminary	3200440P0	1	1

Midwestern University OPTI-AZ

Phoenix	Code	Quota	Matched
Emergency Medicine/Kingman	2156110C0	6	6
Family Medicine/Sierra Vista	2156120C0	4	0
Family Medicine/Kingman	2156120C1	5	5
Family Medicine/Mesa	2156120C2	5	3
Internal Medicine/Cottonwood	2156140C0	5	5
Internal Medicine/Mesa	2156140C1	5	5
Internal Medicine/Sierra Vista	2156140C2	5	5
General Surgery/Mesa	2156440C0	2	2

North Country HealthCare-AZ

Flagstaff	Code	Quota	Matched
Family Medicine	2243120C0	4	4

Phoenix Childrens Hospital-AZ

Phoenix	Code	Quota	Matched
Child Neurology	2952185C0	4	4
Pediatrics	2952320C0	36	36

Tucson Hospitals Med Ed-AZ

Tucson	Code	Quota	Matched
Pediatrics	1014320C0	4	4
Transitional	1014999P0	13	13

U Arizona COM-Phoenix

Phoenix	Code	Quota	Matched
Family Medicine	1011120C0	8	8
Internal Medicine	1011140C0	23	23
Medicine-Primary	1011140M0	2	2
Medicine-Preliminary	1011140P0	8	8
Neurology	1011180C0	3	3
Obstetrics-Gynecology	1011220C0	9	9
Orthopaedic Surgery	1011260C0	4	4
Psychiatry	1011400C0	6	6
Interventional Radiology (Integ)	1011416A0	2	2
General Surgery	1011440C0	7	7
General Surgery/Rural	1011440C1	1	1
Surgery-Preliminary	1011440P1	5	3
Medicine-Pediatrics	1011700C0	6	6

U Arizona COM-South Campus

Tucson	Code	Quota	Matched
Emergency Medicine	1371110C0	6	6
Family Medicine	1371120C0	8	6

U Arizona COM-Tucson

Tucson	Code	Quota	Matched
Anesthesiology	1015040A0	12	12
Anesthesiology	1015040R0	2	2
Dermatology	1015080A2	3	3
Emergency Medicine	1015110C0	15	15
Family Medicine	1015120C0	8	8
Internal Medicine	1015140C0	38	38
Medicine-Preliminary	1015140P0	7	6
Neurological Surgery	1015160C0	1	1
Neurology	1015180C0	6	6

U Arizona COM-Tucson (Continued)

Obstetrics-Gynecology	1015220C0	4	4
Orthopaedic Surgery	1015260C0	4	4
Otolaryngology	1015280C0	2	2
Pathology	1015300C0	4	4
Pediatrics	1015320C0	14	14
Psychiatry	1015400C0	12	12
Interventional Radiology (Integ)	1015416A0	1	1
Radiology-Diagnostic	1015420A0	9	9
Radiation Oncology	1015430A0	1	1
General Surgery	1015440C0	8	8
Surgery-Preliminary	1015440P0	8	8
Vascular Surgery	1015451C0	1	1
Pediatrics-Emergency Med	1015725C0	3	3

Yuma Regional Med Ctr-AZ

Yuma	Code	Quota	Matched
Family Medicine	1488120C1	8	7

ARKANSAS

Arkansas Coll Osteo Med

Fort Smith	Code	Quota	Matched
Family Medicine/Mercy-Ft Smith	2295120C0	8	8
Internal Medicine/Poplar Bluff	2295140C0	6	6
Internal Medicine/Mercy-Ft Smith	2295140C1	8	8

Baptist Health-AR

North Little Rock	Code	Quota	Matched
Family Medicine	2198120C0	12	11
Internal Medicine	2198140C0	12	12
Psychiatry	2198400C0	4	4
Transitional	2198999P0	12	6

Baptist Mem Med Education-AR

Jonesboro	Code	Quota	Matched
Internal Medicine	2269140C0	8	8

CHI St Vincent Hot Springs-AR

Hot Springs	Code	Quota	Matched
Internal Medicine	2277140C0	6	6

Conway Reg Health Sys-AR

Conway	Code	Quota	Matched
Family Medicine	2250120C0	4	4
Internal Medicine	2250140C0	5	5

St Bernards Med Ctr-AR

Jonesboro	Code	Quota	Matched
Internal Medicine	2214140C0	8	7

U Arkansas COM-Little Rock

Little Rock	Code	Quota	Matched
Anesthesiology	1018040C0	13	13
Anesthesiology	1018040R0	1	1
Dermatology	1018080C0	3	3
Emergency Medicine	1018110C0	12	11
Family Medicine	1018120C0	6	6
Internal Medicine	1018140C0	21	21
Neurological Surgery	1018160C0	2	2
Neurology	1018180C0	4	4
Child Neurology	1018185C0	1	1
Obstetrics-Gynecology	1018220C0	5	5
Orthopaedic Surgery	1018260C0	5	5
Otolaryngology	1018280C0	3	3
Pathology	1018300C0	5	5
Pediatrics	1018320C0	25	25
Phys Medicine & Rehab	1018340C0	4	4
Psychiatry	1018400C0	8	8
Radiology-Diagnostic	1018420C0	7	7
Radiation Oncology	1018430A0	1	0
General Surgery	1018440C0	5	5
Vascular Surgery	1018451C0	1	1
Medicine-Pediatrics	1018700C0	5	5

U Arkansas-Fayetteville Comm Progs

Fayetteville	Code	Quota	Matched
Internal Medicine	1871140C0	11	11

UAMS Regional Centers-AR

Little Rock	Code	Quota	Matched
Family Medicine/Fayetteville	1582120C0	10	10
Family Medicine/Fort Smith	1582120C1	9	9
Family Medicine/Jonesboro	1582120C2	8	5
Family Medicine/Pine Bluff	1582120C4	9	9
Family Medicine/Texarkana	1582120C5	8	8
Family Medicine/Batesville	1582120C6	6	4

Unity Health-AR

Searcy	Code	Quota	Matched
Emergency Medicine	2104110C0	6	1
Family Medicine	2104120C0	6	3
Internal Medicine	2104140C0	12	7
Psychiatry	2104400C0	5	5
Transitional	2104999P0	13	8

White River Health System-AR

Batesville	Code	Quota	Matched
Internal Medicine	1991140C0	10	10

CALIFORNIA

Adventist Health Glendale-CA

Glendale	Code	Quota	Matched
Family Medicine	1023120C0	8	8

Adventist Health Hanford-CA

Hanford	Code	Quota	Matched
Family Medicine	2029120C0	6	6
Family Medicine/Tulare	2029120C1	6	6

Adventist Health Ukiah Valley-CA

Ukiah	Code	Quota	Matched
Family Medicine	2180120C0	7	2

Adventist Health White Memorial-CA

Los Angeles	Code	Quota	Matched
Family Medicine	1040120C0	8	8
Internal Medicine	1040140C0	6	6
Medicine-Preliminary	1040140P0	4	2
Obstetrics-Gynecology	1040220C0	5	5

Alameda Health Sys-Highland Hosp-CA

Oakland	Code	Quota	Matched
Emergency Medicine	1041110C0	11	11
Internal Medicine	1041140C0	15	15
Medicine-Primary	1041140M0	5	5
Medicine-Preliminary	1041140P0	12	12

AltaMed Health Services-CA

South Gate	Code	Quota	Matched
Family Medicine	2236120C0	6	5

Arrowhead Reg Med Ctr-CA

Colton	Code	Quota	Matched
Emergency Medicine	1047110C0	8	8
Family Medicine	1047120C0	16	16
Internal Medicine	1047140C0	16	16
Neurology	1047180C0	2	0
Obstetrics-Gynecology	1047220C0	3	3
Psychiatry	1047400C0	6	6
Radiology-Diagnostic	1047420A0	2	2
General Surgery	1047440C0	5	5
Surgery-Preliminary	1047440P0	2	2

CA Pacific Med Center

San Francisco	Code	Quota	Matched
Internal Medicine	1061140C0	14	14
Medicine-Preliminary	1061140P0	9	9
Med-Prelim/Neurology	1061140P1	1	1
Med-Prelim/Ophthalmology	1061140P2	3	3
Med-Prelim/Anesthesiology	1061140P3	2	2
Psychiatry	1061400C0	4	4

California Hosp Med Ctr

Los Angeles	Code	Quota	Matched
Family Medicine	2092120C0	8	8

Casa Colina Hosp-CA

Pomona	Code	Quota	Matched
Phys Medicine & Rehab	2151340A0	3	3

Cedars-Sinai Med Ctr-CA

West Hollywood	Code	Quota	Matched
Anesthesiology	1030040C0	14	14
Internal Medicine	1030140C0	22	22
Internal Medicine/PSTP	1030140C1	2	2
Medicine-Primary	1030140M0	7	7
Medicine-Preliminary	1030140P0	2	2
Med-Prelim/Neurology	1030140P1	5	5
Neurological Surgery	1030160C0	2	2
Neurology	1030180A0	4	4
Neurology/PSTP	1030180A1	1	1
Obstetrics-Gynecology	1030220C0	7	7
Orthopaedic Surgery	1030260C0	5	5
Otolaryngology	1030280C0	2	2
Pathology	1030300C0	4	4
Pathology/Phys Scientist	1030300C1	1	0
Radiology-Diagnostic	1030420A0	3	3
Radiation Oncology	1030430A0	1	1
General Surgery	1030440C0	6	6
Surgery-Preliminary	1030440P0	1	1
Thoracic Surgery	1030461C0	2	2

Charles R Drew University-CA

Los Angeles	Code	Quota	Matched
Family Medicine	2114120C0	8	8
Internal Medicine	2114140C0	8	8
Psychiatry	2114400C0	6	6

Childrens Hospital-LA-CA

Los Angeles	Code	Quota	Matched
Child Neurology	1031185C0	3	3
Pediatrics	1031320C0	35	35

Childrens Hospital-Oakland-CA

Oakland	Code	Quota	Matched
Pediatrics	1939320C0	27	25
Peds-Prelim/Child Neurology	1939320P0	1	1

City Of Hope-CA

Duarte	Code	Quota	Matched
Radiation Oncology	1183430A0	1	1

Clinica Sierra Vista-CA

Bakersfield	Code	Quota	Matched
Family Medicine	1708120C0	8	8

College Med Ctr-CA

Long Beach	Code	Quota	Matched
Internal Medicine	2133140C0	5	2

Community Mem Health Sys-CA

Ventura	Code	Quota	Matched
Family Medicine	2018120C0	8	6
Internal Medicine	2018140C0	8	8
Orthopaedic Surgery	2018260C0	4	4
Psychiatry	2018400C0	4	4
General Surgery	2018440C0	3	3

Contra Costa Reg Med Ctr-CA

Martinez	Code	Quota	Matched
Family Medicine	2071120C0	13	13

Desert Regional Med Ctr-CA

Palm Springs	Code	Quota	Matched
Emergency Medicine	2131110C0	10	10
Family Medicine	2131120C0	10	10

Dignity Health Northridge Hosp Med Ctr-CA

Northridge	Code	Quota	Matched
Family Medicine	3036120C1	8	8

Dignity Methodist Hosp-Sacramento-CA

Sacramento	Code	Quota	Matched
Family Medicine	1140120C0	8	8

Eisenhower Med Ctr-CA

Rancho Mirage	Code	Quota	Matched
Emergency Medicine	1485110C0	8	8
Family Medicine	1485120C0	12	12
Internal Medicine	1485140C0	20	20

Emanate Health-CA

West Covina	Code	Quota	Matched
Family Medicine	1974120C0	8	8

Family Health Ctrs of San Diego-CA

San Diego	Code	Quota	Matched
Family Medicine	1682120C0	6	6

Harbor-UCLA Med Ctr-CA

Torrance	Code	Quota	Matched
Anesthesiology	1067040C0	9	9
Dermatology	1067080A0	1	1
Emergency Medicine	1067110C0	16	16
Family Medicine	1067120C0	12	12
Internal Medicine	1067140C0	17	17
Medicine-Preliminary	1067140P0	10	7
Med-Prelim/Radiology	1067140P1	2	2
Med-Prelim/Dermatology	1067140P2	0	0
Neurology	1067180C0	4	4
Obstetrics-Gynecology	1067220C0	5	5
Orthopaedic Surgery	1067260C0	5	5
Pathology	1067300C0	4	4
Pediatrics	1067320C0	10	10
Psychiatry	1067400C0	7	7
Radiology-Diagnostic	1067420A0	6	6
General Surgery	1067440C0	6	6
Surgery-Preliminary	1067440P0	8	0
Surg-Prelim/Radiology	1067440P2	0	0
Vascular Surgery	1067451C0	1	1

Huntington Memorial Hosp-CA

Pasadena	Code	Quota	Matched
Internal Medicine	1044140C0	8	8
Medicine-Preliminary	1044140P0	6	6
General Surgery	1044440C0	4	4

John Muir Health-CA

Walnut Creek	Code	Quota	Matched
Family Medicine	1917120C0	8	8

KPC Health Hemet Valley Med Ctr-CA

Corona	Code	Quota	Matched
Radiology-Diagnostic	2124420C0	3	3
Transitional	2124999P0	15	11

Kaiser Permanente-Central Valley-CA

Modesto	Code	Quota	Matched
Emergency Medicine	2272110C0	8	8

Kaiser Permanente-Fontana-CA

Fontana	Code	Quota	Matched
Family Medicine	2037120C0	9	9
Internal Medicine	2037140C0	8	8
Medicine-Preliminary	2037140P0	2	2
Psychiatry	2037400C0	6	6

Kaiser Permanente-Los Angeles-CA

Pasadena	Code	Quota	Matched
Dermatology	2055080C0	2	2
Family Med/LA Med Ctr	2055120C0	9	9
Internal Medicine	2055140C0	11	11
Internal Med/Research	2055140C2	1	1
Medicine-Preliminary	2055140P0	6	6
Neurology	2055180C0	3	3
Obstetrics-Gynecology	2055220C0	5	5
Pediatrics	2055320C0	8	8
Interventional Radiology (Integ)	2055416C0	1	1
Radiology-Diagnostic	2055420C0	2	2
Radiation Oncology	2055430A0	2	0
General Surgery	2055440C0	4	4
Surgery-Preliminary	2055440P0	5	5

Kaiser Permanente-Napa/Solano-CA

Vallejo	Code	Quota	Matched
Family Medicine	1637120C0	6	6

Kaiser Permanente-Oakland-CA

Oakland	Code	Quota	Matched
Internal Medicine	1042140C0	9	9
Internal Medicine/MPH	1042140C1	2	2
Med-Primary/Equity & Disparities	1042140M0	2	2
Medicine-Preliminary	1042140P0	7	7
Obstetrics-Gynecology	1042220C0	6	6
Otolaryngology	1042280C0	2	2
Pediatrics	1042320C0	8	8
Pediatrics/MPH	1042320C1	2	2
Psychiatry/East Bay	1042400C0	6	6

Kaiser Permanente-Orange Co-CA

Santa Ana	Code	Quota	Matched
Family Medicine	1073120C0	8	8

Kaiser Permanente-Riverside-CA

Riverside	Code	Quota	Matched
Family Medicine	3620120C0	6	6

Kaiser Permanente-SF-CA

San Francisco	Code	Quota	Matched
Internal Medicine	1959140C0	10	10
Medicine-Preliminary	1959140P0	8	8
Obstetrics-Gynecology	1959220C0	4	4
Medicine-Preventive Med	1959751C0	2	2

Kaiser Permanente-Sacramento Valley-CA

Sacramento	Code	Quota	Matched
Family Medicine	2273120C0	6	6

Kaiser Permanente-San Diego-CA

San Diego	Code	Quota	Matched
Emergency Medicine	1454110C0	6	6
Family Medicine	1454120C0	6	6

Kaiser Permanente-San Jose-CA

San Jose	Code	Quota	Matched
Family Medicine	2119120C0	6	6
Psychiatry	2119400C0	6	6

Kaiser Permanente-Santa Clara-CA

Santa Clara	Code	Quota	Matched
Internal Medicine	2135140C0	12	12
Medicine-Primary/CHOICE	2135140M0	4	4
Medicine-Preliminary	2135140P0	4	4
Obstetrics-Gynecology	2135220C0	6	6

Kaiser Permanente-Santa Rosa-CA

Santa Rosa	Code	Quota	Matched
Family Medicine	2115120C0	6	6

Kaiser Permanente-Woodland Hills-CA

Woodland Hills	Code	Quota	Matched
Family Medicine	1001120C0	6	6

Kaweah Delta Health Care District-CA

Visalia	Code	Quota	Matched
Anesthesiology	1572040C0	4	4
Emergency Medicine	1572110C0	13	13
Family Medicine	1572120C0	7	7
Psychiatry	1572400C0	7	7
General Surgery	1572440C0	3	3
Surgery-Preliminary	1572440P0	2	0
Transitional	1572999P0	12	12

Keck Medicine-CA

Los Angeles	Code	Quota	Matched
Family Medicine	2284120C0	6	6

Kern Med Ctr-CA

Bakersfield	Code	Quota	Matched
Emergency Medicine	1921110C0	7	6
Internal Medicine	1921140C0	12	12
Obstetrics-Gynecology	1921220C0	4	4
Psychiatry	1921400C0	6	6

Lifelong Medical Care-CA

Berkeley	Code	Quota	Matched
Family Medicine	2217120C0	6	6

Loma Linda Univ Med Ctr-Murrieta-CA

Murrieta	Code	Quota	Matched
Family Medicine	2251120C0	12	12

Loma Linda University-CA

Loma Linda	Code	Quota	Matched
Anesthesiology	1024040C0	14	14
Dermatology	1024080A0	3	3
Emergency Medicine	1024110C0	16	16
Family Medicine	1024120C0	12	12
Internal Medicine	1024140C0	28	28
Medicine-Primary	1024140M0	3	3
Medicine-Preliminary	1024140P0	11	11
Neurological Surgery	1024160C0	1	1
Neurology	1024180C0	4	4
Child Neurology	1024185C0	1	1
Obstetrics-Gynecology	1024220C0	9	9
Orthopaedic Surgery	1024260C0	5	5
Otolaryngology	1024280C0	4	4
Pathology	1024300C0	5	5
Pediatrics	1024320C0	23	23
Pediatrics-Primary	1024320M0	4	4
Phys Medicine & Rehab	1024340A0	1	1
Phys Medicine & Rehab	1024340C0	4	4
Physical Medicine and Rehabilitation	1024340R0	1	0
Plastic Surgery (Integrated)	1024362C0	2	2
Psychiatry	1024400C0	8	8
Psychiatry/CAP	1024400C2	2	2
Interventional Radiology (Integ)	1024416A0	1	1
Radiology-Diagnostic	1024420A0	8	8
Radiology-Diagnostic/ESIR Pathway	1024420A2	1	1
Radiology-Diagnostic	1024420R0	1	1
Radiation Oncology	1024430A0	1	1
General Surgery	1024440C0	3	3
Gen Surg/Dedicated Research	1024440C1	2	2
Surgery-Preliminary	1024440P0	12	7
Vascular Surgery	1024451C0	1	1
Medicine-Pediatrics	1024700C0	4	4
Medicine-Anesthesiology	1024742C0	2	2
Transitional	1024999P0	5	5
Transitional/Preventive Med	1024999P1	1	1
Transitional/Occupational Med	1024999P2	1	1

Long Beach Mem Med Ctr-CA

Long Beach	Code	Quota	Matched
Family Medicine	1027120C0	8	8

Los Robles Heaith System-CA

Thousand Oaks	Code	Quota	Matched
Anesthesiology	2264040C0	6	6
Internal Medicine	2264140C0	15	11
Medicine-Preliminary	2264140P0	5	2
Neurology	2264180C0	3	1
General Surgery	2264440C0	3	3

MLK Jr Community Hospital

Los Angeles	Code	Quota	Matched
Internal Medicine	2311140C0	5	5

Marian Regional Med Ctr-CA

Santa Maria	Code	Quota	Matched
Family Medicine	1690120C0	6	6
Obstetrics-Gynecology	1690220C0	3	3

Mercy Med Ctr-Merced-CA

Merced	Code	Quota	Matched
Family Medicine	3080120C0	8	8

Mercy Med Ctr-Redding-CA

Redding	Code	Quota	Matched
Family Medicine/MFHC	3081120C0	6	4

Natividad Med Ctr-CA

Salinas	Code	Quota	Matched
Family Medicine	2971120C0	10	10

Olive View-UCLA Med Ctr-CA

Sylmar	Code	Quota	Matched
Internal Medicine	2950140C0	21	21
Medicine-Preliminary	2950140P0	4	4
Med-Prelim/Neurology	2950140P2	3	3
Med-Prelim/Ophthalmology	2950140P3	7	7
Psychiatry	2950400C0	7	7

PIH Health Hosp Downey-CA

Downey	Code	Quota	Matched
Family Medicine	2215120C0	7	7

Pomona Valley Hosp-CA

Pomona	Code	Quota	Matched
Family Medicine	1350120C0	8	3

Presby Intercommunity Hosp-CA

Whittier	Code	Quota	Matched
Family Medicine	2013120C0	4	4

Presby Intercommunity Hosp-CA (Continued)

Fam Med/Tropical Med	2013120C1	2	2
Fam Med/Chronic Dz Mgmt	2013120C2	0	0

Prime West/Chino Valley Med Ctr-CA

Chino	Code	Quota	Matched
Dermatology	2150080R0	1	1
Family Medicine	2150120C0	4	4

Prime West/West Anaheim Med Ctr-CA

Anaheim	Code	Quota	Matched
Internal Medicine	2224140C0	5	4

Riverside Community Hospital-CA

Riverside	Code	Quota	Matched
Anesthesiology	1877040C0	8	8
Emergency Medicine	1877110C0	13	13
Family Medicine	1877120C0	8	1
Internal Medicine	1877140C0	15	15
Medicine-Preliminary	1877140P0	10	10
Neurology	1877180C0	4	4
Obstetrics-Gynecology	1877220C0	4	4
Radiology-Diagnostic	1877420A0	4	4
General Surgery	1877440C0	3	3
Surgery-Preliminary	1877440P0	3	0
Transitional	1877999P0	17	17

Riverside University Health Sys-CA

Moreno Valley	Code	Quota	Matched
Anesthesiology	1850040C0	5	5
Emergency Medicine	1850110C0	10	9
Family Medicine	1850120C0	12	12
Internal Medicine	1850140C0	13	13
Neurological Surgery	1850160C0	1	1
Neurology	1850180C0	2	2
Orthopaedic Surgery	1850260C0	3	3
Psychiatry	1850400C0	6	6
Radiology-Diagnostic	1850420C0	2	2
General Surgery	1850440C0	4	4
Surgery-Preliminary	1850440P0	4	0

San Joaquin Gen Hosp-CA

French Camp	Code	Quota	Matched
Family Medicine	1021120C0	8	8
Internal Medicine	1021140C0	10	10
Medicine-Preliminary	1021140P0	2	2
General Surgery	1021440C0	3	3
Surgery-Preliminary	1021440P1	3	1

San Mateo Behavioral Hlth & Recovery Svcs-CA

San Mateo	Code	Quota	Matched
Psychiatry	1010400C0	4	4

San Ysidro Health-CA

San Ysidro	Code	Quota	Matched
Internal Medicine	2220140C0	6	5

Santa Barbara Cottage Hosp-CA

Santa Barbara	Code	Quota	Matched
Internal Medicine	1064140C0	10	10
Medicine-Preliminary	1064140P0	5	5
Pediatrics	1064320C0	6	6
Radiology-Diagnostic	1064420A0	4	4
General Surgery	1064440C0	4	4

Santa Clara Valley Med Ctr-CA

San Jose	Code	Quota	Matched
Internal Medicine	1063140C0	18	18
Medicine-Preliminary	1063140P0	4	4
Med-Prelim/Neurology	1063140P1	4	4
Obstetrics-Gynecology	1063220C0	4	4
Radiology-Diagnostic	1063420A0	5	5
Transitional	1063999P0	13	13

Scripps Clinic/Green Hospital-CA

La Jolla	Code	Quota	Matched
Internal Medicine	1340140C0	15	15

Scripps Mercy Hosp-Chula Vista-CA

Chula Vista	Code	Quota	Matched
Family Medicine	1375120C0	9	9

Scripps Mercy Hosp-San Diego-CA

San Diego	Code	Quota	Matched
Internal Medicine	1048140C0	14	14
Transitional	1048999P0	12	12
Transitional/Anesthesia	1048999P2	6	6

Shasta Community Health Ctr-CA

Redding	Code	Quota	Matched
Family Medicine	1531120C0	4	4

Sierra View Med Ctr-CA

Porterville	Code	Quota	Matched
Internal Medicine	2278140C0	12	12
Medicine-Preliminary	2278140P0	4	3

St Agnes Med Ctr-CA

Fresno	Code	Quota	Matched
Emergency Medicine	2138110C0	8	8
Family Medicine	2138120C0	8	8
Internal Medicine	2138140C0	11	11
Transitional	2138999P0	12	12

St Joseph Hospital-Eureka-CA

Eureka	Code	Quota	Matched
Family Medicine	2160120C0	6	2

St Josephs Med Ctr-CA

Stockton	Code	Quota	Matched
Anesthesiology	2161040C0	8	8
Emergency Medicine	2161110C0	12	6
Family Medicine	2161120C0	6	6
Internal Medicine	2161140C0	10	10
Psychiatry	2161400C0	7	7
Transitional	2161999P0	16	16

St Mary Med Ctr-Long Beach-CA

Long Beach	Code	Quota	Matched
Internal Medicine	1025140C0	6	2
Medicine-Primary	1025140M0	0	0
Medicine-Preliminary	1025140P0	9	0

St Marys Med Ctr-SF-CA

San Francisco	Code	Quota	Matched
Internal Medicine	1057140C0	7	7
Medicine-Preliminary	1057140P0	9	3
Orthopaedic Surgery	1057260C0	3	3

Stanford Health Care-CA

Stanford	Code	Quota	Matched
Anesthesiology	1820040A0	13	13
Anesthesiology	1820040C0	14	14
Anesthesiology	1820040R0	3	3
Dermatology	1820080A0	7	7
Emergency Medicine	1820110C0	15	15
Family Medicine/OConnor	1820120C0	8	8
Internal Medicine	1820140C0	42	42
Internal Med/Global Health	1820140C1	2	2
Neurological Surgery	1820160C0	3	3
Neurology	1820180A0	6	6
Neurology	1820180C0	6	6
Child Neurology	1820185C0	4	4
Obstetrics-Gynecology	1820220C0	6	6
Orthopaedic Surgery	1820260C0	7	7
Otolaryngology	1820280C0	4	4
Otolaryngology/Research	1820280C1	1	1
Pathology	1820300C0	9	9
Clinical Pathology Track	1820300C1	2	2
Path-Anatomic Neuro Track	1820300C2	1	1
Pediatrics	1820320C0	27	27
Pediatrics/Research Trk	1820320C1	4	4
Phys Medicine & Rehab	1820340A0	7	7
Plastic Surgery (Integrated)	1820362C0	4	4
Psychiatry	1820400C0	9	9
Psychiatry/Research	1820400C1	2	2
Psychiatry/Public	1820400C2	2	2
Interventional Radiology (Integ)	1820416A0	3	3
Radiology-Diagnostic	1820420A0	9	9
Radiation Oncology	1820430A0	4	4
General Surgery	1820440C0	6	6
General Surgery/SASS	1820440C1	1	1
Surgery-Preliminary	1820440P0	6	5
Surg-Prelim/Opthalmology	1820440P4	5	5
Vascular Surgery	1820451C0	2	2
Thoracic Surgery	1820461C0	3	3
Pediatrics-Anesthesiology	1820726C0	2	2
Medicine-Anesthesiology	1820742C0	1	1
Pediatrics-Medical Genetics	1820765C0	2	2
Radiology-Nuclear Medicine	1820770A0	1	1
Trans/Anesthesiology Santa Clara	1820999P0	3	3

Sutter Health-CA

Sacramento	Code	Quota	Matched
Family Med/Sacramento	1135120C0	5	5
Family Medicine/Davis	1135120C1	2	2
Family Medicine/Amador	1135120C2	2	2
Internal Medicine	1135140C0	13	13
General Surgery	1135440C0	4	4
Surgery-Preliminary	1135440P0	2	0

Sutter Med Ctr of Santa Rosa-CA

Santa Rosa	Code	Quota	Matched
Family Medicine	1065120C0	12	12

U Southern California

Los Angeles	Code	Quota	Matched
Anesthesiology	1033040C0	18	18
Dermatology	1033080A0	4	4
Emergency Medicine	1033110C0	20	20
Internal Medicine	1033140C0	55	55
Neurological Surgery	1033160C0	3	3
Neurology	1033180A0	6	6
Obstetrics-Gynecology	1033220C0	9	9
Orthopaedic Surgery	1033260C0	8	8
Otolaryngology	1033280C0	3	3
Otolaryngology/Research	1033280C1	1	1
Pathology	1033300C0	6	6
Pediatrics	1033320C0	11	8
Plastic Surgery (Integrated)	1033362C0	3	3
Psychiatry	1033400C0	12	12
Interventional Radiology (Integ)	1033416A0	2	2
Radiology-Diagnostic	1033420A0	8	8
Radiation Oncology	1033430A0	1	1
General Surgery	1033440C0	7	7
Surg-Prelim/OMS	1033440P3	2	2
Vascular Surgery	1033451C0	1	1
Thoracic Surgery	1033461C0	2	2
Medicine-Pediatrics	1033700C0	6	6

UC Davis Med Ctr-CA

Sacramento	Code	Quota	Matched
Anesthesiology	1046040C0	14	14
Dermatology	1046080A0	5	5
Emergency Medicine	1046110C0	15	15
Family Medicine	1046120C0	10	9
Family Medicine/OB	1046120C2	1	1
Internal Medicine	1046140C0	21	21
Medicine-Primary	1046140M0	4	4
Med-Primary/Innovations	1046140M1	2	2
Neurological Surgery	1046160C0	2	2
Neurology	1046180C0	8	8
Obstetrics-Gynecology	1046220C0	7	7
Orthopaedic Surgery	1046260C0	3	3
Ortho Surgery/6 Yr Prog	1046260C1	1	1
Otolaryngology	1046280C0	3	3
Pathology	1046300C0	3	3
Pediatrics	1046320C0	13	13
Phys Medicine & Rehab	1046340A0	2	2
Phys Medicine & Rehab	1046340C0	2	2
Plastic Surgery (Integrated)	1046362C0	1	1
Psychiatry	1046400C0	9	9
Interventional Radiology (Integ)	1046416A0	2	2
Radiology-Diagnostic	1046420A0	6	6
Radiation Oncology	1046430A0	1	1
General Surgery	1046440C0	7	7
Surgery-Preliminary	1046440P0	10	10
Vascular Surgery	1046451C0	1	1
Thoracic Surgery	1046461C0	1	1
Medicine-Psychiatry	1046715C1	2	2

UC Davis Med Ctr-CA (Continued)

Psychiatry-Family Med	1046720C0	2	2
Radiology-Nuclear Medicine	1046770A0	1	1

UC Irvine Med Ctr-CA

Orange	Code	Quota	Matched
Anesthesiology	1043040C0	12	12
Anesthesiology/Critical Care Med	1043040C1	0	0
Dermatology	1043080A0	5	5
Emergency Medicine	1043110C0	9	9
Family Medicine	1043120C0	10	10
Internal Medicine	1043140C0	26	26
Medicine-Preliminary	1043140P0	20	20
Med-Prelim/Neurology	1043140P1	5	5
Neurological Surgery	1043160C0	1	1
Neurology	1043180A0	5	5
Child Neurology	1043185C0	2	2
Obstetrics-Gynecology	1043220C0	7	7
Orthopaedic Surgery	1043260C0	4	4
Otolaryngology	1043280C0	2	2
Pathology	1043300C0	6	6
Pediatrics/UCI-CHOC	1043320C1	25	25
Phys Medicine & Rehab	1043340A0	5	5
Plastic Surgery (Integrated)	1043362C0	3	3
Psychiatry	1043400C0	9	9
Interventional Radiology (Integ)	1043416A0	1	1
Radiology-Diagnostic	1043420A0	6	6
Radiation Oncology	1043430A0	1	0
General Surgery	1043440C0	6	6
Surg-Prelim/Non-designated	1043440P0	4	4
Surg-Prelim/Int Radiology	1043440P3	0	0

UC Riverside SOM-CA

Riverside	Code	Quota	Matched
Internal Med/St. Bernardine	1522140C1	15	15
Med-Prelim/St. Bernardine	1522140P0	10	3
Psychiatry	1522400C0	8	8

UC San Diego Med Ctr-CA

San Diego	Code	Quota	Matched
Anesthesiology	1049040A0	16	16
Anesthesiology	1049040R0	2	2
Dermatology	1049080A0	5	5
Emergency Medicine	1049110C0	12	12
Family Medicine	1049120C0	9	9
Internal Medicine	1049140C0	42	42
Int Med/Investigator Path	1049140C1	0	0
Neurological Surgery	1049160C0	2	2
Neurology	1049180A0	6	6
Child Neurology	1049185C0	2	2
Obstetrics-Gynecology	1049220C0	6	6
Orthopaedic Surgery	1049260C0	4	4
Ortho Surgery/Research	1049260C1	1	1
Otolaryngology	1049280C0	3	3
Pathology	1049300C0	6	6
Pediatrics	1049320C0	15	15
Pediatrics-Research	1049320C1	2	2
Plastic Surgery (Integrated)	1049362C0	2	2
Psychiatry	1049400C0	8	8
Psychiatry/Research	1049400C1	2	2
Psychiatry/Community	1049400C2	2	2
Interventional Radiology (Integ)	1049416A0	1	1
Intervent Rad (Integ)/Research	1049416A1	1	1
Radiology-Diagnostic	1049420A0	6	6
Rad-Diag/Research	1049420A1	2	2
Radiation Oncology	1049430A0	3	3
General Surgery	1049440C0	7	7
Surgery-Preliminary	1049440P0	1	1
Vascular Surgery	1049451C0	1	1
Medicine-Pediatrics	1049700C0	4	4

UC San Francisco-CA

San Francisco	Code	Quota	Matched
Anesthesiology	1062040A0	16	16
Anesthesiology	1062040C0	10	10
Anesthesiology/Research	1062040C1	0	0
Anesthesiology/Critical Care	1062040C2	0	0
Anesthesiology	1062040R0	0	0
Dermatology	1062080A0	5	5
Dermatology/2+2 Scientists	1062080A1	2	2
Emergency Medicine	1062110C0	15	15
Family Medicine	1062120C0	15	15
Internal Medicine	1062140C0	45	45
Medicine-Primary/UC	1062140M0	10	10
Medicine-Primary/SFGH	1062140M1	8	8
Neurological Surgery	1062160C0	3	3
Neurology	1062180A0	2	2
Neurology	1062180C0	10	10
Child Neurology/Adv PGY3	1062185A0	1	1
Child Neurology	1062185C0	2	2
Obstetrics-Gynecology	1062220C0	10	10
Orthopaedic Surgery	1062260C0	6	6
Ortho Surgery/Research	1062260C1	1	1
Otolaryngology	1062280C0	5	5
Pathology	1062300C0	10	10
Pediatrics	1062320C0	20	20
Pediatrics/Physician Scientist	1062320C2	3	3
Pediatrics-Primary/PLUS	1062320M0	5	5
Plastic Surgery (Integrated)	1062362C0	2	2
Plastic Surgery (Integ)/Research	1062362C1	1	1
Psychiatry	1062400C0	13	13
Psychiatry/Research	1062400C2	3	3
Interventional Radiology (Integ)	1062416A0	1	1
Radiology-Diagnostic	1062420A0	14	14
Radiation Oncology	1062430A0	3	3
General Surgery	1062440C0	8	8
Surg-Prelim/General/Specialty	1062440P0	18	10
Surg-Prelim/Int Radiology	1062440P2	0	0
Vascular Surgery	1062451C0	1	1
Pediatrics-Medical Genetics	1062765C0	1	1

UC San Francisco-East Bay-CA

Oakland	Code	Quota	Matched
General Surgery	3625440C0	7	7
Surgery-Preliminary	3625440P0	9	5

UC San Francisco-Fresno-CA

Fresno	Code	Quota	Matched
Emergency Medicine	1022110C0	12	12
Family Medicine	1022120C0	12	12
Internal Medicine	1022140C0	23	23
Obstetrics-Gynecology	1022220C0	4	4
Orthopaedic Surgery	1022260C0	4	4
Pediatrics	1022320C0	7	7
Psychiatry	1022400C0	6	6
General Surgery	1022440C0	5	5

UCLA Med Ctr-CA

Los Angeles	Code	Quota	Matched
Anesthesiology	1956040C0	27	27
Dermatology	1956080A0	3	3
Dermatology/5yr Star	1956080A1	2	1
Emergency Medicine	1956110C0	15	15
Fam Med/UCLA/Santa Monica	1956120C1	12	12
Internal Medicine	1956140C0	47	47
Internal Med/ProSTAR/PSTP	1956140C1	2	2
Medicine-Primary/UCLA-VA	1956140M0	6	6
Med-Primary/UCLA-Olive View	1956140M1	6	6
Med-Prelim/Neurology	1956140P1	3	3
Neurological Surgery	1956160C0	3	3
Neurology	1956180A0	9	9
Child Neurology	1956185C0	2	2
Obstetrics-Gynecology	1956220C0	8	8
Ob-Gyn/Preliminary	1956220P0	2	0
Orthopaedic Surgery	1956260C0	6	6
Otolaryngology	1956280C0	5	5
Pathology	1956300C0	6	6
Pediatrics	1956320C0	26	26
Pediatrics/PSTP	1956320C1	1	1
Plastic Surgery (Integrated)	1956362C0	3	3
Interventional Radiology (Integ)	1956416C0	3	3
Radiology-Diagnostic	1956420A0	12	12
Radiation Oncology	1956430A0	3	3
General Surgery	1956440C0	7	7
Surgery-Preliminary	1956440P0	3	2
Vascular Surgery	1956451C0	1	1
Medicine-Pediatrics	1956700C0	4	4

UCLA Semel Inst for Neuroscience-CA

Los Angeles	Code	Quota	Matched
Psychiatry	3030400C0	14	14
Psychiatry/Research	3030400C1	0	0
Psych/Harbor-NPI-WLAVA	3030400C2	1	1

UHS So California Med Ed Consortium

Temecula	Code	Quota	Matched
Emergency Medicine	2213110C0	10	10
Family Medicine	2213120C0	6	6
Internal Medicine	2213140C0	20	20
Transitional Year	2213999P0	13	13

VA Greater LA Hlth Sys-CA

Los Angeles	Code	Quota	Matched
Phys Medicine & Rehab	1039340A0	9	9
Psychiatry/UCLA/SFVP	1039400C0	6	6

Valley Childrens Healthcare-CA

Madera	Code	Quota	Matched
Pediatrics	1907320C0	13	13

Valley Consortium-CA

Modesto	Code	Quota	Matched
Family Medicine	1444120C0	12	12
Orthopaedic Surgery	1444260C0	3	3

Valley Health Team-CA

San Joaquin	Code	Quota	Matched
Family Medicine	2111120C0	4	4

Ventura County Med Ctr-CA

Ventura	Code	Quota	Matched
Family Medicine	1068120C0	15	15

COLORADO

Denver Health Med Ctr-CO

Denver	Code	Quota	Matched
Emergency Medicine	1077110C0	17	17

HealthONE-CO

Denver	Code	Quota	Matched
Family Medicine/Aurora	1997120C0	8	8
Internal Medicine/Sky Ridge	1997140C0	18	13
Neurology/Swedish Med Ctr	1997180C0	6	6
Psychiatry/Aurora	1997400C0	8	8
General Surgery/Swedish Med Ctr	1997440C0	3	3
General Surgery/Sky Ridge	1997440C1	3	3
Transitional/Sky Ridge	1997999P0	8	8

North Colorado Med Ctr

Greeley	Code	Quota	Matched
Family Medicine	1853120C0	6	6
Family Med/Wray	1853120C1	1	0
Family Med/Sunrise	1853120C2	2	2
Family Med/Hospitalist	1853120C3	0	0
Family Medicine/Sterling RTT	1853120C4	2	2

Parkview Med Ctr-CO

Pueblo	Code	Quota	Matched
Internal Medicine	2050140C0	10	10

Penrose Hospital-CO

Colorado Springs	Code	Quota	Matched
Pathology	2021300C0	2	2

Poudre Valley Hospital-CO

Fort Collins	Code	Quota	Matched
Family Medicine	3063120C0	8	8

St Anthony Hospital North-CO

Westminister	Code	Quota	Matched
Family Med/Health Campus	1922120C0	7	7
Family Med/84th Street	1922120C1	3	3

St Joseph Hospital SCL Health-CO

Denver	Code	Quota	Matched
Family Medicine	1074120C0	9	9
Internal Medicine	1074140C0	10	10
Medicine-Preliminary	1074140P0	8	8
Obstetrics-Gynecology	1074220C0	5	5
General Surgery	1074440C0	5	5
Surgery-Preliminary	1074440P0	8	8

St Mary-Corwin Med Ctr-CO

Pueblo	Code	Quota	Matched
Family Medicine	3005120C0	6	6
Family Medicine/Alamosa	3005120C1	2	2

St Marys Med Ctr SCL Health-CO

Grand Junction	Code	Quota	Matched
Family Medicine	3069120C0	9	9

U Colorado SOM-Denver

Aurora	Code	Quota	Matched
Anesthesiology	1076040A0	11	11
Anesthesiology/Critical Care	1076040A1	1	1
Anesthesiology	1076040C0	3	3
Anesthesiology/Critical Care	1076040C1	1	1
Anesthesiology	1076040R0	2	2
Dermatology	1076080A0	6	6
Family Med/Denver Hlth	1076120C0	5	5
Family Med/Swedish Med	1076120C2	6	6
Family Med/Univ Hosp	1076120C3	6	6
Family Med/Rural	1076120C4	2	1
Internal Medicine	1076140C0	33	33
Internal Med/Hospitalist	1076140C1	6	6
Int Med/Physician Scientist	1076140C2	2	2
Medicine-Primary	1076140M0	9	9
Medicine-Preliminary	1076140P0	9	9
Neurological Surgery	1076160C0	2	2
Neurology	1076180C0	9	9
Child Neurology	1076185C0	1	1
Child Neurology/Adult	1076185R1	1	0
Obstetrics-Gynecology	1076220C0	9	9
Ob-Gyn/Preliminary	1076220P0	1	0
Orthopaedic Surgery	1076260C0	6	6
Ortho Surgery/Research	1076260C1	1	1
Otolaryngology	1076280C0	3	3
Otolaryngology/Research	1076280C1	1	1
Pathology	1076300C0	6	5
Pediatrics	1076320C0	30	30
Phys Medicine & Rehab	1076340A0	6	6
Plastic Surgery (Integrated)	1076362C0	2	2
Psychiatry	1076400C0	13	13
Psychiatry/Research	1076400C2	2	2
Interventional Radiology (Integ)	1076416A0	2	2
Radiology-Diagnostic	1076420A0	9	9
Radiation Oncology	1076430A0	1	1
General Surgery/2 Yr Research	1076440C0	11	11
Surgery-Preliminary	1076440P0	14	4
Medicine-Pediatrics	1076700C0	4	4
Pediatrics-PM&R	1076735C0	1	1
Pediatrics-Medical Genetics	1076765C0	2	2

CONNECTICUT

Bridgeport Hospital-CT

Bridgeport	Code	Quota	Matched
Internal Medicine	1079140C0	18	18
Medicine-Preliminary	1079140P0	4	4
Med-Prelim/Radiology	1079140P1	0	0
Obstetrics-Gynecology	1079220C0	4	4
Radiology-Diagnostic	1079420A0	4	4

Danbury Hospital-CT

Danbury	Code	Quota	Matched
Internal Medicine	1081140C0	16	16
Obstetrics-Gynecology	1081220C0	3	3
Pathology	1081300C0	2	2
General Surgery	1081440C0	4	4
Surgery-Preliminary	1081440P0	3	0

Eastern CT Health Network

Manchester	Code	Quota	Matched
Family Medicine	2186120C0	7	7
Transitional	2186999P0	8	8

Greenwich Hospital-CT

Greenwich	Code	Quota	Matched
Internal Medicine	1082140C0	6	6
Medicine-Preliminary	1082140P0	7	7

Griffin Hospital-CT

Derby	Code	Quota	Matched
Internal Medicine	1977140C0	6	6
Medicine-Primary	1977140M0	2	2
Medicine-Preliminary	1977140P0	6	6
Medicine-Preventive Med/General	1977751C0	3	3

Hartford Hospital-CT

Hartford	Code	Quota	Matched
Pathology	1083300C0	3	3
Psychiatry	1083400C0	6	6
Radiology-Diagnostic	1083420A0	5	5

Middlesex Hospital-CT

Middleton	Code	Quota	Matched
Family Medicine	1087120C0	7	7

Norwalk Hospital-CT

Norwalk	Code	Quota	Matched
Internal Medicine	1093140C0	15	15
Radiology-Diagnostic	1093420A0	2	2

St Francis Hospital-CT

Hartford	Code	Quota	Matched
Obstetrics-Gynecology	1085220C0	5	5

St Marys Hospital-CT

Waterbury	Code	Quota	Matched
Internal Medicine	1096140C0	10	10
Medicine-Preliminary	1096140P0	4	4
General Surgery	1096440C0	2	2

St Marys Hospital-CT (Continued)

Surgery-Preliminary	1096440P0	2	2

St Vincents Med Ctr-CT

Bridgeport	Code	Quota	Matched
Internal Medicine	1080140C0	10	10
Medicine-Preliminary	1080140P0	4	4
Med-Prelim/Radiology	1080140P1	0	0
Radiology-Diagnostic	1080420A0	3	3

Stamford Hospital/Columbia-CT

Stamford	Code	Quota	Matched
Family Medicine	1095120C0	5	5
Internal Medicine	1095140C0	8	7
Obstetrics-Gynecology	1095220C0	4	4
General Surgery	1095440C0	3	3
Surgery-Preliminary	1095440P0	2	2

U Connecticut School of Medicine

Farmington	Code	Quota	Matched
Anesthesiology	1094040A0	3	3
Anesthesiology	1094040C0	6	6
Dermatology	1094080A0	4	4
Emergency Medicine	1094110C0	18	18
Family Medicine	1094120C0	7	7
Internal Medicine	1094140C0	40	40
Medicine-Primary	1094140M0	16	16
Medicine-Preliminary	1094140P0	5	5
Neurological Surgery	1094160C0	1	1
Neurology	1094180C0	7	7
Obstetrics-Gynecology	1094220C0	10	10
Orthopaedic Surgery	1094260C0	5	5
Otolaryngology	1094280C0	3	3
Pediatrics	1094320C0	20	20
Phys Medicine & Rehab	1094340C1	4	4
Psychiatry	1094400C0	7	7
Radiology-Diagnostic	1094420A0	2	2
General Surgery	1094440C0	6	6
Surgery-Preliminary	1094440P0	6	3

Waterbury Hospital-CT

Waterbury	Code	Quota	Matched
General Surgery	1097440C0	2	2
Surgery-Preliminary	1097440P0	2	2

Yale-New Haven Hosp-CT

New Haven	Code	Quota	Matched
Anesthesiology	1089040A0	1	1
Anesthesiology	1089040C0	21	21
Dermatology	1089080A0	6	6
Emergency Medicine	1089110C0	18	18
Emergency Medicine/Research	1089110C1	1	1
Internal Medicine	1089140C0	36	36
Int Med/Physician Scientist	1089140C1	6	6
Internal Medicine/Yale-Waterbury	1089140C2	10	10
Medicine-Primary	1089140M0	16	16
Medicine-Primary/HIV	1089140M1	2	2
Medicine-Preliminary	1089140P0	2	2
Med-Prelim/Neurology	1089140P2	9	9
Med-Prelim/Yale-Waterbury	1089140P4	6	6
Med-Prelim/Ophthalmology	1089140P6	5	5
Neurological Surgery	1089160C0	2	2
Neurology	1089180A0	10	10
Child Neurology	1089185C0	2	2
Obstetrics-Gynecology	1089220C0	8	8
Ob-Gyn/Preliminary	1089220P1	1	1
Orthopaedic Surgery	1089260C0	5	5
Otolaryngology	1089280C0	4	4
Pathology/Comb-Anat & Clin	1089300C0	8	8
Pathology/Anatomic Only	1089300C1	0	0
Pathology/Clinical Only	1089300C2	1	1
Pathology/AP & NP	1089300C3	0	0
Pediatrics	1089320C0	20	20
Plastic Surgery (Integrated)	1089362C0	3	3
Psychiatry	1089400C0	13	13
Psychiatry/Combined Adult/Child	1089400C2	2	2
Psychiatry/Research	1089400C3	3	3
Interventional Radiology (Integ)	1089416C0	3	3
Radiology-Diagnostic	1089420A0	14	14
Radiation Oncology	1089430A0	3	3
General Surgery	1089440C0	8	8
Surgery-Preliminary	1089440P0	9	7
Vascular Surgery	1089451C0	1	1
Thoracic Surgery	1089461C0	2	2
Medicine-Pediatrics	1089700C0	4	4

DELAWARE

Bayhealth Med Ctr-DE

Dover	Code	Quota	Matched
Family Medicine	2260120C0	8	0
Internal Medicine	2260140C0	12	12
General Surgery	2260440C0	3	3

Christiana Care-DE

Newark	Code	Quota	Matched
Emergency Medicine	1099110C0	12	12
Family Medicine	1099120C0	9	9
Internal Medicine	1099140C0	13	13
Obstetrics-Gynecology	1099220C0	7	7
Psychiatry	1099400C0	4	4
Interventional Radiology (Integ)	1099416C0	1	1
Radiology-Diagnostic	1099420C0	4	4
General Surgery	1099440C0	6	6
Medicine-Pediatrics	1099700C0	5	5
Medicine-Emergency Med	1099705C0	3	3
Emergency Med-Family Med	1099795C0	3	3

St Francis Hospital-DE

Wilmington	Code	Quota	Matched
Family Medicine	2058120C0	6	6

DISTRICT OF COLUMBIA

Childrens National Med Ctr-DC

Washington	Code	Quota	Matched
Child Neurology	1070185C0	3	3
Pediatrics	1070320C0	20	20
Pediatrics-Research	1070320C3	2	2
Pediatrics-Primary	1070320M0	5	5
Peds-Primary/Community Health	1070320M1	8	8
Pediatrics-Medical Genetics	1070765C0	1	1

George Washington Univ-DC

Washington	Code	Quota	Matched
Anesthesiology	1802040A0	5	5
Anesthesiology	1802040C0	5	5
Anesthesiology	1802040R0	2	2
Dermatology	1802080A0	2	2
Emergency Medicine	1802110C0	11	11
Internal Medicine	1802140C0	28	28
Int Med/Sponsored IMG	1802140C1	2	2
Medicine-Primary	1802140M0	5	5
Medicine-Preliminary	1802140P0	6	6
Med-Prelim/Dermatology	1802140P4	0	0
Med-Prelim/Radiology	1802140P5	1	1
Neurological Surgery	1802160C0	1	1
Neurology	1802180C0	4	4
Obstetrics-Gynecology	1802220C0	8	8
Orthopaedic Surgery	1802260C0	4	4
Otolaryngology	1802280C0	2	2
Pathology	1802300C0	4	4
Psychiatry	1802400C0	6	6
Interventional Radiology (Integ)	1802416A0	1	1
Radiology-Diagnostic	1802420A0	4	4
General Surgery	1802440C0	5	5

Howard Univ Hosp-DC

Washington	Code	Quota	Matched
Dermatology	2193080A0	4	4
Family Medicine	2193120C0	6	6
Internal Medicine	2193140C0	22	22
Medicine-Preliminary	2193140P0	13	11
Neurology	2193180A0	2	2
Obstetrics-Gynecology	2193220C0	4	4
Orthopaedic Surgery	2193260C0	4	4
Pathology	2193300C0	3	3
Psychiatry	2193400C0	4	4
General Surgery	2193440C0	5	5
Surgery-Preliminary	2193440P0	4	3

MedStar Georgetown Univ Hosp-DC

Washington	Code	Quota	Matched
Anesthesiology	1801040C0	12	12
Internal Medicine	1801140C0	29	29
Neurological Surgery	1801160C0	2	2
Neurology	1801180C0	6	6
Neurology/Clinician Scientist	1801180C1	1	1
Orthopaedic Surgery	1801260C0	4	4
Otolaryngology	1801280C0	3	3
Pathology	1801300C0	3	3
Pediatrics	1801320C0	11	11
Plastic Surgery (Integrated)	1801362C0	4	4
Psychiatry	1801400C0	9	9
Interventional Radiology (Integ)	1801416C0	2	2
Radiology-Diagnostic	1801420A0	4	4
Radiation Oncology	1801430A0	2	1
Gen Surgery/Georgetown-WHC	1801440C0	10	10
Surg-Prelim/Georgetown-WHC	1801440P0	9	0
Medicine-Pediatrics	1801700C0	4	4

MedStar National Rehab Hosp-DC

Washington	Code	Quota	Matched
Phys Medicine & Rehab	3191340C0	6	6

MedStar Washington Hosp Ctr-DC

Washington	Code	Quota	Matched
Dermatology	1800080A0	2	2
Emergency Med/Georgetown-WHC	1800110C0	10	10
Family Med/Georgetown-WHC	1800120C0	4	4
Internal Medicine	1800140C0	29	29
Medicine-Preliminary	1800140P0	11	11
Obstetrics-Gynecology	1800220C0	10	10
Vascular Surgery	1800451C0	2	2
Medicine-Dermatology	1800785C0	2	2

St Elizabeths Hospital/DBH-DC

Washington	Code	Quota	Matched
Psychiatry	1804400C0	9	9

FLORIDA

AdventHealth Florida

Orlando	Code	Quota	Matched
Emergency Medicine	1102110C0	6	6
Family Medicine	1102120C0	12	12
Fam Med/East Orlando/Osteopathic	1102120C1	8	8
Family Medicine/Sebring	1102120C2	8	4
Internal Medicine	1102140C0	12	12
Internal Medicine/Sebring	1102140C1	8	8
Medicine-Primary	1102140M0	2	2
Pediatrics	1102320C0	6	6
Radiology-Diagnostic	1102420A0	4	4
General Surgery	1102440C0	4	4

BayCare Health System-FL

Clearwater	Code	Quota	Matched
Pediatrics	2300320C0	8	8
Psychiatry	2300400C0	6	6

Bayfront Med Ctr-FL

St Petersburg	Code	Quota	Matched
Family Medicine	1911120C0	8	8
Obstetrics-Gynecology	1911220C0	4	4

Borinquen Health Care Ctr-FL

Miami	Code	Quota	Matched
Family Medicine	2254120C0	4	4

Broward Health Med Ctr-FL

Fort Lauderdale	Code	Quota	Matched
Dermatology	1892080A0	3	3
Emergency Medicine	1892110C0	13	8
Family Medicine	1892120C0	5	5
Internal Medicine	1892140C0	16	12
Internal Med/North Program	1892140C1	15	15
Orthopaedic Surgery	1892260C0	3	3
Pediatrics	1892320C0	8	8
Psychiatry	1892400C0	5	5
General Surgery	1892440C0	6	6

Broward Health Med Ctr-FL (Continued)

Transitional	1892999P0	4	4
Transitional/North Program	1892999P1	16	16

Centerstone-FL

Bradenton	Code	Quota	Matched
Psychiatry	2242400C0	5	5

Citrus Health Network-FL

Hialeah	Code	Quota	Matched
Psychiatry	1864400C0	4	4

Cleveland Clinic Florida

Weston	Code	Quota	Matched
Anesthesiology	1383040C0	5	5
Internal Medicine	1383140C0	9	9
Med-Prelim/Neurology	1383140P0	2	2
Medicine-Preliminary	1383140P1	2	2
Neurology	1383180A0	2	2
General Surgery	1383440C0	3	3
Surgery-Preliminary	1383440P0	3	3

Community Health of South Florida

Miami	Code	Quota	Matched
Family Medicine	2194120C0	6	6
Psychiatry	2194400C0	5	5

FAU-Schmidt COM-FL

Boca Raton	Code	Quota	Matched
Emergency Medicine	1586110C0	6	6
Internal Medicine	1586140C0	24	24
Medicine-Preliminary	1586140P0	2	2
Neurology	1586180C0	3	3
Psychiatry	1586400C0	4	4
General Surgery	1586440C0	6	6
Surgery-Preliminary	1586440P0	5	1

FIU Herbert Wertheim COM-FL

Miami	Code	Quota	Matched
Medicine-Primary	2317140M0	6	6

Florida State University COM

Tallahassee	Code	Quota	Matched
Emergency Medicine/Sarasota	1826110C0	9	9
Family Medicine/Lee Memorial	1826120C0	8	8
Family Medicine/Winter Haven	1826120C1	8	8
Internal Medicine/Tallahassee	1826140C0	8	8
Internal Medicine/Sarasota	1826140C1	13	13
Internal Medicine/Cape Coral	1826140C2	12	12
Med-Prelim/Tallahassee	1826140P0	2	2
General Surgery	1826440C0	2	2
Surgery-Preliminary	1826440P0	2	0

HCA Healthcare East FL Division GME

Tamarac	Code	Quota	Matched
Anesthesiology/Kendall	2232040A0	6	6
Anesthesiology/Westside	2232040C0	6	6
Emergency Medicine/Aventura	2232110C0	12	11
Emergency Medicine/St Lucie	2232110C1	6	0
Emergency Medicine/Kendall	2232110C2	12	10
Emergency Medicine/Westside	2232110C3	13	6
Family Medicine/St Lucie	2232120C0	6	5
Internal Medicine/Westside	2232140C0	15	2
Internal Medicine/Aventura	2232140C1	15	8
Internal Medicine/Kendall	2232140C2	14	14
Obstetrics-Gynecology/Westside	2232220C0	4	4
Pathology/Westside	2232300C0	2	1
Pediatrics/Palms West	2232320C0	6	2
Psychiatry/Aventura	2232400C0	5	5
Psychiatry/University	2232400C1	8	8
Radiology-Diagnostic/Aventura	2232420C0	5	5
General Surgery/Westside	2232440C0	4	4
General Surgery/Kendall	2232440C1	5	5
Surgery-Preliminary/Kendall	2232440P0	4	0
Surg-Prelim/Anesthesiology-Kendall	2232440P1	1	1
Transitional/Aventura	2232999P0	8	8
Transitional/Kendall	2232999P1	8	8
Trans/Anesthesiology-Kendall	2232999P2	5	5
Transitional/Westside	2232999P3	15	4

HCA Healthcare/JFK Med Center-UMiami-FL

Atlantis	Code	Quota	Matched
Internal Medicine	1384140C0	19	12
General Surgery	1384440C0	3	3
Surgery-Preliminary	1384440P0	1	1

HCA Healthcare/USF Morsani GME-Blake-FL

Bradenton	Code	Quota	Matched
Internal Medicine	1899140C0	22	7
Medicine-Preliminary	1899140P0	6	0
Transitional	1899999P0	10	10

HCA Healthcare/USF Morsani GME-Brandon-FL

Brandon	Code	Quota	Matched
Emergency Medicine	1772110C0	15	11
Internal Medicine	1772140C0	15	8
Obstetrics-Gynecology	1772220C0	5	5
Pathology	1772300C0	2	2
General Surgery	1772440C0	4	4
Surgery-Preliminary	1772440P0	4	0
Transitional	1772999P0	11	11

HCA Healthcare/USF Morsani GME-Citrus-FL

Inverness	Code	Quota	Matched
Internal Medicine	2195140C0	15	2
Medicine-Preliminary	2195140P0	5	0

HCA Healthcare/USF Morsani GME-Largo-FL

Largo	Code	Quota	Matched
Dermatology	1981080A0	3	3
Internal Medicine	1981140C0	13	13
Orthopaedic Surgery	1981260C0	2	2
Psychiatry	1981400C0	4	4
Transitional	1981999P0	8	4
Transitional/Dermatology	1981999P1	2	2

HCA Healthcare/USF Morsani GME-Oak Hill-FL

Brooksville	Code	Quota	Matched
Anesthesiology	1662040A0	6	6
Anesthesiology	1662040R1	2	2
Emergency Medicine	1662110C0	6	4
Family Medicine	1662120C0	8	5
Internal Medicine	1662140C0	20	1

HCA Healthcare/USF Morsani GME-Oak Hill-FL (Continued)

Medicine-Preliminary	1662140P0	5	0
Transitional	1662999P0	10	4
Transitional/Anesthesiology	1662999P1	0	0

HCA Healthcare/USF Morsani GME-St Pete-FL

St. Petersburg	Code	Quota	Matched
Family Medicine	2196120C0	10	10
Transitional	2196999P0	9	8

HCA Healthcare/USF Morsani GME-Trinity-FL

Trinity	Code	Quota	Matched
Internal Medicine	2235140C0	20	4
Radiology-Diagnostic	2235420A0	6	6
Transitional	2235999P0	8	1
Transitional/Radiology	2235999P1	2	2

HCA Healthcare/USF Morsani-Bayonet Pt-FL

Hudson	Code	Quota	Matched
Internal Medicine	2137140C0	20	5
General Surgery	2137440C0	3	3
Surgery-Preliminary	2137440P0	3	0
Transitional	2137999P0	11	2
Transitional/Ophthalmology	2137999P1	2	1

HCA Healthcare/USF Morsani-Northside-FL

St Petersburg	Code	Quota	Matched
Internal Medicine	2107140C0	10	3

Halifax Med Ctr-FL

Daytona Beach	Code	Quota	Matched
Family Medicine	1629120C0	8	7

Johns Hopkins All Childrens Hosp-FL

St Petersburg	Code	Quota	Matched
Pediatrics	1589320C0	12	12

Lakeside Med Ctr-FL

Belle Glade	Code	Quota	Matched
Family Medicine	2282120C0	5	5

Larkin Comm Hosp Palm Springs Campus-FL

Hialeah	Code	Quota	Matched
Dermatology	2238080A0	3	3
Family Medicine	2238120C0	8	8
Internal Medicine	2238140C0	7	7
Neurology	2238180C0	4	4
Osteo Neuromusculo Med	2238275R0	6	4
Phys Medicine & Rehab	2238340C0	8	8
Plastic Surgery (Integrated)	2238362C0	3	3

Larkin Community Hospital-FL

South Miami	Code	Quota	Matched
Anesthesiology	1481040C0	4	4
Dermatology	1481080A0	5	3
Dermatology	1481080R0	3	3
Family Medicine	1481120C0	9	9
Internal Medicine	1481140C0	6	6
Neurology	1481180C0	4	3
Orthopaedic Surgery	1481260C0	4	4
Phys Medicine & Rehab	1481340A0	7	7
Psychiatry	1481400C0	10	10
Radiology-Diagnostic	1481420A0	4	4
General Surgery	1481440C0	2	2

Manatee Memorial Hosp-FL

Bradenton	Code	Quota	Matched
Family Medicine	2109120C0	4	4
Internal Medicine	2109140C0	12	12

Mayo Clinic School of Grad Med Educ-FL

Jacksonville	Code	Quota	Matched
Anesthesiology	1032040C0	6	6
Dermatology	1032080C0	2	2
Family Medicine	1032120C0	6	6
Internal Medicine	1032140C0	14	14
Neurological Surgery	1032160C0	1	1
Neurology	1032180C0	6	6
Child Neurology	1032185A0	2	2
Interventional Radiology (Integ)	1032416C0	1	1
Radiology-Diagnostic	1032420C0	5	5
Radiation Oncology	1032430C0	1	1
General Surgery	1032440C0	3	3
Surgery-Preliminary	1032440P0	2	2

Memorial Healthcare System-FL

Pembroke Pines	Code	Quota	Matched
Anesthesiology	2085040C0	3	3
Emergency Medicine	2085110C0	10	10
Internal Medicine	2085140C0	15	15
Medicine-Preliminary	2085140P0	4	4
Neurology	2085180C0	4	4
Obstetrics-Gynecology	2085220C0	4	4
Pediatrics	2085320C0	8	8
Phys Medicine & Rehab	2085340C0	4	4
Psychiatry	2085400C0	4	4
General Surgery	2085440C0	6	6
Transitional	2085999P0	20	20

Mt Sinai Med Ctr-Miami-FL

Miami Beach	Code	Quota	Matched
Anesthesiology	1105040R0	6	3
Emergency Medicine	1105110C0	7	7
Internal Medicine	1105140C0	17	17
Medicine-Preliminary	1105140P0	4	4
Obstetrics-Gynecology	1105220C0	3	3
Psychiatry	1105400C0	3	3
Radiology-Diagnostic	1105420A0	5	5
General Surgery	1105440C0	3	3
Surgery-Preliminary	1105440P0	3	3

NCH Healthcare Sys-FL

Naples	Code	Quota	Matched
Internal Medicine	1958140C0	16	16
Transitional	1958999P0	6	6

Nemours Childrens Hosp-FL

Orlando	Code	Quota	Matched
Pediatrics	2175320C0	12	12

Nicklaus Childrens Hospital-Miami-FL

Miami	Code	Quota	Matched
Pediatrics	1110320C0	27	27

Nicklaus Childrens Hospital-Miami-FL (Continued)

Pediatrics/SACM	1110320C1	1	1

Nova Southeastern University KPCOM-FL

Clearwater	Code	Quota	Matched
Psychiatry/Orlando	2256400C0	6	6
Psychiatry/Bay Pines	2256400C1	3	1

Orange Park Med Ctr-FL

Orange Park	Code	Quota	Matched
Dermatology	1771080A0	3	3
Emergency Medicine	1771110C0	12	2
Family Medicine	1771120C0	6	4
Internal Medicine	1771140C0	13	3
Psychiatry	1771400C0	4	4
General Surgery	1771440C0	3	3
Transitional	1771999P0	14	10

Orlando Health-FL

Orlando	Code	Quota	Matched
Emergency Medicine	1107110C0	18	18
Internal Medicine	1107140C0	13	13
Medicine-Preliminary	1107140P0	2	2
Neurology	1107180C0	2	2
Obstetrics-Gynecology	1107220C0	7	7
Orthopaedic Surgery	1107260C0	5	5
Pathology	1107300C0	2	2
General Surgery	1107440C0	6	6
Surgery-Preliminary	1107440P0	6	5

Palmetto General Hosp-FL

Hialeah	Code	Quota	Matched
Family Medicine	2121120C0	4	4
Internal Medicine	2121140C0	19	13
Neurology	2121180C0	1	1

St Vincents Med Ctr-FL

Jacksonville	Code	Quota	Matched
Family Medicine	3125120C0	10	10

Tallahassee Mem Healthcare-FL

Tallahassee	Code	Quota	Matched
Family Medicine	2926120C0	11	9

U Central FL/HCA Healthcare GME

Orlando	Code	Quota	Matched
Anesthesiology/Ocala	1587040A0	9	9
Dermatology	1587080A0	2	2
Dermatology	1587080R0	2	2
Emergency Med/Orlando	1587110C0	7	7
Emergency Med/Gainesville	1587110C1	8	8
Emergency Med/Ocala	1587110C2	7	6
Family Medicine/Gainesville	1587120C0	8	8
Family Medicine/Ocala	1587120C1	6	3
Internal Med/Orlando	1587140C0	25	25
Internal Medicine/Ocala	1587140C1	15	8
Internal Med/Gainesville	1587140C2	20	15
Neurology/Kissimmee	1587180C0	4	4
Ob-Gyn/Kissimmee	1587220C0	3	3
Ob-Gyn/Gainesville	1587220C1	4	4
Ob-Gyn/Pensacola	1587220C2	3	3
Orthopaedic Surgery/Ocala	1587260C0	3	3
Phys Med & Rehab/Pensacola	1587340A0	4	4
Psychiatry/Gainesville	1587400C0	8	8
Psychiatry/Kissimmee	1587400C1	6	6
Psychiatry/Tallahassee	1587400C2	6	4
General Surgery/Ocala	1587440C0	4	4
General Surgery/Kissimmee	1587440C1	3	3
Surg-Prelim/Ocala	1587440P0	4	0
Transitional/Orlando	1587999P0	14	14
Transitional/Ocala	1587999P1	13	11
TransitionalGainesville	1587999P2	12	12

U Florida COM-Jacksonville

Jacksonville	Code	Quota	Matched
Anesthesiology	1101040C0	4	4
Emergency Medicine	1101110C0	15	15
Emergency Medicine/Military	1101110C1	1	1
Internal Medicine	1101140C0	14	14
Medicine-Preliminary	1101140P0	6	2
Med-Prelim/Neurology	1101140P1	4	4
Med-Prelim/Radiology	1101140P2	1	1
Neurology	1101180A0	4	4
Obstetrics-Gynecology	1101220C0	6	6
Orthopaedic Surgery	1101260C0	4	4
Pathology	1101300C0	2	2
Pediatrics	1101320C0	14	11
Peds-Prelim/Child Neurology	1101320P0	2	2
Psychiatry	1101400C0	3	3
Psychiatry/CAP	1101400C1	2	2
Interventional Radiology (Integ)	1101416A0	1	1
Radiology-Diagnostic	1101420A0	5	5
General Surgery	1101440C0	5	5
Surgery-Preliminary	1101440P0	6	0
Surg-Prelim/Ophthalmology	1101440P2	0	0

U Florida COM-Shands Hosp

Gainesville	Code	Quota	Matched
Anesthesiology	1824040A0	1	1
Anesthesiology	1824040C0	20	20
Anesthesiology/Research	1824040C1	0	0
Anesthesiology	1824040R1	6	6
Dermatology	1824080A0	4	4
Emergency Medicine	1824110C0	14	14
Family Medicine	1824120C0	9	6
Internal Med/Gainesville	1824140C0	33	33
Internal Med/Pensacola	1824140C1	4	4
Medicine-Preliminary	1824140P0	14	14
Neurological Surgery	1824160C0	2	2
Neurology	1824180C0	8	8
Child Neurology	1824185C0	1	0
Ob-Gyn/Gainesville	1824220C0	5	5
Ob-Gyn/Pensacola	1824220C1	4	4
Orthopaedic Surgery	1824260C0	4	4
Otolaryngology	1824280C0	3	3
Pathology	1824300C0	4	4
Pediatrics/Gainesville	1824320C0	17	17
Peds/Arnold Palmer-Orlando	1824320C1	14	14
Pediatrics/Pensacola	1824320C3	9	9
Phys Medicine & Rehab	1824340A0	4	4
Plastic Surgery (Integrated)	1824362C0	1	1

U Florida COM-Shands Hosp (Continued)

Psychiatry	1824400C0	11	11
Radiology-Diagnostic	1824420A0	11	11
Radiation Oncology	1824430A0	2	2
General Surgery	1824440C0	6	6
Surgery-Preliminary	1824440P0	8	3
Thoracic Surgery	1824461C0	1	1

U Miami MSOM/Holy Cross-FL

Miami	Code	Quota	Matched
Internal Medicine	1821140C0	14	14
Medicine-Preliminary	1821140P0	6	6
General Surgery	1821440C0	3	3
Transitional	1821999P0	15	15

U Miami/Jackson Health System-FL

Miami	Code	Quota	Matched
Anesthesiology	1104040A0	2	2
Anesthesiology	1104040C3	26	26
Dermatology	1104080A0	5	5
Emergency Medicine	1104110C0	14	14
Emergency Med/Funded	1104110C1	1	0
Family Medicine	1104120C0	8	8
Internal Medicine	1104140C0	24	24
Internal Med/Funded	1104140C1	1	1
Internal Med/Harrington	1104140C2	11	11
Internal Med/Urban Health	1104140C3	2	2
Medicine-Preliminary	1104140P0	4	4
Med-Prelim/BPEI	1104140P3	7	7
Neurological Surgery	1104160C0	3	3
Neurology	1104180A0	3	3
Neurology	1104180C0	9	9
Neurology	1104180R0	1	1
Obstetrics-Gynecology	1104220C0	8	8
Orthopaedic Surgery	1104260C0	7	7
Otolaryngology	1104280C0	3	3
Otolaryngology/Research	1104280C1	1	1
Pathology	1104300C0	6	6
Pediatrics	1104320C0	22	22
Phys Medicine & Rehab	1104340A0	8	8
Plastic Surgery (Integrated)	1104362C0	2	2
Psychiatry	1104400C0	14	14
Interventional Radiology (Integ)	1104416A0	3	3
Radiology-Diagnostic	1104420A0	9	9
Rad-Diag/International	1104420A2	1	1
Radiation Oncology	1104430A0	2	1
General Surgery	1104440C0	7	7
Surgery-Preliminary	1104440P1	13	13
Vascular Surgery	1104451C0	1	1
Medicine-Pediatrics	1104700C0	5	5

U South Florida Morsani COM-Tampa

Tampa	Code	Quota	Matched
Dermatology	1109080A0	4	4
Emergency Medicine	1109110C0	10	10
Family Medicine	1109120C0	8	8
Internal Medicine	1109140C0	33	33
Medicine-Preliminary	1109140P0	6	0
Med-Prelim/Dermatology	1109140P1	1	1
Med-Prelim/Radiology	1109140P2	4	4
Med-Prelim/Radiation Onc	1109140P3	2	2
Med-Prelim/Ophthalmology	1109140P4	4	4
Neurological Surgery	1109160C0	2	2
Neurology	1109180C0	8	8
Obstetrics-Gynecology	1109220C0	6	6
Orthopaedic Surgery	1109260C0	4	4
Otolaryngology	1109280C0	3	3
Pathology	1109300C0	3	3
Pediatrics	1109320C0	12	12
Phys Medicine & Rehab	1109340C2	3	3
Plastic Surgery (Integrated)	1109362C0	4	4
Psychiatry	1109400C0	10	10
Interventional Radiology (Integ)	1109416A0	2	2
Radiology-Diagnostic	1109420A0	6	6
Radiology-Diagnostic	1109420R0	1	1
Radiation Oncology	1109430A0	2	2
General Surgery	1109440C0	6	6
Surgery-Preliminary	1109440P0	4	3
Vascular Surgery	1109451C0	2	2
Medicine-Pediatrics	1109700C0	5	5

Wellington Reg Med Ctr-FL

Wellington	Code	Quota	Matched
Internal Medicine	2218140C0	8	8

West Kendall Baptist Hospital-FL

Miami	Code	Quota	Matched
Family Medicine	1538120C0	4	4

GEORGIA

AU-UGA Medical Partnership-GA

Athens	Code	Quota	Matched
Internal Medicine	1744140C0	11	8
Medicine-Preliminary	1744140P0	1	1

Archbold Medical Center

Thomasville	Code	Quota	Matched
Internal Medicine	2324140C0	5	5

Atlanta Med Ctr-GA

Atlanta	Code	Quota	Matched
Family Medicine	1112120C0	6	6
Internal Medicine	1112140C0	10	10
Orthopaedic Surgery	1112260C0	4	4
General Surgery	1112440C0	3	3
Surgery-Preliminary	1112440P0	2	1

Atrium Health Navicent Med Ctr-GA

Macon	Code	Quota	Matched
Family Medicine	1120120C0	6	6
Internal Medicine	1120140C0	9	9
Medicine-Preliminary	1120140P0	3	1
Obstetrics-Gynecology	1120220C0	4	4
Pediatrics	1120320C0	6	2
General Surgery	1120440C0	5	5

Coliseum Med Ctrs-GA

Macon	Code	Quota	Matched
Emergency Medicine	1972110C0	8	4
Internal Medicine	1972140C0	10	1

Coliseum Med Ctrs-GA (Continued)

Psychiatry	1972400C0	5	4
Transitional	1972999P0	13	13

Emory Univ SOM-GA

Atlanta	Code	Quota	Matched
Anesthesiology	1113040A0	4	4
Anesthesiology	1113040C0	8	8
Dermatology	1113080A0	7	7
Emergency Medicine	1113110C0	19	19
Family Medicine	1113120C0	10	10
Internal Medicine	1113140C0	43	43
Internal Med/Research	1113140C1	3	3
Medicine-Primary	1113140M0	8	8
Medicine-Preliminary	1113140P1	6	6
Neurological Surgery	1113160C0	2	2
Neurology	1113180A0	10	10
Child Neurology	1113185C0	3	3
Child Neurology	1113185R1	1	1
Obstetrics-Gynecology	1113220C0	9	9
Orthopaedic Surgery	1113260C0	6	6
Otolaryngology	1113280C0	4	4
Pathology	1113300C0	9	9
Pathology/Research	1113300C1	0	0
Pediatrics	1113320C0	25	25
Phys Medicine & Rehab	1113340A0	6	6
Plastic Surgery (Integrated)	1113362C0	2	2
Psychiatry	1113400C0	11	11
Psychiatry/Research	1113400C1	1	1
Interventional Radiology (Integ)	1113416A0	4	4
Radiology-Diagnostic	1113420A0	11	11
Radiology-Diag/Research	1113420A1	2	2
Rad-Diag/Molecular Imaging	1113420A3	1	1
Radiation Oncology	1113430A0	3	3
General Surgery	1113440C0	10	10
Surgery-Preliminary	1113440P0	3	3
Vascular Surgery	1113451C0	2	2
Thoracic Surgery	1113461C0	1	1
Medicine-Psychiatry	1113715C0	2	2
Transitional	1113999P0	4	4
Transitional/Anesthesiology	1113999P1	4	4
Transitional/Neurology	1113999P2	10	10
Transitional/Radiology	1113999P3	9	9

Floyd Med Ctr-GA

Rome	Code	Quota	Matched
Family Medicine	1992120C0	8	8

Gateway Behavioral Hlth Comm Svc-GA

Savannah	Code	Quota	Matched
Psychiatry	2165400C0	8	8

Hamilton Med Ctr-GA

Dalton	Code	Quota	Matched
Family Medicine	2222120C0	6	6
Internal Medicine	2222140C0	10	10

Houston Healthcare-GA

Warner Robins	Code	Quota	Matched
Family Medicine	2130120C0	6	6

Medical College of Georgia

Augusta	Code	Quota	Matched
Anesthesiology	1985040C0	11	11
Anesthesiology	1985040R0	1	1
Dermatology	1985080A0	3	3
Emergency Medicine	1985110C0	6	6
Family Medicine	1985120C0	11	11
Family Med/Waycross	1985120C1	2	2
Internal Medicine	1985140C0	20	20
Int Med/Research Clinician	1985140C1	1	0
Medicine-Preliminary	1985140P0	6	6
Med-Prelim/Ophthalmology	1985140P1	3	3
Neurological Surgery	1985160C0	1	1
Neurology	1985180C0	6	6
Child Neurology	1985185C0	1	0
Obstetrics-Gynecology	1985220C0	5	5
Orthopaedic Surgery	1985260C0	4	4
Otolaryngology	1985280C0	3	3
Pathology	1985300C0	2	2
Pediatrics	1985320C0	15	15
Psychiatry	1985400C0	7	7
Interventional Radiology (Integ)	1985416A0	1	1
Radiology-Diagnostic	1985420A0	5	5
General Surgery	1985440C0	5	5
Surg-Prelim/Non-designated	1985440P1	2	1

Memorial Health-Univ Med Ctr-GA

Savannah	Code	Quota	Matched
Family Medicine	1971120C0	5	2
Internal Medicine	1971140C0	13	11
Obstetrics-Gynecology	1971220C0	4	4
Pediatrics	1971320C0	7	7
Radiology-Diagnostic	1971420A0	4	4
General Surgery	1971440C0	5	5

Morehouse Sch of Med-GA

Atlanta	Code	Quota	Matched
Family Medicine	2099120C0	6	6
Internal Medicine	2099140C0	27	23
Medicine-Preliminary	2099140P0	4	4
Obstetrics-Gynecology	2099220C0	4	4
Pediatrics	2099320C0	6	3
Psychiatry	2099400C0	5	5
General Surgery	2099440C0	3	3
Surgery-Preliminary	2099440P0	6	3

Northeast Georgia Med Ctr

Gainesville	Code	Quota	Matched
Emergency Medicine	2166110C0	12	12
Family Medicine	2166120C0	12	12
Internal Medicine	2166140C0	20	20
Psychiatry	2166400C0	6	6
General Surgery	2166440C0	6	6

Northside Hospital Gwinnett-GA

Lawrenceville	Code	Quota	Matched
Family Medicine	1796120C0	5	5
Internal Medicine	1796140C0	14	14
Medicine-Preliminary	1796140P0	3	0
Transitional	1796999P0	10	10

Phoebe Putney Mem Hosp-GA

Albany	Code	Quota	Matched
Family Medicine	1020120C0	8	5

Piedmont Athens Regional-GA

Athens	Code	Quota	Matched
Internal Medicine	1805140C0	20	20
Transitional	1805999P0	10	7

Piedmont Columbus Regional-GA

Columbus	Code	Quota	Matched
Family Medicine	1118120C0	12	12

Redmond Regional Med Ctr-GA

Rome	Code	Quota	Matched
Internal Medicine	1867140C0	13	13
Transitional	1867999P0	13	10

South Georgia Med Ctr

Valdosta	Code	Quota	Matched
Internal Medicine	2292140C0	8	8

South Georgia Med Ed & Res Consortium

Moultrie	Code	Quota	Matched
Family Medicine	2147120C0	4	4
Psychiatry	2147400C0	3	3

St Francis-Emory Healthcare-GA

Columbus	Code	Quota	Matched
Internal Medicine	2326140C0	10	8

WellStar Kennestone Reg Med Ctr-GA

Marietta	Code	Quota	Matched
Emergency Medicine	1814110C0	14	14
Family Medicine	1814120C0	8	8
Internal Medicine	1814140C0	17	17
Obstetrics-Gynecology	1814220C0	4	4
Transitional	1814999P0	20	20

Wellstar Spalding Reg Hosp-GA

Griffin	Code	Quota	Matched
Internal Medicine	2328140C0	10	10

HAWAII

Hilo Medical Center-HI

Hilo	Code	Quota	Matched
Family Medicine	1691120C0	6	6

Kaiser Permanente Hawaii

Honolulu	Code	Quota	Matched
Internal Medicine	1727140C0	5	5

Tripler Army Med Ctr-HI

Tripler Amc	Code	Quota	Matched
Internal Medicine	1431140C0	6	6
Psychiatry	1431400C0	1	1
Radiology-Diagnostic	1431420C0	1	1

University of Hawaii

Honolulu	Code	Quota	Matched
Family Medicine	3350120C0	7	7
Internal Medicine	3350140C0	17	17
Medicine-Primary	3350140M0	2	2
Medicine-Preliminary	3350140P0	2	0
Obstetrics-Gynecology	3350220C0	6	6
Orthopaedic Surgery	3350260C0	1	1
Ortho Surgery/Research	3350260C1	1	1
Pathology	3350300C0	3	1
Pediatrics	3350320C0	8	8
Psychiatry	3350400C0	7	7
General Surgery	3350440C0	5	5

IDAHO

Eastern Idaho Reg Med Ctr

Idaho Falls	Code	Quota	Matched
Family Medicine	2140120C0	6	3
Internal Medicine	2140140C0	10	1

Family Medicine Res of Idaho

Boise	Code	Quota	Matched
Family Medicine	3039120C0	12	11
Family Med/Rural	3039120C1	4	4
Family Med/Magic Valley Rural	3039120C2	2	2
Family Med/Nampa	3039120C3	6	6

Idaho State University

Pocatello	Code	Quota	Matched
Family Medicine	1005120C0	7	7
Family Medicine/Rexburg	1005120C1	1	1

Kootenai Health-ID

Coeur D'Alene	Code	Quota	Matched
Family Medicine	1593120C0	7	7

U Washington Boise-ID

Boise	Code	Quota	Matched
Internal Medicine	1172140C0	10	10
Medicine-Preliminary	1172140P1	4	4
Psychiatry	1172400C0	4	4

ILLINOIS

Advocate Health Care-IL

Downers Grove	Code	Quota	Matched
Emergency Medicine/ACMC	2117110C0	14	14
Family Medicine/ACMC	2117120C0	8	8
Family Medicine/AIMMC	2117120C1	8	8
Family Medicine/ALGH	2117120C2	9	9
Internal Medicine/AIMMC	2117140C0	16	16
Internal Medicine/ALGH	2117140C1	18	18
Internal Medicine/ACMC	2117140C2	21	21
Med-Prelim/AIMMC	2117140P0	6	6
Med-Prelim/ALGH	2117140P1	8	8
Medicine-Preliminary/ACMC	2117140P2	2	2
Obstetrics-Gynecology/AIMMC	2117220C0	3	3
Obstetrics-Gynecology/ALGH	2117220C1	4	4
Pediatrics/ACMC	2117320C0	13	13
Pediatrics/ALGH	2117320C1	14	14
Psychiatry/ALGH	2117400C0	4	4
Radiology-Diagnostic/AIMMC	2117420A0	3	3
General Surgery	2117440C0	7	7
Surgery-Preliminary	2117440P0	2	2

Amita Resurrection Med Ctr-IL

Chicago	Code	Quota	Matched
Emergency Medicine	1937110C0	13	13
Family Medicine	1937120C0	6	6
Transitional	1937999P0	14	14

Amita St Francis Hosp-IL

Evanston	Code	Quota	Matched
Internal Medicine	1168140C0	16	16
Medicine-Preliminary	1168140P0	6	6
Obstetrics-Gynecology	1168220C0	6	6
Radiology-Diagnostic	1168420A0	3	2
Transitional	1168999P0	10	10

Amita St Joseph Hosp-IL

Chicago	Code	Quota	Matched
Family Medicine	1405120C0	6	6
Internal Medicine	1405140C0	20	20
Medicine-Preliminary	1405140P0	5	5
Obstetrics-Gynecology	1405220C0	3	1
General Surgery	1405440C0	2	2
Surgery-Preliminary	1405440P0	2	2
Transitional	1405999P0	6	6

Amita Sts Mary and Elizabeth Med Ctr-IL

Chicago	Code	Quota	Matched
Family Medicine	1389120C0	12	12

Carle Foundation Hosp-IL

Urbana	Code	Quota	Matched
Family Medicine/Urbana	1226120C0	6	6
Family Medicine/Normal	1226120C2	2	0
Internal Medicine	1226140C0	11	11
Int Med/ABIM Research Path	1226140C1	0	0
Medicine-Primary	1226140M0	2	2
Medicine-Preliminary	1226140P0	2	2
Neurology	1226180C0	1	1
Obstetrics-Gynecology	1226220C0	4	4
Psychiatry	1226400C0	4	4
General Surgery	1226440C0	4	4
Vascular Surgery	1226451C0	1	1

Cook County Health and Hosps Sys-IL

Chicago	Code	Quota	Matched
Anesthesiology	1127040C0	9	9
Dermatology	1127080A0	3	3
Emergency Medicine	1127110C0	17	17
Family Medicine	1127120C0	12	12
Internal Medicine	1127140C0	41	41
Medicine-Primary	1127140M0	4	4
Pediatrics	1127320C0	4	4
Radiology-Diagnostic	1127420A0	4	4

Franciscan Health Olympia Fields-IL

Olympia Fields	Code	Quota	Matched
Emergency Medicine	1950110C0	8	8
Internal Medicine	1950140C0	16	16
Orthopaedic Surgery	1950260C0	4	4
Radiology-Diagnostic	1950420C0	3	3
General Surgery	1950440C0	3	3

Hinsdale Hospital-IL

Hinsdale	Code	Quota	Matched
Family Medicine	3006120C0	9	9

La Grange Mem Hosp-IL

La Grange	Code	Quota	Matched
Family Medicine	3037120C0	7	7

Lawndale Christian Health Ctr-IL

Chicago	Code	Quota	Matched
Family Medicine	2237120C0	6	6

Loyola Univ Med Ctr-IL

Maywood	Code	Quota	Matched
Anesthesiology	1170040C0	13	13
Anesthesiology	1170040R0	1	1
Dermatology	1170080A0	3	3
Emergency Medicine	1170110C0	6	6
Internal Medicine	1170140C0	34	34
Medicine-Preliminary	1170140P0	5	5
Neurological Surgery	1170160C0	2	2
Neurology	1170180C0	6	6
Obstetrics-Gynecology	1170220C0	5	5
Orthopaedic Surgery	1170260C0	5	5
Otolaryngology	1170280C0	3	3
Pathology	1170300C0	4	4
Pediatrics	1170320C0	10	10
Plastic Surgery (Integrated)	1170362C0	1	1
Psychiatry	1170400C0	6	6
Radiology-Diagnostic	1170420A0	7	7
Radiation Oncology	1170430A0	2	2
General Surgery	1170440C0	6	6
Surgery-Preliminary	1170440P0	10	1
Vascular Surgery	1170451C0	1	1
Medicine-Pediatrics	1170700C0	4	4

MacNeal Hospital-IL

Berwyn	Code	Quota	Matched
Family Medicine	1121120C0	12	12
Internal Medicine	1121140C0	14	14
Transitional	1121999P0	12	12
Transitional/Ophthalmology	1121999P1	4	3

Marianjoy Rehab Hosp-IL

Wheaton	Code	Quota	Matched
Phys Medicine & Rehab	1103340A0	6	6

Mercyhealth GME Consortium-IL

Rockford	Code	Quota	Matched
Family Medicine	2163120C0	10	10
Internal Medicine	2163140C0	13	13

Mt Sinai Hosp Med Ctr-IL

Chicago	Code	Quota	Matched
Medicine-Preliminary	1144140P0	3	1
Obstetrics-Gynecology	1144220C0	4	4

Northwestern McGaw/Lurie Childrens-IL

Chicago	Code	Quota	Matched
Child Neurology	1842185C0	3	3
Pediatrics	1842320C0	31	31

Northwestern McGaw/NMH/VA-IL

Chicago	Code	Quota	Matched
Anesthesiology/3 Yr	2247040A0	8	8
Anesthesiology/4 Yr	2247040C0	15	15
Anesthesiology	2247040R0	1	1
Dermatology	2247080A0	5	5
Emergency Medicine	2247110C0	15	15
Family Med/Erie-Swedish	2247120C0	8	8
Family Med/Lake Forest	2247120C1	8	8
Family Med/Delnor	2247120C2	8	8
Internal Medicine	2247140C0	34	34
Internal Medicine/PSTP	2247140C1	4	4
Medicine-Preliminary	2247140P0	1	1
Med-Prelim/Neurology	2247140P1	10	10
Neurological Surgery	2247160C0	3	3
Neurology	2247180A0	10	10
Obstetrics-Gynecology	2247220C0	12	12
Orthopaedic Surgery	2247260C0	6	6
Otolaryngology	2247280C0	3	3
Pathology	2247300C0	5	5
Pathology/Investigator Trk	2247300C1	1	1
Plastic Surgery (Integrated)	2247362C0	2	2
Psychiatry	2247400C0	8	8
Psychiatry/Research	2247400C1	1	1
Interventional Radiology (Integ)	2247416A0	2	2
Radiology-Diagnostic	2247420A0	10	10
Radiology-Diagnostic	2247420R0	1	1
Radiation Oncology/4 yr	2247430A0	2	2
General Surgery	2247440C0	6	6
Surgery-Preliminary	2247440P0	4	3
Vascular Surgery	2247451C0	1	1
Thoracic Surgery	2247461C0	1	1
Medicine-Dermatology	2247785C0	1	1

Northwestern McGaw/RIC-IL

Chicago	Code	Quota	Matched
Phys Medicine & Rehab	2155340A0	8	8
Phys Medicine & Rehab	2155340C0	4	4

Quincy Fam Prac Ctr-IL

Quincy	Code	Quota	Matched
Family Medicine	2026120C0	6	5

RFUMS/Chicago Medical School-IL

North Chicago	Code	Quota	Matched
Internal Medicine	3053140C0	10	10
Internal Medicine/McHenry	3053140C1	13	13
Psychiatry	3053400C0	8	8

Riverside Medical Ctr-IL

Kankakee	Code	Quota	Matched
Internal Medicine	2177140C0	5	5
Psychiatry	2177400C0	3	3

Rush University Med Ctr-IL

Chicago	Code	Quota	Matched
Anesthesiology	1147040C0	16	16
Anesthesiology	1147040R0	4	4
Dermatology	1147080A0	2	2
Emergency Medicine	1147110C0	12	12
Family Medicine	1147120C0	8	3
Internal Medicine	1147140C0	34	34
Neurological Surgery	1147160C0	3	3
Neurology	1147180C0	8	8
Obstetrics-Gynecology	1147220C0	6	6
Orthopaedic Surgery	1147260C0	5	5
Otolaryngology	1147280C0	2	2
Pathology	1147300C0	4	4
Pediatrics	1147320C0	11	10
Phys Medicine & Rehab	1147340C0	4	4
Plastic Surgery (Integrated)	1147362C0	2	2
Psychiatry	1147400C0	8	8
Interventional Radiology (Integ)	1147416C0	4	4
Radiology-Diagnostic	1147420A0	5	5
Radiation Oncology	1147430A1	1	1
Radiation Oncology	1147430C1	1	1
General Surgery	1147440C0	9	9
Surgery-Preliminary	1147440P0	12	1
Medicine-Pediatrics	1147700C0	4	4

Rush-Copley Mem Hosp-IL

Aurora	Code	Quota	Matched
Family Medicine	1323120C0	4	4

SIU Carbondale-IL

Carbondale	Code	Quota	Matched
Family Medicine	2948120C0	6	6

SIU Decatur-IL

Decatur	Code	Quota	Matched
Family Medicine	2016120C0	5	5

SIU SOM & Affil Hosps-IL

Springfield	Code	Quota	Matched
Dermatology	2922080C0	3	3
Emergency Medicine	2922110C0	8	7
Family Medicine	2922120C0	10	10
Family Medicine/Alton	2922120C1	6	6
Internal Medicine	2922140C0	16	16
Medicine-Preliminary	2922140P0	2	2
Neurological Surgery	2922160C0	1	1
Neurology	2922180C0	4	4
Obstetrics-Gynecology	2922220C0	4	4
Orthopaedic Surgery	2922260C0	3	3
Otolaryngology	2922280C0	2	2
Pediatrics	2922320C0	8	8
Plastic Surgery (Integrated)	2922362C0	2	2
Psychiatry	2922400C0	4	4
Psychiatry/Child Psych	2922400C2	2	2
Radiology-Diagnostic	2922420C0	4	4
General Surgery	2922440C0	5	5
Vascular Surgery	2922451C0	1	1
Medicine-Psychiatry	2922715C0	2	2

Schwab Rehab Hosp-IL

Chicago	Code	Quota	Matched
Phys Medicine & Rehab	1339340A0	5	5

Swedish Hospital-IL

Chicago	Code	Quota	Matched
Emergency Medicine	1159110C0	5	5

Swedish Hospital-IL (Continued)

Family Medicine	1159120C1	4	4
Internal Medicine	1159140C0	10	10

U Illinois COM-Chicago

Chicago	Code	Quota	Matched
Anesthesiology	1150040C0	14	14
Anesthesiology	1150040R0	1	1
Dermatology	1150080A0	4	4
Emergency Medicine	1150110C0	15	15
Family Medicine/UIH	1150120C1	8	8
Family Med/Gibson City	1150120C2	1	0
Internal Medicine/UIH	1150140C1	35	35
Med-Prelim/UIH	1150140P0	10	10
Neurological Surgery	1150160C0	1	1
Neurology	1150180C0	5	5
Obstetrics-Gynecology	1150220C0	7	7
Orthopaedic Surgery	1150260C0	6	6
Otolaryngology	1150280C0	3	3
Pathology	1150300C1	6	6
Pediatrics	1150320C0	10	10
Pediatrics/Internationally Funded	1150320C1	1	1
Peds-Prelim/Child Neurology	1150320P0	1	1
Psychiatry	1150400C0	8	8
Psychiatry/Research	1150400C2	2	2
Interventional Radiology (Integ)	1150416A0	2	2
Radiology-Diagnostic	1150420A0	4	4
General Surgery	1150440C0	7	7
Surg-Prelim/Undesignated	1150440P1	11	0
Medicine-Pediatrics	1150700C0	4	4
Medicine-Emergency Med	1150705C0	3	3

U Illinois COM-Peoria OSF

Peoria	Code	Quota	Matched
Emergency Medicine	1175110C0	14	14
Internal Medicine	1175140C0	12	12
Neurological Surgery	1175160C0	2	2
Neurology	1175180C0	4	4
Obstetrics-Gynecology	1175220C0	4	4
Pediatrics	1175320C0	12	12
Radiology-Diagnostic	1175420C0	4	4
General Surgery	1175440C0	4	4
Medicine-Pediatrics	1175700C0	9	9
Transitional	1175999P0	8	8

U Illinois COM-Peoria UPHM

Peoria	Code	Quota	Matched
Family Medicine	2267120C0	10	10
Psychiatry	2267400C0	4	4

U Illinois COM-Rockford

Rockford	Code	Quota	Matched
Family Medicine	2268120C0	8	8
Family Med/Dixon Rural	2268120C1	2	2
Family Medicine/Monroe	2268120C2	3	2

UIC/Mt Sinai Hosp Med Ctr-IL

Chicago	Code	Quota	Matched
General Surgery	1287440C0	3	3
Surgery-Preliminary	1287440P0	2	0

Univ of Chicago Med Ctr-IL

Chicago	Code	Quota	Matched
Anesthesiology	1160040A0	8	8
Anesthesiology/UCM-NS Prelim	1160040C0	12	12
Dermatology	1160080A0	3	3
Emergency Medicine	1160110C0	18	18
Family Medicine/NorthShore	1160120C0	6	6
Internal Medicine	1160140C0	33	33
Int Med/MD Scientist	1160140C1	1	1
Internal Medicine/NorthShore	1160140C2	16	16
Medicine-Preliminary	1160140P0	5	5
Med-Prelim/NorthShore	1160140P2	13	13
Med-Prelim/Neurology-NShore	1160140P3	5	5
Med-Prelim/Neurology	1160140P5	1	1
Neurological Surgery	1160160C0	2	2
Neurology	1160180A0	8	8
Child Neurology	1160185C0	2	2
Obstetrics-Gynecology	1160220C0	7	7
Orthopaedic Surgery	1160260C0	5	5
Otolaryngology	1160280C0	3	3
Pathology	1160300C0	7	7
Pathology/Clinical	1160300C1	1	1
Pathology/NorthShore	1160300C2	3	3
Pediatrics	1160320C0	20	20
Pediatrics/Med Education	1160320C1	1	1
Pediatrics/Health Services	1160320C4	0	0
Plastic Surgery (Integrated)	1160362C0	3	3
Psychiatry	1160400C0	7	7
Interventional Radiology (Integ)	1160416A0	2	2
Radiology-Diagnostic	1160420A0	6	6
Radiation Oncology	1160430A0	2	2
General Surgery	1160440C0	7	7
Surgery-Preliminary	1160440P2	4	4
Medicine-Pediatrics	1160700C0	4	4

Weiss Memorial Hospital-IL

Chicago	Code	Quota	Matched
Transitional	1846999P0	8	8

West Suburban Med Ctr-IL

Oak Park	Code	Quota	Matched
Family Medicine	1173120C0	10	2

INDIANA

Ascension St Vincent Hosp-IN

Indianapolis	Code	Quota	Matched
Family Medicine	1189120C0	8	8
Internal Medicine	1189140C0	16	16
Medicine-Preliminary	1189140P0	4	4
Obstetrics-Gynecology	1189220C0	5	5
Pediatrics	1189320C0	6	6
General Surgery	1189440C0	3	3
Transitional	1189999P0	18	18

Community Health Network-IN

Indianapolis	Code	Quota	Matched
Family Medicine	3027120C0	10	10
Family Med/South Hospital	3027120C1	4	4
Psychiatry	3027400C0	4	4

Deaconess Hospital-IN

Evansville	Code	Quota	Matched
Family Medicine	3029120C0	8	8

Franciscan Health-IN

Indianapolis	Code	Quota	Matched
Family Medicine	2963120C0	9	9

Ft Wayne Med Ed Prog-IN

Fort Wayne	Code	Quota	Matched
Family Medicine	1178120C0	8	8

Indiana Univ Health Ball Memorial Hosp

Muncie	Code	Quota	Matched
Family Medicine	1192120C0	8	8
Internal Medicine	1192140C0	8	8
Transitional	1192999P0	11	11

Indiana University SOM

Indianapolis	Code	Quota	Matched
Anesthesiology	1187040A0	22	22
Anesthesiology	1187040C0	4	4
Anesthesiology	1187040R1	1	1
Dermatology	1187080A0	3	3
Dermatology	1187080C0	2	2
Emergency Med/Indianapolis	1187110C0	21	21
Family Med/Indianapolis	1187120C0	13	13
Family Medicine/Arnett	1187120C2	5	5
Family Medicine/Jasper	1187120C3	5	5
Internal Med/Indianapolis	1187140C0	35	35
Internal Medicine/SW Indiana	1187140C1	16	16
Med-Prelim/SW Indiana	1187140P0	8	8
Neurological Surgery	1187160C0	3	3
Neurology	1187180C0	10	10
Child Neurology	1187185C0	2	2
Neurodevelopmental Disabilities	1187186C0	2	2
Obstetrics-Gynecology	1187220C0	10	10
Orthopaedic Surgery	1187260C0	5	5
Ortho Surgery/Research	1187260C1	1	1
Otolaryngology-Clinical	1187280C0	4	4
Pathology	1187300C0	4	4
Pediatrics	1187320C0	24	24
Pediatrics/Research	1187320C1	1	1
Phys Medicine & Rehab	1187340A0	4	4
Plastic Surgery (Integrated)	1187362C0	2	2
Psychiatry/Indianapolis	1187400C0	10	10
Psychiatry/Vincennes	1187400C1	6	6
Psychiatry/Merrillville	1187400C2	4	4
Interventional Radiology (Integ)	1187416A0	2	2
Radiology-Diagnostic	1187420A0	9	9
Radiology-Diagnostic	1187420C0	2	2
Radiation Oncology	1187430A0	1	1
General Surgery	1187440C0	10	10
Surgery-Preliminary	1187440P0	6	4
Vascular Surgery	1187451C0	1	1
Thoracic Surgery	1187461C0	1	1
Medicine-Pediatrics	1187700C0	14	14
Pediatrics-Emergency Med	1187725C0	2	2
Peds/Psych/Child Psych	1187730C0	4	4
Pediatrics-Medical Genetics	1187765C0	1	0
Transitional	1187999P0	15	15

Memorial Hospital-IN

South Bend	Code	Quota	Matched
Family Medicine	1193120C0	9	9

Parkview Health-IN

Fort Wayne	Code	Quota	Matched
Internal Medicine	2306140C0	15	15
General Surgery	2306440C0	4	4

St Josephs Reg Med Ctr-IN

Mishawaka	Code	Quota	Matched
Family Medicine	1194120C0	9	9

Union Hospital-IN

Terre Haute	Code	Quota	Matched
Family Medicine	3007120C0	7	6

IOWA

Broadlawns Med Ctr-IA

Des Moines	Code	Quota	Matched
Family Medicine	1199120C0	8	8
Transitional	1199999P0	4	4

Central Iowa Health System

Des Moines	Code	Quota	Matched
Family Medicine/Lutheran-DSM	1201120C0	6	6
Family Med/Allen-Waterloo	1201120C1	3	2
Internal Medicine/IA Methodist	1201140C0	10	10
Med-Prelim/IA Methodist	1201140P0	2	2
Pediatrics/Blank Childrens	1201320C0	7	7
General Surgery/IA Methodist	1201440C0	4	4
Surg-Prelim/IA Methodist	1201440P0	2	1
Transitional/IA Methodist	1201999P0	4	4

Genesis Quad Cities-IA

Davenport	Code	Quota	Matched
Family Medicine	2969120C0	6	6

Mercy Med Ctr-Des Moines-IA

Des Moines	Code	Quota	Matched
Family Medicine	1346120C0	8	8
Family Medicine/Rural	1346120C1	2	1
Internal Medicine	1346140C0	10	9
Psychiatry	1346400C0	4	4
General Surgery	1346440C1	4	4

MercyOne North Iowa Med Ctr

Mason City	Code	Quota	Matched
Family Medicine	2015120C0	6	4
Family Medicine/Waterloo	2015120C1	4	4
Internal Medicine	2015140C0	6	6

Siouxland Med Ed Fdn-IA

Sioux City	Code	Quota	Matched
Family Medicine	3022120C0	6	0

U Iowa Hosps and Clinics

Iowa City	Code	Quota	Matched
Anesthesiology	1203040C0	15	15

U Iowa Hosps and Clinics (Continued)

Dermatology	1203080A0	5	5
Emergency Medicine	1203110C0	10	10
Family Medicine	1203120C0	8	8
Internal Medicine	1203140C0	23	23
Medicine-Preliminary	1203140P0	3	3
Med-Prelim/Ophthalmology	1203140P2	5	5
Neurological Surgery	1203160C0	2	2
Neurology	1203180C0	8	8
Child Neurology	1203185C0	2	2
Obstetrics-Gynecology	1203220C0	4	4
Obstetrics-Gynecology/Rural	1203220C1	2	2
Orthopaedic Surgery	1203260C0	6	6
Otolaryngology	1203280C0	3	3
Otolaryngology/Research	1203280C1	2	2
Pathology	1203300C0	6	6
Pediatrics	1203320C0	15	15
Psychiatry	1203400C0	9	9
Interventional Radiology (Integ)	1203416C0	1	1
Radiology-Diagnostic	1203420A0	3	3
Radiology-Diagnostic	1203420C0	4	4
Radiation Oncology	1203430A0	3	3
General Surgery	1203440C0	7	7
Surgery-Preliminary	1203440P3	2	2
Vascular Surgery	1203451C0	1	1
Thoracic Surgery	1203461C0	1	1
Medicine-Psychiatry	1203715C0	2	2
Psychiatry-Family Med	1203720C0	2	2

UnityPoint Broadlawns-IA

Des Moines	Code	Quota	Matched
Psychiatry	2184400C0	4	4

KANSAS

U Kansas SOM-Kansas City

Kansas City	Code	Quota	Matched
Anesthesiology	1208040C0	11	11
Anesthesiology	1208040R0	2	2
Dermatology	1208080A0	5	5
Emergency Medicine	1208110C0	10	10
Family Medicine	1208120C0	9	9
Family Medicine/KU-CHCSEK Rura	1208120C3	2	2
Internal Medicine	1208140C0	23	23
Medicine-Preliminary	1208140P0	8	8
Med-Prelim/PM&R	1208140P1	1	1
Med-Prelim/Radiology	1208140P3	2	2
Med-Prelim/Dermatology	1208140P5	0	0
Med-Prelim/Radiation Onc	1208140P6	1	1
Med-Prelim/Ophthalmology	1208140P7	0	0
Med-Prelim/Int Radiology	1208140P8	1	1
Neurological Surgery	1208160C0	2	2
Neurology	1208180C0	5	5
Obstetrics-Gynecology	1208220C0	4	4
Orthopaedic Surgery	1208260C0	5	5
Otolaryngology	1208280C0	4	4
Pathology	1208300C0	4	3
Phys Medicine & Rehab	1208340A0	4	4
Plastic Surgery (Integrated)	1208362C0	2	2
Psychiatry	1208400C0	6	6
Interventional Radiology (Integ)	1208416A0	2	2
Radiology-Diagnostic	1208420A0	6	6
Radiology-Diagnostic	1208420R0	1	1
Radiation Oncology	1208430A0	2	2
General Surgery	1208440C0	5	5
Medicine-Psychiatry	1208715C0	2	2

U Kansas SOM-Wichita

Wichita	Code	Quota	Matched
Anesthesiology	3054040C0	5	5
Family Med/Via Christi	3054120C0	18	18
Family Med/Smoky Hill	3054120C1	5	5
Family Med/Wesley	3054120C2	9	8
Internal Medicine	3054140C0	12	12
Medicine-Preliminary	3054140P0	6	6
Obstetrics-Gynecology	3054220C0	5	5
Orthopaedic Surgery	3054260C0	4	4
Pediatrics	3054320C0	5	5
Psychiatry	3054400C0	6	6
Radiology-Diagnostic	3054420A0	4	4
General Surgery	3054440C0	7	7
Surgery-Preliminary	3054440P0	1	1
Medicine-Pediatrics	3054700C0	3	3

KENTUCKY

Appalachian OPTIC-KY

Pikeville	Code	Quota	Matched
Family Med/Lake Cumberland	2134120C1	6	5
Internal Medicine	2134140C0	7	3

Appalachian Regional Healthcare-KY

Lexington	Code	Quota	Matched
Internal Medicine	2227140C0	4	4

Baptist Health Deaconess-KY

Madisonville	Code	Quota	Matched
Family Medicine	2912120C0	5	5

St Elizabeth Med Ctr-KY

Edgewood	Code	Quota	Matched
Family Medicine	1213120C0	10	10

U Kentucky Med Ctr

Lexington	Code	Quota	Matched
Anesthesiology	1848040C0	16	16
Emergency Medicine	1848110C0	12	12
Family Medicine	1848120C0	6	4
Family Med/East Kentucky	1848120C1	4	4
Family Med/Rural-Morehead	1848120C3	4	4
Internal Medicine	1848140C0	18	18
Int Med/Bowling Green	1848140C1	7	2
Medicine-Primary	1848140M0	6	6
Medicine-Preliminary	1848140P0	4	3
Neurological Surgery	1848160C0	2	2
Neurology	1848180C0	7	7

U Kentucky Med Ctr (Continued)

Child Neurology	1848185C0	2	2
Obstetrics-Gynecology	1848220C0	5	5
Ob-Gyn/Bowling Green	1848220C1	3	3
Orthopaedic Surgery	1848260C0	5	5
Otolaryngology	1848280C0	4	4
Pathology	1848300C0	4	4
Pediatrics	1848320C0	12	12
Phys Medicine & Rehab	1848340C0	5	5
Plastic Surgery (Integrated)	1848362C0	2	2
Psychiatry	1848400C0	4	4
Psychiatry/Adult Child Integ	1848400C2	2	2
Radiology-Diagnostic	1848420A0	8	8
General Surgery	1848440C0	8	8
Gen Surg/Bowling Green	1848440C1	2	2
Surgery-Preliminary	1848440P0	17	2
Thoracic Surgery	1848461C0	1	1
Medicine-Pediatrics	1848700C0	6	6
Medicine-Psychiatry	1848715C0	2	2
Peds/Psych/Child Psych	1848730C0	2	2
Transitional/Bowling Green	1848999P0	12	12

U Louisville SOM-KY

Louisville	Code	Quota	Matched
Anesthesiology	1217040C0	11	11
Dermatology	1217080A0	2	2
Emergency Medicine	1217110C0	12	12
Family Medicine	1217120C0	8	8
Family Med/Glasgow	1217120C1	4	4
Family Med/Owensboro	1217120C2	6	3
Internal Medicine	1217140C0	24	24
Medicine-Preliminary	1217140P0	12	12
Med-Prelim/Ophthalmology	1217140P1	4	4
Neurological Surgery	1217160C0	2	2
Neurology	1217180C0	4	4
Child Neurology	1217185C0	3	3
Obstetrics-Gynecology	1217220C0	6	6
Orthopaedic Surgery	1217260C0	5	5
Otolaryngology	1217280C0	3	3
Pathology	1217300C0	3	3
Pediatrics	1217320C0	24	22
Phys Medicine & Rehab	1217340A0	4	4
Plastic Surgery (Integrated)	1217362C0	2	2
Psychiatry	1217400C0	9	9
Radiology-Diagnostic	1217420A0	6	6
Radiology-Diagnostic	1217420R0	1	1
Radiation Oncology	1217430A0	1	1
General Surgery	1217440C0	9	9
Surg-Prelim/Non-Desig	1217440P1	2	1
Medicine-Pediatrics	1217700C0	5	5

LOUISIANA

Baton Rouge Gen Med Ctr-LA

Baton Rouge	Code	Quota	Matched
Family Medicine	1139120C0	8	8
Internal Medicine	1139140C0	12	12

East Jefferson Gen Hosp-LA

Metairie	Code	Quota	Matched
Family Medicine	1404120C0	6	6

LSU SOM-Baton Rouge-LA

Baton Rouge	Code	Quota	Matched
Emergency Medicine	1221110C0	12	12
Internal Medicine	1221140C0	12	9
Medicine-Preliminary	1221140P0	4	4
Obstetrics-Gynecology	1221220C0	4	4

LSU SOM-New Orleans-LA

New Orleans	Code	Quota	Matched
Anesthesiology	1224040C0	7	7
Dermatology	1224080A0	6	6
Emergency Medicine	1224110C0	12	12
Family Medicine	1224120C0	6	2
Family Med/Rural-Bogalusa	1224120C1	6	6
Internal Medicine	1224140C0	18	18
Medicine-Preliminary	1224140P0	5	5
Neurological Surgery	1224160C0	2	2
Neurology	1224180C0	4	4
Child Neurology	1224185C0	1	1
Obstetrics-Gynecology	1224220C0	6	6
Orthopaedic Surgery	1224260C0	4	4
Otolaryngology	1224280C0	4	4
Pathology	1224300C0	3	3
Pediatrics	1224320C0	14	14
Phys Medicine & Rehab	1224340C0	6	6
Plastic Surgery (Integrated)	1224362C0	2	2
Psychiatry	1224400C0	12	12
Psychiatry-LSU-OLOL	1224400C1	8	8
Interventional Radiology (Integ)	1224416A0	2	2
Radiology-Diagnostic	1224420A0	5	5
General Surgery	1224440C0	11	11
Surgery-Preliminary	1224440P3	8	2
Vascular Surgery	1224451C0	2	2
Medicine-Pediatrics	1224700C0	6	6
Medicine-Emergency Med	1224705C0	2	2
Pediatrics-Emergency Med	1224725C0	2	2

LSUHSC University Hosps & Clinics-LA

Lafayette	Code	Quota	Matched
Family Medicine	1225120C0	8	8
Internal Medicine	1225140C0	9	5
Medicine-Preliminary	1225140P0	2	2

LSUHSC-Lake Charles-LA

Lake Charles	Code	Quota	Matched
Family Medicine	1278120C0	7	3

LSUHSC-Shreveport-LA

Shreveport	Code	Quota	Matched
Anesthesiology	1232040C0	8	8
Emergency Medicine	1232110C0	9	8
Family Medicine	1232120C0	6	6
Family Med/N Caddo	1232120C1	3	3
Family Med/Monroe	1232120C3	8	8
Internal Medicine	1232140C0	26	26
Medicine-Preliminary	1232140P0	2	1

LSUHSC-Shreveport-LA (Continued)

Med-Prelim/Ophthalmology	1232140P1	4	4
Neurological Surgery	1232160C0	2	2
Neurology	1232180C0	4	4
Obstetrics-Gynecology	1232220C0	7	7
Orthopaedic Surgery	1232260C0	3	3
Otolaryngology	1232280C0	3	3
Pathology	1232300C0	4	4
Pediatrics	1232320C0	8	8
Psychiatry	1232400C0	5	5
Interventional Radiology (Integ)	1232416C0	1	1
Radiology-Diagnostic	1232420C0	4	4
General Surgery	1232440C0	5	5
Surgery-Preliminary	1232440P1	4	1
Medicine-Pediatrics	1232700C0	5	5
Emergency Med-Family Med	1232795C0	2	2

Ochsner Clinic Foundation-LA

New Orleans	Code	Quota	Matched
Anesthesiology	1966040C0	11	11
Emergency Medicine	1966110C0	6	6
Internal Medicine	1966140C0	17	17
Medicine-Primary	1966140M0	2	2
Medicine-Preliminary	1966140P0	1	1
Neurology	1966180C0	3	3
Obstetrics-Gynecology	1966220C0	6	6
Orthopaedic Surgery	1966260C0	3	3
Radiology-Diagnostic	1966420C0	5	5
General Surgery	1966440C0	7	7
Surgery-Preliminary	1966440P0	1	1

Our Lady of the Lake Reg Med Ctr-LA

Baton Rouge	Code	Quota	Matched
Pediatrics	1421320C0	12	12
Pediatrics-Primary	1421320M0	0	0

Rapides Reg Med Ctr-LA

Shreveport	Code	Quota	Matched
Family Medicine	1273120C0	6	6

Tulane Univ SOM-LA

New Orleans	Code	Quota	Matched
Anesthesiology	3073040C0	6	6
Dermatology	3073080A0	4	4
Internal Medicine	3073140C0	32	32
Int Med-Primary Care	3073140C1	1	1
Internal Medicine/Research	3073140C2	1	1
Medicine-Preliminary	3073140P0	10	10
Neurological Surgery	3073160C0	1	1
Neurology	3073180C0	5	5
Obstetrics-Gynecology	3073220C0	6	6
Orthopaedic Surgery	3073260C0	4	4
Otolaryngology	3073280C0	3	3
Pathology	3073300C0	3	3
Pediatrics	3073320C0	8	8
Pediatrics/Research	3073320C1	1	1
Psychiatry	3073400C0	7	7
Radiology-Diagnostic	3073420C0	5	5
General Surgery	3073440C0	5	5
Surg-Prelim/Non-Desig	3073440P1	4	1
Medicine-Pediatrics	3073700C0	6	6
Medicine-Psychiatry	3073715C0	2	2
Peds/Psych/Child Psych	3073730C0	2	2

Willis-Knighton Health System-LA

Shreveport	Code	Quota	Matched
Internal Medicine	2313140C0	10	10
General Surgery	2313440C0	3	3

MAINE

Central Maine Med Ctr

Lewiston	Code	Quota	Matched
Family Medicine	2327120C0	7	7

Eastern Maine Med Ctr

Bangor	Code	Quota	Matched
Family Medicine	2520120C0	10	10

Maine Med Ctr

Portland	Code	Quota	Matched
Anesthesiology	1236040C0	8	8
Anesthesiology	1236040R0	1	1
Emergency Medicine	1236110C0	10	10
Family Medicine	1236120C0	7	7
Internal Medicine	1236140C0	12	12
Internal Medicine/Geriatrics	1236140C1	1	0
Medicine-Primary/Rural	1236140M0	1	1
Neurology	1236180C0	3	3
Obstetrics-Gynecology	1236220C0	4	4
Pediatrics	1236320C0	6	6
Psychiatry	1236400C0	4	4
Psychiatry/Comb General-Child	1236400C1	1	1
Psychiatry/Rural	1236400C2	2	2
Interventional Radiology (Integ)	1236416C0	1	1
Radiology-Diagnostic	1236420C0	3	3
General Surgery	1236440C0	4	4
Surgery-Preliminary	1236440P0	1	0
Vascular Surgery	1236451C0	1	1
Medicine-Pediatrics	1236700C0	4	4

Maine-Dartmouth Family Med

Augusta	Code	Quota	Matched
Family Medicine	2956120C0	10	10

MARYLAND

Anne Arundel Med Ctr-MD

Annapolis	Code	Quota	Matched
Internal Medicine	1942140C0	15	15
Obstetrics-Gynecology	1942220C0	4	4
General Surgery	1942440C0	3	3

Greater Baltimore Med Ctr-MD

Baltimore	Code	Quota	Matched
Medicine-Primary	1241140M0	13	13
Medicine-Preliminary	1241140P0	4	4

Johns Hopkins Hosp-MD

Baltimore	Code	Quota	Matched
Anesthesiology	1242040A0	20	20
Anesthesiology/Critical Care	1242040A1	1	1

Johns Hopkins Hosp-MD (Continued)

Anesthesiology/Research	1242040A2	2	2
Anesthesiology	1242040R0	2	1
Dermatology	1242080A0	6	6
Dermatology/Research	1242080A1	1	1
Emergency Medicine	1242110C0	11	11
Internal Medicine	1242140C0	41	41
Medicine-Primary	1242140M0	4	4
Medicine-Preliminary	1242140P0	1	1
Neurological Surgery	1242160C0	4	4
Neurology	1242180A0	10	10
Child Neurology	1242185C0	4	4
Neurodevelopmental Disabilities	1242186A0	2	2
Neurodevelopmental Disabilities	1242186R0	1	1
Obstetrics-Gynecology	1242220C0	9	9
Orthopaedic Surgery	1242260C0	6	6
Otolaryngology	1242280C0	2	2
Otolaryngology/T32 Research	1242280C1	2	2
Pathology AP/CP or AP Only	1242300C0	12	12
Pathology CP Only	1242300C1	0	0
Pathology AP/NP	1242300C2	1	1
Pediatrics	1242320C0	19	19
Pediatrics/Research	1242320C1	2	1
Peds/Health Equity-Urban Health	1242320C2	2	2
Pediatrics/Global Health	1242320C3	2	2
Peds-Prelim/NDD	1242320P2	1	1
Phys Medicine & Rehab	1242340A0	8	8
Plastic Surgery (Integrated)	1242362C0	4	4
Psychiatry	1242400C0	10	10
Psychiatry/Peds	1242400C1	1	0
Interventional Radiology (Integ)	1242416A0	3	3
Radiology-Diagnostic	1242420A0	8	8
Radiation Oncology	1242430A0	4	4
General Surgery	1242440C0	6	6
Surgery-Preliminary	1242440P0	7	7
Surg-Prelim/Designated	1242440P1	5	4
Medicine-Pediatrics	1242700C0	4	4
Pediatrics-Anesthesiology	1242726C0	1	1
Pediatrics-Medical Genetics	1242765C0	1	0
Medicine-Medical Genetics	1242766C0	1	0
Radiology-Nuclear Medicine	1242770A0	1	1
Emergency Med-Anesthesiology	1242796C0	2	2

Johns Hopkins/Bayview-MD

Baltimore	Code	Quota	Matched
Internal Medicine	1237140C0	14	14
Medicine-Primary	1237140M0	2	2
Medicine-Preliminary	1237140P0	1	1
Med-Prelim/Neurology	1237140P1	6	6

Kaiser Permanente Mid-Atlantic-MD

Rockville	Code	Quota	Matched
Internal Medicine	2219140C0	6	6

MedStar Franklin Square Med Ctr-MD

Baltimore	Code	Quota	Matched
Family Medicine	1240120C0	8	8
Family Med-Preventive Med	1240752C0	1	1

MedStar Union Memorial Hosp-MD

Baltimore	Code	Quota	Matched
Internal Medicine	1251140C0	44	44
Medicine-Preliminary	1251140P0	7	7
Med-Prelim/Neurology-JHU	1251140P3	3	3
Med-Prelim/Radiology-GT	1251140P4	0	0
Med-Prelim/Anesthesiology-JHU	1251140P5	6	6
Orthopaedic Surgery	1251260C0	2	2
General Surgery	1251440C0	3	3
Surgery-Preliminary	1251440P0	6	2

Meritus Medical Center-MD

Hagerstown	Code	Quota	Matched
Family Medicine	2274120C0	6	6

Natl Insts of Health-MD

Bethesda	Code	Quota	Matched
Neurological Surgery	2006160C0	1	1
Pathology	2006300C0	3	3

Sinai Hospital of Baltimore-MD

Baltimore	Code	Quota	Matched
Internal Medicine	1249140C0	16	16
Medicine-Preliminary	1249140P0	4	4
Med-Prelim/Anesthesiology	1249140P1	2	2
Med-Prelim/KEI	1249140P2	3	3
Obstetrics-Gynecology	1249220C0	4	4
Orthopaedic Surgery	1249260C0	2	2
Pediatrics	1249320C0	8	8
Peds-Prelim/Child Neurology/NDD	1249320P0	0	0
Phys Medicine & Rehab	1249340A0	4	4
General Surgery	1249440C0	4	4

St Agnes Hospital-MD

Baltimore	Code	Quota	Matched
Internal Medicine	1247140C0	12	12
Medicine-Primary	1247140M0	2	2
Medicine-Preliminary	1247140P0	4	3
General Surgery	1247440C0	3	3
Surgery-Preliminary	1247440P0	4	4

TidalHealth

Salisbury	Code	Quota	Matched
Internal Medicine	2316140C0	10	10

U Maryland Med Ctr

Baltimore	Code	Quota	Matched
Anesthesiology	1252040A0	8	8
Anesthesiology	1252040C0	8	8
Dermatology	1252080A0	3	3
Emergency Medicine	1252110C0	11	11
Family Medicine	1252120C0	10	10
Internal Medicine	1252140C0	28	28
Internal Med/Research Pathway	1252140C1	2	2
Internal Med/Intl Scholars	1252140C2	3	3
Medicine-Preliminary	1252140P0	8	8
Med-Prelim/Intl Scholars	1252140P2	1	1
Neurological Surgery	1252160C0	2	2
Neurology	1252180C0	7	7
Obstetrics-Gynecology	1252220C0	8	8
Orthopaedic Surgery	1252260C0	6	6

U Maryland Med Ctr (Continued)

Otolaryngology	1252280C0	3	3
Pathology	1252300C0	4	4
Pediatrics	1252320C0	14	11
Peds-Prelim/Child Neurology/NDD	1252320P0	1	1
Psychiatry/Sheppard Pratt	1252400C0	16	16
Psychiatry/Physician Scientist	1252400C1	1	1
Interventional Radiology (Integ)	1252416A0	2	2
Radiology-Diagnostic	1252420A0	7	7
Radiation Oncology	1252430A0	3	3
General Surgery	1252440C0	6	6
Surgery-Preliminary	1252440P0	5	5
Surg-Prelim/SACM	1252440P3	1	1
Surg-Prelim/Int Radiology	1252440P4	1	1
Thoracic Surgery	1252461C0	1	1
Medicine-Pediatrics	1252700C0	4	4
Medicine-Emergency Med	1252705C0	2	2
Pediatrics-Emergency Med	1252725C0	2	2

U Maryland Med Ctr Midtown Campus

Baltimore	Code	Quota	Matched
Internal Medicine	1244140C0	9	9
Transitional	1244999P0	6	6
Transitional/Ophthalmology	1244999P1	4	3

U Maryland Mercy Med Ctr

Baltimore	Code	Quota	Matched
Medicine-Preliminary	1245140P0	12	12
Med-Prelim/Anesthesiology-JHU	1245140P1	6	6

U Maryland Prince Georges Hosp Ctr

Largo	Code	Quota	Matched
Family Medicine	1905120C0	4	4
Internal Medicine	1905140C0	12	12
Medicine-Preliminary	1905140P0	6	6

MASSACHUSETTS

B I Deaconess Med Ctr-MA

Boston	Code	Quota	Matched
Anesthesiology	1256040A0	6	6
Anesthesiology	1256040C0	12	12
Anesthesiology/Clin Scientist	1256040C1	0	0
Emergency Medicine	1256110C0	13	13
Internal Medicine	1256140C0	49	49
Medicine-Primary	1256140M0	2	2
Medicine-Preliminary	1256140P0	8	8
Med-Prelim/Neurology	1256140P1	4	4
Neurological Surgery	1256160C0	1	1
Neurology	1256180A0	4	4
Neurology	1256180C0	4	4
Obstetrics-Gynecology	1256220C0	6	6
Otolaryngology	1256280C0	2	2
Pathology	1256300C0	10	10
Plastic Surgery (Integrated)	1256362C0	1	1
Psychiatry	1256400C0	9	9
Psychiatry/Research	1256400C1	1	1
Interventional Radiology (Integ)	1256416A0	2	2
Radiology-Diagnostic	1256420A0	8	8
General Surgery	1256440C0	9	9
Surgery-Preliminary	1256440P0	5	5
Vascular Surgery	1256451C0	1	1
Transitional/Brockton-BIDMC	1256999P0	9	9

Baystate Franklin Med Ctr-MA

Greenfield	Code	Quota	Matched
Family Medicine	2303120C0	4	4

Berkshire Med Ctr-MA

Pittsfield	Code	Quota	Matched
Internal Medicine	1281140C0	13	13
Medicine-Preliminary	1281140P0	5	5
Psychiatry	1281400C0	4	4
General Surgery	1281440C1	2	2
Surgery-Preliminary	1281440P1	2	2

Boston Univ Med Ctr-MA

Boston	Code	Quota	Matched
Anesthesiology	1257040A0	4	4
Anesthesiology	1257040C0	7	7
Dermatology	1257080A0	5	5
Emergency Medicine	1257110C0	14	14
Family Medicine	1257120C0	12	8
Internal Medicine	1257140C0	41	41
Int Med/ABIM Research Pathway	1257140C1	0	0
Medicine-Primary	1257140M0	5	5
Med-Prelim/Ophthalmology	1257140P2	4	4
Neurology	1257180C0	7	7
Child Neurology	1257185C0	1	1
Child Neurology	1257185R0	1	0
Obstetrics-Gynecology	1257220C0	5	5
Orthopaedic Surgery	1257260C0	4	4
Ortho Surgery/Research	1257260C1	1	1
Otolaryngology	1257280C0	4	4
Pathology	1257300C0	2	2
Psychiatry	1257400C0	8	8
Interventional Radiology (Integ)	1257416A0	1	1
Radiology-Diagnostic	1257420A0	9	9
General Surgery	1257440C0	5	5
Surgery-Preliminary	1257440P0	4	4
Psychiatry-Family Med	1257720C0	2	2

Brigham & Womens Hosp-MA

Boston	Code	Quota	Matched
Anesthesiology	1265040A0	7	7
Anesthesiology	1265040C0	16	16
Anesthesiology/Research	1265040C1	2	2
Anesthesiology	1265040R0	1	1
Internal Medicine	1265140C0	41	41
Medicine-Primary/DGM	1265140M0	8	8
Medicine-Primary/HVMA	1265140M1	4	4
Medicine-Preliminary	1265140P0	11	11
Med-Prelim/Neurology	1265140P1	8	8
Neurological Surgery	1265160C0	3	3
Neurology/BWH-MGH	1265180A0	19	19
Obstetrics-Gynecology/BWH-MGH	1265220C0	11	11
Pathology/AP only or AP/CP	1265300C0	9	9
Pathology/CP only	1265300C1	2	2
Plastic Surgery (Integrated)	1265362C0	3	3
Psychiatry	1265400C0	10	10

Brigham & Womens Hosp-MA (Continued)

Psychiatry/Research	1265400C1	2	2
Psychiatry/Child	1265400C2	2	2
Interventional Radiology (Integ)	1265416C0	2	2
Radiology-Diagnostic	1265420A0	8	8
General Surgery	1265440C0	9	9
Surgery-Preliminary	1265440P0	5	3
Thoracic Surgery/Non-cardiac	1265461C0	1	1
Thoracic Surgery/Cardiac	1265461C1	1	1
Med-Peds/Harvard BWH/CHB	1265700C0	4	4

Cambridge Health Alliance-MA

Cambridge	Code	Quota	Matched
Family Medicine/Tufts	1268120C0	8	8
Medicine-Primary	1268140M0	8	8
Psychiatry	1268400C0	8	8
Transitional	1268999P0	7	7

Childrens Hospital-Boston-MA

Boston	Code	Quota	Matched
Child Neurology	1259185C0	5	5
Child Neurology	1259185R0	1	1
Neurodevelopmental Disabilities	1259186A0	1	1
Peds/Childrens Hosp	1259320C0	35	35
Peds/Urban Health Advocacy-BMC	1259320C1	10	10
Pediatrics-Anesthesiology	1259726C0	1	1
Pediatrics-Medical Genetics	1259765C0	2	2

Grtr Lawrence Fam Hlth Ctr-MA

Lawrence	Code	Quota	Matched
Family Medicine	1283120C0	12	12

Harvard Med School/Mass Eye and Ear

Boston	Code	Quota	Matched
Otolaryngology	1180280C0	4	4
Otolaryngology/Research	1180280C1	1	1

Harvard South Shore-MA

Brockton	Code	Quota	Matched
Psychiatry	3120400C0	8	8

Harvard Spaulding Rehab Hosp-MA

Charlestown	Code	Quota	Matched
Phys Medicine & Rehab	1260340A0	8	8

Lahey Clinic-MA

Burlington	Code	Quota	Matched
Anesthesiology	3130040C0	8	8
Internal Medicine	3130140C0	12	12
Med-Prelim/Neurology-Tufts	3130140P1	6	6
Plastic Surgery (Integrated)	3130362C0	1	1
Radiology-Diagnostic	3130420A0	4	4
General Surgery	3130440C0	5	5

Lemuel Shattuck Hosp-MA

Jamaica Plain	Code	Quota	Matched
Transitional	3112999P0	6	6

Massachusetts Gen Hosp

Boston	Code	Quota	Matched
Anesthesiology/PG 1-4	1261040C0	24	24
Anesthesiology/Research	1261040C1	2	2
Anesthesiology/IS	1261040R0	2	2
Dermatology/Harvard Combined	1261080A0	8	8
Emergency Med/BWH-Harvard	1261110C0	15	15
Internal Medicine	1261140C0	54	54
Medicine-Primary	1261140M0	7	7
Medicine-Preliminary	1261140P0	8	8
Med-Prelim/Neurology	1261140P1	7	7
Neurological Surgery	1261160C0	3	3
Child Neurology	1261185C0	2	2
Ortho Surgery/Harvard Combined	1261260C0	12	12
Pathology/CP only	1261300C0	2	2
Pathology/AP only or AP/CP	1261300C1	9	9
Pediatrics	1261320C0	14	14
Pediatrics-Preliminary	1261320P0	2	2
Peds/Adult/Child Psychiatry	1261400C0	2	2
Psychiatry	1261400C1	14	14
Interventional Radiology (Integ)	1261416C0	3	3
Radiology-Diagnostic	1261420A0	8	8
Radiation Oncology/BWH-Harvard	1261430A0	6	6
General Surgery	1261440C0	10	10
Surgery-Preliminary	1261440P0	4	2
Vascular Surgery	1261451C0	2	2
Med-Peds/Harvard MGH	1261700C2	4	4
Medicine-Dermatology/BWH	1261785C0	1	1

MetroWest Med Ctr-Framingham-MA

Framingham	Code	Quota	Matched
Internal Medicine	1812140C0	8	8
Transitional	1812999P0	12	10

Mt Auburn Hospital-MA

Cambridge	Code	Quota	Matched
Internal Medicine	1269140C0	13	13
Medicine-Primary	1269140M0	1	1
Medicine-Preliminary	1269140P0	8	8
Med-Prelim/Neurology	1269140P1	0	0
Radiology-Diagnostic	1269420A0	3	3

Newton-Wellesley Hosp-MA

Newton	Code	Quota	Matched
Transitional	1280999P0	10	10

North Shore Med Ctr/Salem Hosp-MA

Salem	Code	Quota	Matched
Internal Medicine	1284140C0	7	7
Medicine-Preliminary	1284140P0	4	4
Med-Prelim/Neurology-MGH	1284140P1	0	0

St Elizabeths Med Ctr-MA

Boston	Code	Quota	Matched
Anesthesiology	1266040A0	2	2
Anesthesiology	1266040C0	6	6
Anesthesiology	1266040R0	1	1
Internal Medicine	1266140C0	15	15
Medicine-Preliminary	1266140P0	8	4
Psychiatry	1266400C0	5	5
General Surgery	1266440C0	3	3
Surgery-Preliminary	1266440P0	4	1

St Vincent Hosp-Worcester-MA

Worcester	Code	Quota	Matched
Internal Medicine	1290140C0	24	24
Medicine-Preliminary	1290140P0	4	4
Radiology-Diagnostic	1290420A0	4	4

Steward Carney Hospital-MA

Boston	Code	Quota	Matched
Internal Medicine	1258140C0	7	7
Medicine-Preliminary	1258140P0	1	1
Transitional	1258999P0	7	7

Tufts Medical Center-MA

Boston	Code	Quota	Matched
Anesthesiology	1263040A0	10	10
Dermatology	1263080A0	4	4
Internal Medicine	1263140C0	26	26
Neurological Surgery	1263160C0	1	1
Neurology	1263180A0	6	6
Obstetrics-Gynecology	1263220C0	5	5
Ob-Gyn/Preliminary	1263220P0	1	1
Orthopaedic Surgery	1263260C0	4	4
Otolaryngology	1263280C0	2	2
Pathology	1263300C0	3	3
Phys Medicine & Rehab	1263340A0	3	3
Psychiatry	1263400C0	7	7
Radiology-Diagnostic	1263420A0	5	5
Radiation Oncology	1263430A0	2	0
General Surgery	1263440C0	4	4
Surgery-Preliminary	1263440P0	3	0
Surg-Prelim/Anesthesiology	1263440P2	2	2

UMass Chan - Baystate-MA

Springfield	Code	Quota	Matched
Anesthesiology-4 yr	1286040C0	8	8
Emergency Medicine	1286110C0	16	16
Internal Medicine	1286140C0	16	16
Medicine-Primary	1286140M0	2	2
Obstetrics-Gynecology	1286220C0	6	6
Pathology	1286300C0	4	4
Pediatrics	1286320C0	9	9
Peds-Prelim/Boston Childrens NDD	1286320P1	1	1
Psychiatry	1286400C0	4	4
Radiology-Diagnostic	1286420A0	4	4
General Surgery	1286440C0	7	7
Medicine-Pediatrics	1286700C0	8	8

UMass Chan Medical School-MA

Worcester	Code	Quota	Matched
Anesthesiology	3050040A1	1	1
Anesthesiology	3050040C0	8	8
Dermatology	3050080A0	4	4
Dermatology	3050080R0	1	1
Emergency Medicine	3050110C0	14	14
Fam Med/Hahnemann FHC	3050120C0	4	4
Fam Med/Queen St FHC	3050120C1	4	4
Family Med/Barre FHC	3050120C2	4	4
Family Med/Fitchburg	3050120C3	5	5
Internal Medicine	3050140C0	29	29
Medicine-Primary	3050140M0	4	4
Medicine-Preliminary	3050140P0	4	4
Med-Prelim/Neurology	3050140P1	7	7
Neurological Surgery	3050160C0	1	1
Neurology	3050180A0	8	8
Obstetrics-Gynecology	3050220C0	5	5
Orthopaedic Surgery	3050260C0	4	4
Ortho Surgery/Research	3050260C1	1	1
Pathology	3050300C0	4	4
Pediatrics	3050320C0	8	8
Plastic Surgery (Integrated)	3050362C0	2	2
Psychiatry	3050400C0	4	4
Psychiatry/Child Psych	3050400C1	2	2
Interventional Radiology (Integ)	3050416A0	1	1
Radiology-Diagnostic	3050420A0	4	4
General Surgery	3050440C0	8	8
Surgery-Preliminary	3050440P0	4	4
Vascular Surgery	3050451C0	2	2
Medicine-Pediatrics	3050700C0	4	4
Psychiatry-Neurology	3050755C1	1	1

MICHIGAN

Ascension Genesys Hospital-MI

Grand Blanc	Code	Quota	Matched
Emergency Medicine	1308110C0	6	4
Family Medicine	1308120C0	13	13
Internal Medicine	1308140C0	13	13
Obstetrics-Gynecology	1308220C0	3	3
Orthopaedic Surgery	1308260C0	3	3
General Surgery	1308440C0	3	3

Ascension Macomb-Oakland Hosp-MI

Warren	Code	Quota	Matched
Emergency Medicine	1930110C0	8	1
Family Medicine/Osteopathic	1930120C0	5	2
Internal Medicine	1930140C0	12	12
Neurology	1930180C0	3	1
Obstetrics-Gynecology	1930220C0	3	3
Orthopaedic Surgery	1930260C0	2	2
Otolaryngology	1930280C0	2	2
General Surgery	1930440C0	4	4

Ascension Providence/MSUCHM-MI

Southfield	Code	Quota	Matched
Emergency Medicine	1303110C0	10	4
Family Medicine	1303120C0	9	9
Internal Medicine	1303140C0	17	17
Neurological Surgery	1303160C0	2	2
Obstetrics-Gynecology	1303220C0	5	5
Orthopaedic Surgery	1303260C0	3	3
Radiology-Diagnostic	1303420A0	3	3
General Surgery	1303440C0	3	3
Surgery-Preliminary	1303440P0	6	6
Transitional	1303999P0	7	7
Transitional/Radiology	1303999P1	3	2

Ascension St John Hosp-MI

Detroit	Code	Quota	Matched
Emergency Medicine	1915110C0	12	12
Family Medicine	1915120C0	7	7
Internal Medicine	1915140C0	21	21

Ascension St John Hosp-MI (Continued)

Medicine-Preliminary	1915140P0	4	0
Obstetrics-Gynecology	1915220C0	4	4
Pathology	1915300C0	2	2
Pediatrics	1915320C0	8	7
General Surgery	1915440C0	5	5
Surgery-Preliminary	1915440P0	2	0

Authority Health GME-MI

Detroit	Code	Quota	Matched
Family Medicine	1920120C0	6	6
Internal Medicine	1920140C0	3	3
Pediatrics	1920320C0	8	6
Psychiatry	1920400C0	9	9

Beaumont Health-MI

Southfield	Code	Quota	Matched
Anesthesiology/Royal Oak	1978040C0	6	6
Dermatology/Trenton	1978080C0	2	2
Derm/Farm Hills/Osteopathic	1978080C2	2	0
Emergency Medicine/Royal Oak	1978110C0	14	14
Emergency Med/Farm Hills	1978110C1	7	5
Emer Med/Trenton & Dearborn	1978110C2	8	8
Family Medicine/Troy	1978120C0	8	8
Family Med/Grosse Pointe	1978120C1	6	6
Fam Med/Farm Hills/Osteopathic	1978120C2	5	5
Family Medicine/Wayne	1978120C3	10	10
Internal Medicine/Royal Oak	1978140C0	24	24
Internal Medicine/Dearborn	1978140C1	10	10
Internal Medicine/Trenton	1978140C2	5	3
Internal Medicine/Farm Hills	1978140C3	8	8
Med-Prelim/Dearborn	1978140P1	3	3
Neuro Surg/Royal Oak & Dearborn	1978160C0	1	1
Neurology/Farm Hills & Royal Oak	1978180C0	4	4
Obstetrics-Gynecology/Royal Oak	1978220C0	6	6
Obstetrics-Gynecology/Dearborn	1978220C1	4	4
Obstetrics-Gynecology/Trenton	1978220C2	2	2
Obstetrics-Gynecology/Farm Hills	1978220C3	2	2
Ortho Surgery/Royal Oak & Taylor	1978260C0	8	8
Ortho Surg/Farm Hills & Dearborn	1978260C1	4	4
Otolaryngology/Farmington Hills	1978280C0	1	1
Pathology/Royal Oak	1978300C0	3	3
Pediatrics/Royal Oak	1978320C0	8	8
Phys Med & Rehab/Royal Oak	1978340C0	4	4
Phys Medicine & Rehab/Taylor	1978340C1	5	5
Psychiatry/Southfield	1978400C0	6	6
Intervent Rad (Integ)/Royal Oak	1978416C0	2	2
Radiology-Diagnostic/Royal Oak	1978420C0	8	8
Radiology-Diagnostic/Dearborn	1978420C1	4	4
Radiology-Diagnostic/Farm Hills	1978420C2	2	2
Radiation Oncology/Royal Oak	1978430C0	3	3
General Surgery/Royal Oak	1978440C0	6	6
Gen Surg/Trenton & Dearborn	1978440C1	4	4
General Surgery/Farm Hills	1978440C2	3	3
Surg-Prelim/Royal Oak	1978440P0	2	2
Medicine-Pediatrics/Royal Oak	1978700C0	4	4
Trans/Ophthalmology/Royal Oak	1978999P1	3	3
Trans/Ophthal/Dearborn & Taylor	1978999P4	2	2

Central Michigan University COM

Saginaw	Code	Quota	Matched
Emergency Medicine	1320110C0	10	10
Family Medicine	1320120C0	6	6
Family Medicine/MIDOCS	1320120C1	2	2
Internal Medicine	1320140C0	8	8
Internal Medicine/MIDOCS	1320140C2	2	0
Obstetrics-Gynecology	1320220C0	4	4
Pediatrics	1320320C0	4	4
Psychiatry	1320400C0	4	4
Psychiatry/MIDOCS	1320400C1	2	1
General Surgery	1320440C0	4	4

Childrens Hosp of Michigan

Detroit	Code	Quota	Matched
Pediatrics	1843320C0	24	24
Peds-Prelim/Child Neurology	1843320P0	2	2

Detroit Med Ctr/WSU-MI

Detroit	Code	Quota	Matched
Anesthesiology	1295040C0	12	12
Anesthesiology/Military	1295040C1	1	0
Emergency Medicine	1295110C0	14	14
Emergency Med/Sinai-Grace	1295110C1	12	12
Family Medicine	1295120C0	5	5
Int Med/Det/Harper/VA	1295140C0	36	36
Internal Med/Sinai-Grace	1295140C1	20	20
Internal Medicine/HVSH	1295140C2	8	6
Neurology	1295180C0	9	9
Child Neurology	1295185A0	2	2
Child Neurology	1295185R0	1	0
Obstetrics-Gynecology	1295220C0	10	10
Orthopaedic Surgery	1295260C0	4	4
Otolaryngology/Huron Valley	1295280C1	2	2
Pathology	1295300C0	3	3
Phys Medicine & Rehab	1295340A0	4	4
Psychiatry	1295400C0	9	9
Psychiatry/Child Psych	1295400C2	2	2
Radiology-Diagnostic	1295420A0	9	9
Radiation Oncology	1295430A0	2	2
General Surgery	1295440C0	7	7
General Surgery/Sinai-Grace	1295440C1	3	3
Surgery-Preliminary	1295440P0	10	2
Medicine-Pediatrics	1295700C0	5	5
Pediatrics-Medical Genetics	1295765C0	1	1
Transitional	1295999P0	22	13

Garden City Hospital-MI

Garden City	Code	Quota	Matched
Emergency Medicine	2106110C0	6	2
Family Medicine	2106120C0	4	4
Internal Medicine	2106140C0	8	8
Neurology	2106180C0	2	1
Obstetrics-Gynecology	2106220C0	3	3
Orthopaedic Surgery	2106260C0	2	2
General Surgery	2106440C0	2	2

Henry Ford Allegiance Health-MI

Jackson	Code	Quota	Matched
Emergency Medicine	1741110C0	8	0
Family Medicine	1741120C0	6	6

Henry Ford Allegiance Health-MI (Continued)

Internal Medicine	1741140C0	8	8
Psychiatry	1741400C0	4	4
General Surgery	1741440C0	4	4
Transitional	1741999P0	6	6

Henry Ford Hospital-MI

Detroit	Code	Quota	Matched
Anesthesiology	1300040C0	12	12
Dermatology	1300080A0	7	7
Emergency Medicine	1300110C0	15	15
Family Medicine	1300120C0	8	8
Internal Medicine	1300140C0	36	36
Neurological Surgery	1300160C0	2	2
Neurology	1300180C0	6	6
Obstetrics-Gynecology	1300220C0	5	5
Orthopaedic Surgery	1300260C0	6	6
Otolaryngology	1300280C0	3	3
Pathology	1300300C0	4	4
Psychiatry	1300400C0	6	6
Interventional Radiology (Integ)	1300416C0	1	1
Radiology-Diagnostic	1300420C0	8	8
Radiation Oncology	1300430A0	2	0
General Surgery	1300440C0	6	6
Surgery-Preliminary	1300440P0	2	1
Medicine-Emergency Med	1300705C0	2	2
Transitional	1300999P0	15	15

Henry Ford Macomb Hospital-MI

Clinton Township	Code	Quota	Matched
Emergency Medicine	1924110C0	8	8
Family Medicine	1924120C0	4	4
Internal Medicine	1924140C0	13	13
Obstetrics-Gynecology	1924220C0	3	3
Orthopaedic Surgery	1924260C0	2	2
Otolaryngology	1924280C0	1	1
General Surgery	1924440C0	4	3

Henry Ford Wyandotte Hospital-MI

Wyandotte	Code	Quota	Matched
Emergency Medicine	2043110C0	9	6
Obstetrics-Gynecology	2043220C0	3	3
General Surgery	2043440C0	3	3

Hurley Medical Ctr-MI

Flint	Code	Quota	Matched
Internal Medicine	1307140C0	15	11
Obstetrics-Gynecology	1307220C0	4	4
Pediatrics	1307320C0	7	7
Medicine-Pediatrics	1307700C0	3	3
Transitional	1307999P0	6	2

MSUCOM Statewide Campus Sys-MI

East Lansing	Code	Quota	Matched
Osteo Neuromusculo Med	2123275C0	4	4

Mary Free Bed Hospital-MI

Grand Rapids	Code	Quota	Matched
Phys Medicine & Rehab	1944340A0	4	4

McLaren Health Care Corp-MI

Grand Blanc	Code	Quota	Matched
Anesthesiology/Lansing	1866040C0	4	4
Anesthesiology/Oakland	1866040C1	3	3
Emergency Medicine/Macomb	1866110C0	6	5
Emergency Medicine/Oakland	1866110C1	6	6
Family Medicine/Flint	1866120C0	6	6
Family Medicine/Macomb	1866120C1	4	3
Family Medicine/Oakland	1866120C2	4	3
Family Medicine/Lansing	1866120C3	4	4
Family Medicine/Bay	1866120C4	4	0
Family Medicine/St Lukes	1866120C5	6	3
Family Medicine/Petoskey	1866120C6	2	2
Internal Medicine/Flint	1866140C0	12	12
Internal Medicine/Lansing	1866140C1	10	8
Internal Medicine/Macomb	1866140C2	8	8
Internal Medicine/Oakland	1866140C3	5	5
Obstetrics-Gynecology/Lansing	1866220C0	3	3
Obstetrics-Gynecology/Macomb	1866220C1	2	2
Orthopaedic Surgery/Flint	1866260C0	3	3
Orthopaedic Surgery/Oakland	1866260C1	3	3
Orthopaedic Surgery/Macomb	1866260C2	3	3
Orthopaedic Surgery/Lansing	1866260C3	4	4
Otolaryngology/Oakland	1866280C0	2	2
Radiology-Diagnostic/Oakland	1866420C0	3	3
General Surgery/Lansing	1866440C0	3	3
General Surgery/Macomb	1866440C1	5	5
Transitional/Oakland	1866999P0	4	2

Mercy Health Grand Rapids-MI

Grand Rapids	Code	Quota	Matched
Family Medicine	1995120C0	10	10
Internal Medicine	1995140C0	7	7
Neurology	1995180C0	4	4
Transitional	1995999P0	6	4

Mercy Health Muskegon-MI

Muskegon	Code	Quota	Matched
Emergency Medicine	2102110C0	7	7
Family Medicine	2102120C0	6	6
Internal Medicine	2102140C0	6	6
Obstetrics-Gynecology	2102220C0	3	3

Metro Health/U Michigan Health

Wyoming	Code	Quota	Matched
Emergency Medicine	2170110C0	6	4
Family Medicine/Osteopathic	2170120C0	5	1
Internal Medicine	2170140C0	6	6
Obstetrics-Gynecology/Osteopathic	2170220C0	3	3
Orthopaedic Surgery	2170260C0	2	2
General Surgery/Osteopathic	2170440C0	2	2

Michigan St Univ CHM-East Lansing

Lansing	Code	Quota	Matched
Family Medicine	2436120C0	4	1
Psychiatry	2436400C0	5	5
Psychiatry/Rural	2436400C1	2	2

MidMichigan Med Center-MI

Midland	Code	Quota	Matched
Family Medicine/Midland	1961120C0	6	6
Family Med/Rural-Alpena	1961120C1	2	0

Munson Med Ctr-MI

Traverse City	Code	Quota	Matched
Family Medicine	1349120C0	6	4

Oakland Physicians Med Ctr-MI

Pontiac	Code	Quota	Matched
Psychiatry	1318400C0	2	2

Pine Rest Christian Mental Hlth Svcs-MI

Grand Rapids	Code	Quota	Matched
Psychiatry	1634400C0	10	10
Psychiatry/Rural	1634400C1	2	2

Promedica Monroe Reg Hosp-MI

Monroe	Code	Quota	Matched
Emergency Medicine	1530110C0	8	3
Family Medicine	1530120C0	6	3
Transitional	1530999P0	6	6

Sparrow Hospital-MI

Lansing	Code	Quota	Matched
Emergency Medicine	1315110C0	8	8
Family Medicine	1315120C0	9	9
Internal Medicine	1315140C0	15	15
Neurology	1315180C0	5	5
Obstetrics-Gynecology	1315220C0	4	4
Pediatrics	1315320C0	7	7
Phys Medicine & Rehab	1315340C0	4	4
General Surgery	1315440C0	5	5

Spectrum Health Lakeland-MI

Saint Joseph	Code	Quota	Matched
Emergency Medicine	1951110C0	9	5
Family Medicine	1951120C0	5	5
Internal Medicine	1951140C0	7	7

Spectrum Health/Michigan State Univ

Grand Rapids	Code	Quota	Matched
Emergency Medicine	2077110C0	10	10
Family Medicine	2077120C1	6	6
Internal Medicine	2077140C0	15	15
Neurological Surgery	2077160C0	1	1
Neurology	2077180C1	4	4
Child Neurology	2077185C0	2	2
Obstetrics-Gynecology	2077220C0	8	8
Orthopaedic Surgery	2077260C0	5	5
Pediatrics	2077320C0	20	20
Plastic Surgery (Integrated)	2077362C0	3	3
Interventional Radiology (Integ)	2077416C0	3	3
Radiology-Diagnostic	2077420C0	3	3
General Surgery	2077440C0	7	7
Surgery-Preliminary	2077440P0	3	0
Vascular Surgery	2077451C0	1	1
Medicine-Pediatrics	2077700C0	4	4
Transitional	2077999P0	6	6

St Joseph Mercy-Ann Arbor-MI

Ann Arbor	Code	Quota	Matched
Internal Medicine	1292140C0	16	16
Obstetrics-Gynecology	1292220C0	4	4
General Surgery	1292440C0	5	5
Transitional	1292999P0	12	12

St Joseph Mercy-Livingston-MI

Howell	Code	Quota	Matched
Dermatology	1400080A0	4	4
Family Medicine	1400120C0	6	6

St Joseph Mercy-Oakland-MI

Pontiac	Code	Quota	Matched
Internal Medicine	1319140C0	18	18
Obstetrics-Gynecology	1319220C0	4	4
Radiology-Diagnostic	1319420C0	3	3
General Surgery	1319440C0	2	1
Surgery-Preliminary	1319440P0	2	0
Surg-Prelim/Anesthesiology-WSU	1319440P1	2	0
Transitional	1319999P0	2	2

St Mary Mercy Hospital-MI

Livonia	Code	Quota	Matched
Emergency Medicine	1418110C0	6	4
Family Medicine	1418120C0	8	2
Internal Medicine	1418140C0	15	15
Psychiatry	1418400C0	7	7
Transitional	1418999P0	16	16

U Michigan Hosps-Ann Arbor

Ann Arbor	Code	Quota	Matched
Anesthesiology	1293040C0	27	27
Dermatology	1293080A0	8	8
Emergency Medicine	1293110C0	16	16
Family Med/Ypsilanti	1293120C0	5	5
Family Med/Chelsea	1293120C1	7	7
Family Med/Spanish	1293120C3	1	1
Internal Medicine	1293140C0	42	42
Internal Medicine/PSTP	1293140C1	4	4
Med-Prelim/Ophthalmology	1293140P2	7	7
Neurological Surgery	1293160C0	3	3
Neurology	1293180C0	9	9
Child Neurology	1293185C0	4	4
Obstetrics-Gynecology	1293220C0	6	6
Orthopaedic Surgery	1293260C0	7	7
Otolaryngology	1293280C0	4	4
Otolaryngology/Research	1293280C1	1	1
Pathology	1293300C0	6	6
Pathology/PSTP	1293300C1	1	1
Pediatrics	1293320C0	20	20
Pediatrics/PPSTP	1293320C2	1	1
Phys Medicine & Rehab	1293340A0	6	6
Plastic Surgery (Integrated)	1293362C0	4	4
Psychiatry	1293400C0	12	12
Interventional Radiology (Integ)	1293416C0	3	3
Radiology-Diagnostic	1293420A0	8	8
Radiation Oncology	1293430A0	3	3
General Surgery	1293440C0	7	7

U Michigan Hosps-Ann Arbor (Continued)

Surgery-Preliminary	1293440P0	4	2
Vascular Surgery	1293451C0	1	1
Thoracic Surgery	1293461C0	2	2
Medicine-Pediatrics	1293700C0	8	8
Pediatrics-Medical Genetics	1293765C0	2	2

UP Health System-Marquette-MI

Marquette	Code	Quota	Matched
Family Medicine	2014120C0	6	5

Wayne State University SOM-MI

Detroit	Code	Quota	Matched
Anesthesiology	1361040A0	6	6
Dermatology	1361080A0	4	4
Family Medicine	1361120C0	6	4
Family Medicine/Urban	1361120C1	3	0
Internal Medicine	1361140C0	12	12
Otolaryngology	1361280C0	4	4
Transitional	1361999P0	4	4
Transitional/Preventive Med	1361999P1	2	2

Western Michigan Univ Stryker SOM

Kalamazoo	Code	Quota	Matched
Emergency Medicine	1314110C0	15	15
Family Medicine/Kalamazoo	1314120C0	8	8
Family Medicine/Battle Creek	1314120C1	6	6
Family Med/Kalamazoo MIDocs	1314120C2	1	1
Internal Medicine	1314140C0	11	11
Medicine-Primary/MIDocs	1314140M0	1	0
Obstetrics-Gynecology	1314220C0	4	4
Orthopaedic Surgery	1314260C0	3	3
Pediatrics	1314320C0	8	8
Pediatrics-Primary/MIDocs	1314320M0	2	1
Psychiatry	1314400C0	6	6
Psychiatry/MIDocs	1314400C1	1	1
General Surgery	1314440C0	4	4
Gen Surg/MIDocs Rural Surg	1314440C1	1	1
Medicine-Pediatrics	1314700C0	4	4

MINNESOTA

Abbott Northwestern Hosp-MN

Minneapolis	Code	Quota	Matched
Internal Medicine	1330140C0	11	11

Allina Health-MN

St Paul	Code	Quota	Matched
Family Medicine	1342120C0	7	7

HealthPartners Institute-MN

St Paul	Code	Quota	Matched
Dermatology	1335080A0	2	2
Dermatology	1335080R0	1	0
Emergency Medicine	1335110C0	11	11
Family Med/Western WI Rural	1335120C2	2	2

Hennepin Co Med Ctr-MN

Minneapolis	Code	Quota	Matched
Emergency Medicine	1329110C0	12	12
Family Medicine	1329120C0	11	11
Internal Medicine	1329140C0	19	19
Med-Primary/MNDOH Grant	1329140M0	2	1
Psychiatry	1329400C0	7	7
General Surgery	1329440C0	5	5
Surgery-Preliminary	1329440P0	1	0
Medicine-Emergency Med	1329705C0	2	2
Transitional	1329999P0	5	5

Mayo Clinic School of Grad Med Educ-MN

Rochester	Code	Quota	Matched
Anesthesiology	1328040A0	6	6
Anesthesiology	1328040C0	12	12
Anesthesiology	1328040R0	2	2
Dermatology	1328080A0	5	5
Dermatology/Research	1328080A1	1	1
Dermatology	1328080C0	2	2
Emergency Medicine	1328110C0	9	9
Family Medicine	1328120C0	9	9
Family Medicine/Eau Claire	1328120C1	5	5
Family Medicine/LaCrosse	1328120C2	6	6
Internal Medicine	1328140C0	49	49
Int Med/CI Research	1328140C1	3	3
Medicine-Preliminary	1328140P0	2	2
Neurological Surgery	1328160C0	4	4
Neurology	1328180A0	3	3
Neurology	1328180C0	6	6
Child Neurology	1328185C0	2	2
Obstetrics-Gynecology	1328220C0	5	5
Orthopaedic Surgery	1328260C0	12	12
Otolaryngology	1328280C0	5	5
Path-Anatomic and Clinical	1328300C0	6	6
Path-Anatomic/Neuropathology	1328300C2	1	1
Pediatrics	1328320C0	13	13
Phys Medicine & Rehab	1328340A0	6	6
Phys Medicine & Rehab	1328340C0	2	2
Plastic Surgery (Integrated)	1328362C0	4	4
Psychiatry	1328400C0	11	11
Interventional Radiology (Integ)	1328416A0	1	1
Radiology-Diagnostic	1328420A0	12	12
Radiology-Diagnostic	1328420R0	1	1
Radiation Oncology	1328430A0	3	3
General Surgery	1328440C0	9	9
Gen Surg/Integrated Comm & Rural	1328440C2	1	1
Surgery-Preliminary	1328440P0	12	12
Vascular Surgery	1328451C0	1	1

U Minnesota Med School

Minneapolis	Code	Quota	Matched
Anesthesiology	1334040C0	9	9
Dermatology	1334080A0	4	4
Family Med/Methodist	1334120C0	6	6
Family Med/N Memorial	1334120C1	8	8
Family Med/Smileys	1334120C2	6	6
Family Med/St Johns	1334120C3	6	6
Family Med/Woodwinds	1334120C4	8	8
Family Med/Mankato	1334120C5	5	5
Family Med/St Cloud	1334120C6	6	6
Family Med/Duluth	1334120C7	8	8
Internal Medicine	1334140C0	30	30
Internal Medicine/PSTP	1334140C1	1	1
Medicine-Primary	1334140M0	1	1

U Minnesota Med School (Continued)

Neurological Surgery	1334160C0	2	2
Neurology	1334180C0	6	6
Obstetrics-Gynecology	1334220C0	9	9
Orthopaedic Surgery	1334260C0	8	8
Otolaryngology	1334280C0	4	4
Pathology	1334300C0	3	3
Pathology/CP only	1334300C1	0	0
Pathology/AP only	1334300C2	0	0
Pathology/AP-NP	1334300C3	1	1
Pediatrics	1334320C0	23	23
Pediatrics/MN Immigrant IMG	1334320C1	1	1
Pediatrics/PSTP	1334320C2	2	2
Phys Medicine & Rehab	1334340A0	1	1
Phys Medicine & Rehab	1334340C0	4	4
Plastic Surgery (Integrated)	1334362C0	2	2
Psychiatry	1334400C0	7	7
Psychiatry/PSTP	1334400C1	1	1
Interventional Radiology (Integ)	1334416C0	2	2
Radiology-Diagnostic	1334420C0	8	8
Radiology-Diagnostic	1334420R0	1	1
Radiation Oncology	1334430A0	1	0
General Surgery	1334440C0	7	7
General Surgery/Rural	1334440C1	1	1
Surgery-Preliminary	1334440P0	4	4
Surg-Prelim/Gen Surg & Neurosurg	1334440P1	1	1
Vascular Surgery	1334451C0	1	1
Medicine-Pediatrics	1334700C0	10	10
Medicine-Dermatology	1334785C0	2	2

MISSISSIPPI

Baptist Mem Hosp DeSoto-MS

Southaven	Code	Quota	Matched
Family Medicine	2299120C0	6	6
Transitional	2299999P0	6	4

Baptist Mem Hosp Golden Triangle-MS

Columbus	Code	Quota	Matched
Internal Medicine	2266140C0	6	6

Baptist Mem Hosp North-MS

Oxford	Code	Quota	Matched
Internal Medicine	2288140C0	12	12

East Central Mississippi Health

Meridian	Code	Quota	Matched
Family Medicine	2144120C0	6	6

Forrest General Hospital-MS

Hattiesburg	Code	Quota	Matched
Family Medicine	1692120C0	6	3

Magnolia Regional Health Ctr-MS

Corinth	Code	Quota	Matched
Emergency Medicine	1923110C0	6	6
Internal Medicine	1923140C0	6	6

Memorial Hospital at Gulfport-MS

Gulfport	Code	Quota	Matched
Family Medicine	2294120C0	9	9

Merit Health Wesley-MS

Hattiesburg	Code	Quota	Matched
Emergency Medicine	2174110C0	6	5
Internal Medicine	2174140C0	8	8
Transitional	2174999P0	11	1

Mississippi Med Ed Res Consortium

Greenville	Code	Quota	Matched
Family Medicine	2253120C0	6	4

Mississippi State Hospital

Whitfield	Code	Quota	Matched
Psychiatry	2296400C0	6	6

North Mississippi Med Ctr

Tupelo	Code	Quota	Matched
Family Medicine	1218120C0	8	8
Internal Medicine	1218140C0	12	12

University Hosps-Jackson-MS

Jackson	Code	Quota	Matched
Anesthesiology	1957040C0	8	8
Anesthesiology	1957040R0	2	2
Dermatology	1957080A0	4	4
Emergency Medicine	1957110C0	16	16
Family Medicine	1957120C0	10	10
Internal Medicine	1957140C0	25	25
Medicine-Primary	1957140M0	1	1
Medicine-Preliminary	1957140P0	4	4
Med-Prelim/Ophthalmology	1957140P2	4	4
Med-Prelim/Dermatology	1957140P4	4	1
Med-Prelim/Radiation Onc	1957140P5	1	1
Med-Prelim/Prevent Med	1957140P6	2	1
Neurological Surgery	1957160C0	2	2
Neurology	1957180C0	4	4
Child Neurology	1957185C0	1	1
Child Neurology	1957185R0	1	1
Obstetrics-Gynecology	1957220C0	6	6
Orthopaedic Surgery	1957260C0	4	4
Otolaryngology	1957280C0	3	3
Pathology	1957300C0	4	4
Pediatrics	1957320C0	16	16
Plastic Surgery (Integrated)	1957362C0	2	2
Psychiatry	1957400C0	7	7
Psychiatry/Child/Adult Psych	1957400C1	2	2
Interventional Radiology (Integ)	1957416C0	1	1
Radiology-Diagnostic	1957420A0	1	1
Radiology-Diagnostic	1957420C0	8	8
Radiation Oncology	1957430A0	1	1
General Surgery	1957440C0	5	5
Surgery-Preliminary	1957440P0	5	3
Medicine-Pediatrics	1957700C0	5	5

MISSOURI

Barnes-Jewish Hosp-MO

St Louis	Code	Quota	Matched
Anesthesiology/3 yr	1353040A0	1	1
Anesthesiology/4 yr	1353040C0	17	17
Anesthesiology/ASAP 5 yr	1353040C1	2	2
Dermatology	1353080A0	7	7

Barnes-Jewish Hosp-MO (Continued)

Dermatology/Physician Scientist	1353080A1	0	0
Emergency Medicine	1353110C0	14	14
Internal Medicine	1353140C0	41	41
Internal Medicine/PSTP	1353140C1	6	6
Medicine-Primary	1353140M0	5	5
Medicine-Preliminary	1353140P0	5	5
Med-Prelim/Ophthalmology	1353140P2	5	5
Neurological Surgery	1353160C0	4	4
Neurology	1353180C0	11	11
Obstetrics-Gynecology	1353220C0	9	9
Orthopaedic Surgery	1353260C0	8	8
Otolaryngology	1353280C0	3	3
Otolaryngology/Research	1353280C1	2	2
Clinical Pathology	1353300C0	3	3
Anat/Clin & Anat Path	1353300C1	8	8
Phys Medicine & Rehab	1353340A0	3	3
Phys Medicine & Rehab	1353340C0	2	2
Plastic Surgery (Integrated)	1353362C0	4	4
Psychiatry	1353400C0	14	14
Interventional Radiology (Integ)	1353416A0	2	2
Radiology-Diagnostic	1353420A0	16	16
Rad-Diag/Research	1353420A1	1	1
Radiation Oncology	1353430A0	3	3
General Surgery	1353440C0	9	9
Surgery-Preliminary	1353440P2	5	5
Surg-Prelim/Int Radiology	1353440P3	0	0
Vascular Surgery	1353451C0	1	1

Childrens Mercy Hospital-MO

Kansas City	Code	Quota	Matched
Child Neurology	1494185C0	3	1
Pediatrics	1494320C0	27	27
Pediatrics-Preliminary	1494320P0	1	1

CoxHealth-MO

Springfield	Code	Quota	Matched
Family Medicine	3167120C0	8	8
Family Med/Jordan Valley	3167120C1	2	2

HCA Healthcare Kansas City-MO

Kansas City	Code	Quota	Matched
Family Med/Research Med Ctr	2984120C0	8	7
Internal Med/Overland Park	2984140C0	12	1
Ob-Gyn/Overland Park	2984220C0	5	5
General Surgery/Menorah	2984440C0	5	4

KCU-GME Consortium-MO

Kansas City	Code	Quota	Matched
Dermatology/ADCS-Orlando	1987080A2	3	3
Emergency Medicine/Freeman	1987110C0	6	4
Family Medicine/Reid	1987120C0	5	5
Family Med/St Lukes Des Peres	1987120C1	4	4
Family Medicine/Freeman	1987120C2	5	3
Internal Medicine/Freeman	1987140C0	5	3
Orthopaedic Surgery/HCA	1987260C0	4	4
Otolaryngology/Freeman	1987280C0	1	1
Psychiatry/Ozark	1987400C0	4	4
General Surgery/St Anthony	1987440C0	2	2
General Surgery/St Marys	1987440C1	2	2

Mercy Hospital St Louis-MO

St Louis	Code	Quota	Matched
Family Medicine	1362120C0	6	6
Internal Medicine	1362140C0	8	8
Obstetrics-Gynecology	1362220C0	6	6
Transitional	1362999P0	7	7

SSM St Marys Hospital-St Louis-MO

St Louis	Code	Quota	Matched
Internal Medicine	1999140C0	10	10

St Louis Childrens Hosp-MO

St Louis	Code	Quota	Matched
Child Neurology	1869185C0	5	5
Child Neurology	1869185R0	1	1
Pediatrics	1869320C0	31	31
Pediatrics-Preliminary	1869320P0	1	1
Pediatrics-Medical Genetics	1869765C0	2	2

St Louis Univ SOM-MO

St Louis	Code	Quota	Matched
Anesthesiology	1365040C0	10	10
Dermatology	1365080A0	4	4
Emergency Medicine	1365110C0	6	6
Family Med/Belleville	1365120C0	6	6
Family Medicine	1365120C1	6	6
Internal Medicine	1365140C0	26	26
Internal Medicine/Med-Geri Trk	1365140C1	0	0
Medicine-Preliminary	1365140P0	6	6
Neurological Surgery	1365160C0	2	2
Neurology	1365180C0	5	5
Child Neurology	1365185C0	2	1
Obstetrics-Gynecology	1365220C0	6	6
Orthopaedic Surgery	1365260C0	5	5
Otolaryngology	1365280C0	2	2
Pathology	1365300C0	3	3
Pediatrics	1365320C0	20	20
Plastic Surgery (Integrated)	1365362C0	2	2
Psychiatry	1365400C0	8	8
Interventional Radiology (Integ)	1365416A0	1	1
Interventional Radiology (Integ)	1365416R0	1	1
Radiology-Diagnostic	1365420A0	6	6
Radiology-Diagnostic	1365420R0	1	1
General Surgery	1365440C0	5	5
Surgery-Preliminary	1365440P0	6	0
Vascular Surgery	1365451C0	1	1

St Lukes Hospital-St Louis-MO

Chesterfield	Code	Quota	Matched
Internal Medicine	1364140C0	13	13
Medicine-Preliminary	1364140P0	3	3

Still OPTI-Northeast Reg Med Ctr-MO

Kirksville	Code	Quota	Matched
Dermatology/Osteopathic	2152080A0	2	2
Family Medicine	2152120C0	4	4
Osteo Neuromusculo Med	2152275C0	3	2

Univ of Missouri-KC Programs

Kansas City	Code	Quota	Matched
Anesthesiology/St Lukes	1343040C0	6	6

Univ of Missouri-KC Programs (Continued)

Emergency Medicine	1343110C0	11	11
Family Medicine	1343120C0	12	11
Internal Medicine	1343140C0	19	19
Medicine-Preliminary	1343140P0	7	7
Neurology	1343180C0	3	3
Obstetrics-Gynecology	1343220C0	8	8
Orthopaedic Surgery	1343260C0	4	4
Pathology	1343300C0	2	2
Radiology-Diagnostic	1343420A0	6	6
General Surgery	1343440C0	5	5
Surgery-Preliminary	1343440P0	4	4
Medicine-Pediatrics	1343700C0	6	6

Univ of Missouri-KC/CBM

Kansas City	Code	Quota	Matched
Psychiatry	2075400C0	6	6

University Hosps-Columbia-MO

Columbia	Code	Quota	Matched
Anesthesiology	1994040C0	4	4
Anesthesiology	1994040R0	1	1
Dermatology	1994080A0	3	3
Emergency Medicine	1994110C0	10	10
Family Medicine	1994120C0	14	14
Family Medicine/CRMC	1994120C1	3	3
Family Med/Bothwell Rural	1994120C2	2	1
Internal Medicine	1994140C0	21	21
Medicine-Preliminary	1994140P0	6	6
Neurological Surgery	1994160C0	1	1
Neurology	1994180C0	6	6
Obstetrics-Gynecology	1994220C0	4	4
Orthopaedic Surgery/5 Yr	1994260C0	5	5
Otolaryngology	1994280C0	3	3
Pathology	1994300C0	3	3
Pediatrics	1994320C0	7	7
Peds/Health Informatics	1994320C1	1	1
Phys Medicine & Rehab	1994340A0	4	4
Plastic Surgery (Integrated)	1994362C0	1	1
Psychiatry	1994400C0	10	10
Radiology-Diagnostic	1994420A0	5	5
General Surgery	1994440C0	4	4
Surgery-Preliminary	1994440P0	7	0
Medicine-Pediatrics	1994700C0	4	4

MONTANA

Billings Clinic-MT

Billings	Code	Quota	Matched
Internal Medicine	1633140C0	8	8
Medicine-Preliminary	1633140P0	4	2

Montana Family Medicine

Billings	Code	Quota	Matched
Family Medicine	1216120C0	10	4

University of Montana

Missoula	Code	Quota	Matched
Family Medicine/Missoula	1524120C0	7	2
Family Medicine/Kalispell	1524120C1	3	1

NEBRASKA

Clarkson Family Med Res-NE

Omaha	Code	Quota	Matched
Family Medicine	3197120C0	6	4

Creighton University-NE

Omaha	Code	Quota	Matched
Family Medicine	1372120C0	8	8
Internal Medicine	1372140C0	23	23
Medicine-Primary	1372140M0	2	2
Neurology	1372180C0	2	2
Obstetrics-Gynecology	1372220C0	4	4
Pathology	1372300C0	2	2
Psychiatry	1372400C0	6	6
Radiology-Diagnostic	1372420A0	3	3
General Surgery	1372440C0	4	4
Surgery-Preliminary	1372440P0	2	2

Lincoln Med Ed Partnership-NE

Lincoln	Code	Quota	Matched
Family Medicine	3021120C0	8	8

University of Nebraska Med Ctr

Omaha	Code	Quota	Matched
Anesthesiology	1376040A0	2	2
Anesthesiology	1376040C0	8	8
Anesthesiology	1376040R0	1	1
Dermatology	1376080A0	3	3
Emergency Medicine	1376110C0	12	12
Fam Med/Grand Island	1376120C1	2	2
Fam Med/North Platte	1376120C3	1	1
Fam Med/Scottsbluff	1376120C4	2	2
Fam Med/Traditional	1376120C5	7	7
Family Med/Kearney	1376120C6	2	2
Family Med/Urban	1376120C7	1	1
Internal Medicine	1376140C0	23	23
Internal Medicine/Geriatrics	1376140C1	1	1
Medicine-Primary	1376140M0	1	1
Medicine-Preliminary	1376140P0	6	6
Neurological Surgery	1376160C0	2	2
Neurology	1376180C0	6	6
Obstetrics-Gynecology	1376220C0	4	4
Orthopaedic Surgery	1376260C0	5	5
Otolaryngology	1376280C0	3	3
Pathology	1376300C0	4	4
Pediatrics	1376320C0	15	15
Phys Medicine & Rehab	1376340C0	4	4
Psychiatry	1376400C0	5	5
Interventional Radiology (Integ)	1376416A0	1	1
Radiology-Diagnostic	1376420A0	5	5
Radiation Oncology	1376430A0	1	1
General Surgery	1376440C0	6	6
Medicine-Pediatrics	1376700C0	4	4

NEVADA

Kirk Kerkorian SOM at UNLV-NV

Las Vegas	Code	Quota	Matched
Emergency Medicine	2028110C0	6	6
Family Medicine	2028120C0	5	3

Kirk Kerkorian SOM at UNLV-NV (Continued)

Family Medicine/Rural	2028120C1	2	0
Internal Medicine	2028140C0	22	20
Medicine-Preliminary	2028140P0	4	4
Obstetrics-Gynecology	2028220C0	4	4
Orthopaedic Surgery	2028260C0	4	4
Otolaryngology	2028280C0	1	1
Pediatrics	2028320C0	10	6
Plastic Surgery (Integrated)	2028362C0	1	1
Psychiatry	2028400C0	10	10
General Surgery	2028440C0	3	3
Surgery-Preliminary	2028440P0	1	0

Sunrise Health GME Consortium-NV

Las Vegas	Code	Quota	Matched
Anesthesiology	1884040C0	8	8
Emergency Medicine	1884110C0	11	11
Family Medicine	1884120C0	8	4
Internal Medicine	1884140C0	22	16
Neurology	1884180C0	3	3
Obstetrics-Gynecology	1884220C0	4	4
Phys Medicine & Rehab	1884340A0	6	6
Phys Medicine & Rehab	1884340R0	1	1
Psychiatry	1884400C0	4	4
Radiology-Diagnostic	1884420A0	5	5
General Surgery	1884440C0	4	4
Surgery-Preliminary	1884440P0	8	0
Transitional/Mountain View	1884999P0	13	13
Transitional/Southern Hills	1884999P1	13	11

U Nevada Reno SOM

Reno	Code	Quota	Matched
Family Medicine	2017120C0	7	7
Family Med/Rural	2017120C1	2	0
Internal Medicine	2017140C0	18	10
Medicine-Preliminary	2017140P0	5	0
Psychiatry	2017400C0	6	6

Valley Health System-NV

Las Vegas	Code	Quota	Matched
Emergency Medicine	2201110C0	8	7
Family Medicine	2201120C0	10	10
General Surgery	2201440C0	4	4
Surgery-Preliminary	2201440P0	8	4

Valley Hosp Med Ctr-NV

Las Vegas	Code	Quota	Matched
Family Medicine	2223120C0	5	2
Internal Medicine	2223140C0	15	15
Neurology	2223180C0	2	2
Orthopaedic Surgery	2223260C0	2	2

NEW HAMPSHIRE

Concord Hospital-NH

Concord	Code	Quota	Matched
Family Medicine	1091120C0	8	8

Dartmouth-Hitchcock Med Ctr-NH

Lebanon	Code	Quota	Matched
Anesthesiology	1377040C0	7	7
Anesthesiology	1377040R0	2	1
Dermatology	1377080A0	3	3
Emergency Medicine	1377110C0	6	6
Internal Medicine	1377140C0	18	18
Medicine-Primary	1377140M0	3	3
Medicine-Preliminary	1377140P0	4	4
Neurological Surgery	1377160C0	1	1
Neurology	1377180C0	5	5
Obstetrics-Gynecology	1377220C0	4	4
Orthopaedic Surgery	1377260C0	4	4
Otolaryngology	1377280C0	1	1
Pathology	1377300C0	4	4
Pediatrics	1377320C0	7	7
Plastic Surgery (Integrated)	1377362C0	1	1
Psychiatry	1377400C0	9	9
Psychiatry/Reseach Track	1377400C1	0	0
Psychiatry/Child Track	1377400C2	0	0
Interventional Radiology (Integ)	1377416A0	2	2
Radiology-Diagnostic	1377420A0	3	3
Radiation Oncology	1377430A0	1	0
General Surgery	1377440C0	4	4
Surgery-Preliminary	1377440P0	6	3
Vascular Surgery	1377451C0	1	1

Portsmouth Regional Hosp-NH

Portsmouth	Code	Quota	Matched
Family Medicine	2248120C0	8	2
Internal Medicine	2248140C0	10	6
Psychiatry	2248400C0	6	6

NEW JERSEY

AtlantiCare Reg Med Ctr-NJ

Atlantic City	Code	Quota	Matched
Family Medicine	1378120C0	4	4
Internal Medicine	1378140C0	14	14
Psychiatry	1378400C0	4	4

Atlantic Health System-NJ

Morristown	Code	Quota	Matched
Pediatrics	3033320C0	12	12

CMSRU/Cooper University Hospital-NJ

Camden	Code	Quota	Matched
Anesthesiology	1380040C0	5	5
Dermatology	1380080A0	2	2
Emergency Medicine	1380110C0	13	13
Family Medicine	1380120C0	10	10
Internal Medicine	1380140C0	22	22
Medicine-Primary	1380140M0	3	3
Medicine-Primary/3-yr MD Path	1380140M1	2	2
Medicine-Preliminary	1380140P0	1	1
Neurology	1380180C0	4	4
Obstetrics-Gynecology	1380220C0	4	4
Orthopaedic Surgery	1380260C0	2	2
Otolaryngology	1380280C0	1	1
Pediatrics	1380320C0	8	8

CMSRU/Cooper University Hospital-NJ (Continued)

Pediatrics Primary/3-yr MD Path	1380320M1	2	2
Plastic Surgery (Integrated)	1380362C0	1	1
Psych/Cooper Hosp	1380400C0	4	4
Radiology-Diagnostic	1380420A0	5	5
General Surgery	1380440C0	4	4
Vascular Surgery	1380451C0	2	2

Capital Health Reg Med Ctr-NJ

Trenton	Code	Quota	Matched
Emergency Medicine	2003110C0	6	6
Family Medicine	2003120C0	6	6
Internal Medicine	2003140C0	20	20
Transitional Year	2003999P0	13	7

Englewood Hosp-NJ

Englewood	Code	Quota	Matched
Internal Medicine	1386140C0	13	13
Medicine-Preliminary	1386140P0	3	3

HMH-Palisades Med Ctr-NJ

North Bergen	Code	Quota	Matched
Dermatology	2136080A0	3	3
Family Medicine	2136120C0	4	4
Internal Medicine	2136140C0	10	10
Internal Medicine/Phase 3-R	2136140C1	1	1
General Surgery	2136440C0	4	4
Surgery-Preliminary	2136440P0	2	2
Transitional	2136999P0	18	18

Hackensack U Med Ctr-NJ

Hackensack	Code	Quota	Matched
Anesthesiology	1387040C0	1	1
Anesthesiology/Phase 3-R	1387040C1	2	2
Emergency Medicine	1387110C0	10	10
Internal Medicine	1387140C0	7	7
Internal Medicine/Phase 3-R	1387140C1	5	5
Medicine-Preliminary	1387140P0	1	1
Obstetrics-Gynecology	1387220C0	3	3
Obstetrics-Gynecology/Phase 3-R	1387220C1	1	1
Pediatrics	1387320C0	5	5
Pediatrics/Phase 3-R	1387320C1	3	3
General Surgery	1387440C0	3	3
General Surgery/Phase 3-R	1387440C1	2	2
Surgery-Preliminary	1387440P0	2	2

Hoboken Univ Med Ctr-NJ

Hoboken	Code	Quota	Matched
Family Medicine/NYMC	1451120C0	8	7
Family Medicine/Christ	1451120C1	6	4
Internal Medicine/Bayonne	1451140C0	12	7
General Surgery	1451440C0	4	4
Transitional/Bayonne	1451999P0	4	1

Hunterdon Med Ctr-NJ

Flemington	Code	Quota	Matched
Family Medicine	1838120C0	6	6

Inspira Health Network-NJ

Vineland	Code	Quota	Matched
Emergency Med/Vineland	2086110C0	11	3
Emergency Med/Mullica Hill	2086110C1	8	3
Family Medicine/Mullica Hill	2086120C0	6	4
Family Medicine/Vineland	2086120C2	6	2
Internal Medicine/Vineland	2086140C0	11	11
Internal Med/Mullica Hill	2086140C1	12	9
Obstetrics-Gynecology	2086220C0	4	4
Orthopaedic Surgery	2086260C0	3	3
General Surgery	2086440C0	4	4
Transitional/Vineland	2086999P0	15	0
Transitional/Mullica Hill	2086999P1	12	5

JFK Med Ctr-NJ

Edison	Code	Quota	Matched
Family Medicine	3043120C0	8	8
Neurology	3043180C0	8	8
Neurology/Phase-3-R	3043180C1	1	1
Phys Medicine & Rehab/RWJ	3043340A0	5	5
Phys Medicine & Rehab	3043340R0	1	1

Jersey Shore Univ Med Ctr-NJ

Neptune	Code	Quota	Matched
Internal Medicine	1395140C0	18	18
Internal Medicine/Phase 3-R	1395140C1	2	2
Medicine-Preliminary	1395140P0	9	9
Medicine-Preliminary/Phase 3-R	1395140P1	1	1
Child Neurology	1395185C0	2	2
Child Neurology	1395185R0	0	0
Obstetrics-Gynecology	1395220C0	3	3
Obstetrics-Gynecology/Phase 3-R	1395220C1	1	1
Pediatrics	1395320C0	7	6
Pediatrics/Phase 3-R	1395320C1	2	2
Psychiatry	1395400C0	2	2
Psychiatry/Addiction Medicine	1395400C1	1	1
Psychiatry/Child & Adolescent	1395400C2	0	0
Psychiatry/HUMC	1395400C4	1	1
Psychiatry/Phase 3-R/HUMC	1395400C5	1	1
General Surgery	1395440C0	3	3
Surgery-General/Preliminary	1395440P0	1	1

Morristown Med Ctr-NJ

Morristown	Code	Quota	Matched
Emergency Medicine	1394110C0	10	10
Family Medicine	1394120C0	7	7
Internal Medicine	1394140C0	16	16
Medicine-Preliminary	1394140P0	9	9
Obstetrics-Gynecology	1394220C0	5	5
Radiology-Diagnostic	1394420A0	5	5
General Surgery	1394440C0	7	7
Surgery-Preliminary	1394440P0	3	2

Mountainside Hosp-NJ

Montclair	Code	Quota	Matched
Family Medicine	1393120C0	4	4
Family Medicine/Phase 3-R	1393120C1	3	3
Internal Medicine	1393140C0	8	8
Medicine-Preliminary	1393140P0	2	2

NYMC-St Michaels Med Ctr-NJ

Newark	Code	Quota	Matched
Internal Medicine	1857140C0	19	19

New Bridge Med Ctr-NJ

Paramus	Code	Quota	Matched
Psychiatry	1908400C0	9	9

Ocean Med Ctr-NJ

Brick	Code	Quota	Matched
Family Medicine/Osteopathic	2108120C0	8	4
Internal Medicine	2108140C0	17	17
Psychiatry	2108400C0	5	5
Psychiatry/Addiction Medicine	2108400C1	1	1
Psychiatry/Geriatric Medicine	2108400C3	1	1
Psychiatry/Phase 3-R	2108400C4	2	2
Transitional	2108999P0	12	12

Overlook Hospital-NJ

Summit	Code	Quota	Matched
Family Medicine	1408120C0	7	7
Internal Medicine	1408140C0	13	13
Medicine-Preliminary	1408140P0	2	2

Rowan University SOM-NJ

Stratford	Code	Quota	Matched
Emergency Medicine	2120110C0	11	11
Family Medicine/Osteopathic	2120120C0	8	7
Internal Medicine	2120140C0	18	18
Obstetrics-Gynecology	2120220C0	2	2
Orthopaedic Surgery	2120260C0	5	5
Psychiatry	2120400C0	5	5
Transitional	2120999P0	9	9

Rutgers-Community Med Ctr-NJ

Tom'S River	Code	Quota	Matched
Emergency Medicine	2298110C0	13	13
Internal Medicine	2298140C0	12	12
General Surgery	2298440C0	4	4

Rutgers-Jersey City Med Ctr-NJ

Jersey City	Code	Quota	Matched
Internal Medicine	1390140C0	18	18
Obstetrics-Gynecology	1390220C0	3	3
Orthopaedic Surgery	1390260C0	3	3

Rutgers-Monmouth Med Ctr-NJ

Long Branch	Code	Quota	Matched
Internal Medicine	1392140C0	13	13
Obstetrics-Gynecology	1392220C0	4	4
Orthopaedic Surgery	1392260C0	2	2
Pediatrics	1392320C0	5	5
Radiology-Diagnostic	1392420A0	4	4

Rutgers-New Jersey Medical School

Newark	Code	Quota	Matched
Anesthesiology	1398040A0	8	8
Anesthesiology	1398040C0	6	6
Anesthesiology	1398040R0	2	2
Emergency Medicine	1398110C0	9	9
Internal Medicine	1398140C0	33	33
Internal Med/Trinitas	1398140C2	10	10
Internal Medicine/4 yr IM-PM	1398140C3	2	1
Medicine-Preliminary	1398140P0	9	9
Med-Prelim/Anesthesiology	1398140P3	1	1
Neurological Surgery	1398160C0	3	3
Neurology	1398180C0	5	5
Child Neurology	1398185C0	1	1
Orthopaedic Surgery	1398260C0	6	6
Otolaryngology	1398280C0	4	4
Phys Medicine & Rehab	1398340A0	9	9
Plastic Surgery (Integrated)	1398362C0	2	2
Psychiatry	1398400C0	8	8
Radiology-Diagnostic	1398420A0	4	4
General Surgery	1398440C0	10	10
Surgery-Preliminary	1398440P0	18	5
Surg-Prelim/Anesthesiology	1398440P4	0	0
Vascular Surgery	1398451C0	1	1
Medicine-Pediatrics	1398700C0	4	4

Rutgers-Newark Beth Israel Med Ctr-NJ

Newark	Code	Quota	Matched
Emergency Medicine	1397110C0	8	8
Internal Medicine	1397140C0	12	12
Med-Prelim/Neurology	1397140P1	4	3
Obstetrics-Gynecology	1397220C0	4	4
Pediatrics	1397320C0	10	10
Radiology-Diagnostic	1397420A0	3	3

Rutgers-R W Johnson Medical School-NJ

New Brunswick	Code	Quota	Matched
Anesthesiology	2918040A0	8	8
Anesthesiology	2918040C0	4	4
Dermatology	2918080A0	2	2
Emergency Medicine	2918110C0	6	6
Family Medicine/A-Prog	2918120C0	5	5
Family Med/CentraState	2918120C2	6	6
Internal Medicine	2918140C0	24	24
Neurology	2918180A0	4	4
Obstetrics-Gynecology	2918220C0	5	5
Orthopaedic Surgery	2918260C0	3	3
Pathology	2918300C0	2	2
Pediatrics	2918320C0	11	11
Psychiatry	2918400C0	6	6
Interventional Radiology (Integ)	2918416A0	1	1
Radiology-Diagnostic	2918420A0	4	4
Radiation Oncology	2918430A0	2	1
Radiation Oncology	2918430R1	1	1
General Surgery	2918440C0	7	7
Surgery-Preliminary	2918440P0	5	2
Surg-Prelim/Anesthesiology	2918440P1	2	2
Vascular Surgery	2918451C0	1	1

Rutgers-RWJUH Somerset-NJ

Somerville	Code	Quota	Matched
Family Medicine	1934120C0	7	7

Rutgers-St Barnabas Med Ctr-NJ

Livingston	Code	Quota	Matched
Obstetrics-Gynecology	1396220C0	10	10
Radiology-Diagnostic	1396420A0	4	4

St Francis Med Ctr-NJ

Trenton	Code	Quota	Matched
Internal Medicine	3194140C1	10	10

St Josephs Univ Med Ctr-NJ

Paterson	Code	Quota	Matched
Anesthesiology	1406040A0	7	7
Anesthesiology	1406040R0	1	1
Emergency Medicine	1406110C0	8	8
Family Medicine	1406120C0	4	4
Internal Medicine	1406140C1	19	19
Obstetrics-Gynecology	1406220C0	3	3
Orthopaedic Surgery	1406260C0	3	3
Pediatrics	1406320C0	12	12
General Surgery	1406440C0	3	3
Surg-Prelim/Anesthesiology	1406440P0	2	0
Surgery-Preliminary	1406440P1	1	0

St Lukes Warren Hospital-NJ

Phillipsburg	Code	Quota	Matched
Family Medicine	2091120C0	6	6

St Peters University Hosp-NJ

New Brunswick	Code	Quota	Matched
Internal Medicine	3211140C0	17	17
Obstetrics-Gynecology	3211220C0	5	5
Pediatrics	3211320C0	8	8

Virtua-NJ

Voorhees	Code	Quota	Matched
Family Medicine	3084120C0	6	5
Obstetrics-Gynecology	3084220C0	6	6

NEW MEXICO

Memorial Med Ctr-NM

Las Cruces	Code	Quota	Matched
Family Medicine	1214120C0	10	10
Family Medicine/Rural	1214120C1	2	2

MountainView Reg Med Ctr-NM

Las Cruces	Code	Quota	Matched
Internal Medicine	2182140C0	9	8
Osteo Neuromusculo Med	2182275A0	2	2
Transitional	2182999P0	7	7
Transitional/ONMM	2182999P1	2	2

Northern NM Family Med

Santa Fe	Code	Quota	Matched
Family Medicine	1277120C0	6	6

U New Mexico SOM

Albuquerque	Code	Quota	Matched
Anesthesiology	1962040A0	1	1
Anesthesiology	1962040C0	6	6
Anesthesiology	1962040R0	1	1
Dermatology	1962080A0	3	3
Emergency Medicine	1962110C0	12	12
Family Medicine	1962120C0	14	14
Family Medicine/Shiprock	1962120C1	2	2
Internal Medicine	1962140C0	30	30
Medicine-Preliminary	1962140P0	10	10
Neurology	1962180C0	5	5
Neurology	1962180R0	1	1
Child Neurology	1962185C0	2	1
Obstetrics-Gynecology	1962220C0	6	6
Orthopaedic Surgery	1962260C0	5	5
Otolaryngology	1962280C0	2	2
Pathology	1962300C0	4	4
Pediatrics	1962320C0	21	21
Phys Medicine & Rehab	1962340C0	5	5
Phys Medicine & Rehab	1962340R1	1	1
Plastic Surgery (Integrated)	1962362C0	1	1
Psychiatry	1962400C0	15	15
Psychiatry/Child	1962400C1	1	0
Radiology-Diagnostic	1962420A0	8	8
General Surgery	1962440C0	7	7
Surgery-Preliminary	1962440P1	5	1

NEW YORK

Albany Med Ctr-NY

Albany	Code	Quota	Matched
Anesthesiology	1414040C0	6	6
Emergency Medicine	1414110C0	12	12
Family Medicine	1414120C0	6	6
Internal Medicine	1414140C0	18	18
Medicine-Preliminary	1414140P0	6	6
Neurological Surgery	1414160C0	2	2
Neurology	1414180A0	1	1
Neurology	1414180C0	6	6
Obstetrics-Gynecology	1414220C0	6	6
Orthopaedic Surgery	1414260C0	5	5
Otolaryngology	1414280C0	2	2
Pathology	1414300C0	3	3
Pediatrics	1414320C0	11	11
Phys Medicine & Rehab	1414340C0	2	2
Plastic Surgery (Integrated)	1414362C0	2	2
Psychiatry	1414400C0	6	6
Interventional Radiology (Integ)	1414416C0	1	1
Radiology-Diagnostic	1414420A0	5	5
General Surgery	1414440C0	6	6
Surgery-Preliminary	1414440P0	4	4
Vascular Surgery	1414451C0	1	1
Medicine-Pediatrics	1414700C0	4	4

Arnot Ogden Med Ctr-NY

Elmira	Code	Quota	Matched
Emergency Medicine	2113110C0	6	2
Family Medicine	2113120C0	8	8
Internal Medicine	2113140C0	10	10
Psychiatry	2113400C0	6	5
Radiology-Diagnostic	2113420C0	2	2
General Surgery	2113440C0	3	3

Bassett Med Ctr-NY

Cooperstown	Code	Quota	Matched
Internal Medicine	1442140C0	11	11
Medicine-Preliminary	1442140P0	1	1
General Surgery	1442440C0	3	3
Surgery-Preliminary	1442440P0	2	2
Transitional	1442999P0	9	6
Transitional/Hopkins	1442999P1	0	0

BronxCare Health System-NY

Bronx	Code	Quota	Matched
Pediatrics-Primary	1471320M1	14	14

BronxCare Health System-NY (Continued)

General Surgery	1471440C0	3	3
Surgery-Preliminary	1471440P0	5	4
Transitional	1471999P0	6	6

Brooklyn Hosp Ctr-NY

Brooklyn	Code	Quota	Matched
Emergency Medicine	1420110C0	8	8
Family Medicine	1420120C0	7	7
Internal Medicine	1420140C0	29	29
Obstetrics-Gynecology	1420220C0	4	4
Pediatrics	1420320C0	11	11
General Surgery	1420440C0	3	3
Surgery-Preliminary	1420440P0	6	3

Burke Rehabilitation Hosp-NY

White Plains	Code	Quota	Matched
Phys Medicine & Rehab	1940340A0	6	6

Cayuga Med Ctr-NY

Ithaca	Code	Quota	Matched
Medicine-Primary	2207140M0	8	8
Med-Primary/Cayuga-Cornell	2207140M1	2	2

Coney Island Hospital-NY

Brooklyn	Code	Quota	Matched
Emergency Medicine	1422110C0	4	4
Internal Medicine	1422140C0	25	25
Obstetrics-Gynecology	1422220C0	3	3
Transitional/Ophthalmology	1422999P1	6	6

Creedmoor Psych Ctr-NY

Queens Village	Code	Quota	Matched
Psychiatry	2599400C0	4	4

Ellis Hospital-NY

Schenectady	Code	Quota	Matched
Family Medicine	1513120C0	10	10

Family Health Ctrs at NYU Langone-NY

Brooklyn	Code	Quota	Matched
Internal Medicine	1663140C0	6	6
Psychiatry	1663400C0	3	3

Flushing Hospital Med Ctr-NY

Flushing	Code	Quota	Matched
Internal Medicine	1445140C0	15	15
Medicine-Preliminary	1445140P0	10	9
Obstetrics-Gynecology	1445220C0	3	3
Ob-Gyn/Preliminary	1445220P0	1	1
Pediatrics	1445320C0	10	10
General Surgery	1445440C0	3	3

Garnet Health Med Ctr-NY

Middletown	Code	Quota	Matched
Emergency Medicine	2230110C0	6	3
Family Medicine	2230120C0	3	3
Internal Medicine	2230140C0	10	10
Psychiatry	2230400C0	2	2
General Surgery	2230440C0	3	3
Transitional	2230999P0	12	12

Good Samaritan Hosp Med Ctr-NY

West Islip	Code	Quota	Matched
Emergency Medicine	2007110C0	6	6
Family Medicine	2007120C0	6	6
Obstetrics-Gynecology	2007220C0	4	4
Pediatrics	2007320C0	5	5
Phys Medicine & Rehab	2007340A0	3	3

Harlem Hospital Ctr-NY

New York	Code	Quota	Matched
Internal Medicine	1478140C0	25	25
Pediatrics	1478320C0	8	8
Psychiatry	1478400C0	6	6
Radiology-Diagnostic	1478420A0	3	3
General Surgery	1478440C0	3	3
Surgery-Preliminary	1478440P0	7	6

Hosp For Special Surgery-NY

New York	Code	Quota	Matched
Orthopaedic Surgery	3128260C0	9	9

ISMMS Mount Sinai Beth Israel-NY

New York	Code	Quota	Matched
Internal Medicine	1470140C0	31	31
Medicine-Preliminary	1470140P0	10	10
Med-Prelim/Neurology	1470140P1	5	5
Med-Prelim/Ophthalmology	1470140P2	10	10
Neurology	1470180A0	5	5
Psychiatry	1470400C0	13	13

ISMMS Mount Sinai Hospital-NY

New York	Code	Quota	Matched
Anesthesiology	1490040C0	26	26
Dermatology	1490080A0	9	9
Emergency Medicine	1490110C0	25	25
Family Medicine	1490120C0	6	6
Internal Medicine	1490140C0	43	43
Internal Med/Research	1490140C1	4	4
Internal Med/Comm Prim Care	1490140C2	8	8
Neurological Surgery	1490160C0	2	2
Neurology	1490180A0	2	2
Neurology	1490180C0	8	8
Child Neurology	1490185C0	1	1
Child Neurology	1490185R0	1	0
Obstetrics-Gynecology	1490220C0	8	8
Orthopaedic Surgery	1490260C0	7	7
Otolaryngology	1490280C0	6	6
Pathology	1490300C0	6	6
Pediatrics	1490320C0	14	14
Pediatrics/Research	1490320C1	2	2
Pediatrics-Preliminary	1490320P1	1	1
Phys Medicine & Rehab	1490340A0	2	2
Phys Medicine & Rehab	1490340C0	5	5
Plastic Surgery (Integrated)	1490362C0	3	3
Psychiatry	1490400C0	12	12
Psych/Physician-Scientist	1490400C2	2	2
Interventional Radiology (Integ)	1490416A0	3	3
Radiology-Diagnostic	1490420A0	8	8
Radiation Oncology	1490430A0	3	3

ISMMS Mount Sinai Hospital-NY (Continued)

General Surgery	1490440C0	12	12
Surgery-Preliminary	1490440P0	10	10
Surg-Prelim/Designated	1490440P1	11	10
Vascular Surgery	1490451C0	3	3
Thoracic Surgery	1490461C0	2	2
Medicine-Pediatrics	1490700C1	4	4
Peds/Psych/Child Psych	1490730C0	2	2
Pediatrics-Medical Genetics	1490765C0	1	1
Medicine-Medical Genetics	1490766C0	1	1

ISMMS Mount Sinai Morningside-West-NY

New York	Code	Quota	Matched
Anesthesiology	2070040A0	2	2
Anesthesiology	2070040C0	13	13
Emergency Medicine	2070110C0	20	20
Internal Medicine	2070140C0	43	43
Medicine-Primary	2070140M0	4	4
Medicine-Preliminary	2070140P0	19	19
Obstetrics-Gynecology	2070220C0	6	6
Pathology	2070300C0	5	5
Psychiatry	2070400C0	12	12
Radiology-Diagnostic	2070420A0	11	11

ISMMS Mount Sinai South Nassau-NY

Oceanside	Code	Quota	Matched
Family Medicine	3067120C0	8	8
Internal Medicine	3067140C0	8	8
Int Med/Sabbath Observant	3067140C1	2	2
Obstetrics-Gynecology	3067220C0	3	3
General Surgery	3067440C0	3	3
Transitional	3067999P0	4	2

ISMMS NYC Health+Hospitals/Elmhurst-NY

Elmhurst	Code	Quota	Matched
Internal Medicine	1491140C0	20	20
Medicine-Preliminary	1491140P0	15	14

ISMMS NYC Health+Hospitals/Queens-NY

Jamaica	Code	Quota	Matched
Internal Medicine	1489140C0	20	20
Medicine Preliminary	1489140P0	8	4
Obstetrics-Gynecology	1489220C0	3	3

Institute for Family Health-NY

New York	Code	Quota	Matched
Family Medicine/Mid-Hudson	2004120C0	9	9
Family Medicine/Harlem-Mt Sinai	2004120C1	7	7
Fam Med/Mid-Hudson/Osteopathic	2004120C2	1	1

Jacobi Med Ctr/Einstein-NY

Bronx	Code	Quota	Matched
Internal Medicine	3172140C0	29	29
Int Med/Sabbath Observed	3172140C1	1	1
Internal Med/N Central Bronx	3172140C4	16	16
Medicine-Primary	3172140M0	4	4
Pediatrics	3172320C0	15	15
Radiology-Diagnostic	3172420A0	4	4
Radiology-Diagnostic/Sabbath	3172420A1	1	1

Jamaica Hosp Med Ctr-NY

Jamaica	Code	Quota	Matched
Family Medicine	1449120C0	10	10
Obstetrics-Gynecology	1449220C0	3	3
Ob-Gyn/Preliminary	1449220P0	1	0
Psychiatry	1449400C0	8	8

Lincoln Med Ctr-NY

Bronx	Code	Quota	Matched
Emergency Medicine	1484110C0	11	11
Internal Medicine	1484140C0	34	34
Medicine-Preliminary	1484140P0	11	11
Obstetrics-Gynecology	1484220C0	4	4
Pediatrics-Primary	1484320M0	17	17
General Surgery	1484440C0	3	3
Surgery-Preliminary	1484440P0	3	3
Transitional	1484999P0	13	13

Maimonides Med Ctr-NY

Brooklyn	Code	Quota	Matched
Anesthesiology	1428040A0	9	9
Anesthesiology	1428040R0	1	1
Emergency Medicine	1428110C0	18	18
Internal Medicine	1428140C0	29	29
Internal Medicine/ROAP	1428140C1	1	1
Medicine-Preliminary	1428140P0	16	16
Obstetrics-Gynecology	1428220C0	6	6
Orthopaedic Surgery	1428260C0	3	3
Pediatrics	1428320C0	18	18
Psychiatry	1428400C0	11	11
Radiology-Diagnostic	1428420A0	4	4
General Surgery	1428440C0	4	4
Surgery-Preliminary	1428440P0	4	4

Memorial Sloan-Kettering-NY

New York	Code	Quota	Matched
Radiation Oncology	1466430A0	6	6
Transitional	1466999P0	24	24

Montefiore Med Ctr/Einstein-NY

Bronx	Code	Quota	Matched
Anesthesiology	3153040A0	6	6
Anesthesiology	3153040C0	11	11
Dermatology	3153080A0	6	6
Emergency Medicine/Jacobi	3153110C0	21	21
Family Medicine	3153120C0	10	10
Internal Medicine	3153140C0	39	39
Internal Med/Wakefield	3153140C3	23	23
Med-Primary/Social Int Med	3153140M0	10	10
Med-Prelim/Wakefield	3153140P3	8	4
Med-Prelim/Ophthalmology	3153140P4	5	5
Neurological Surgery	3153160C0	2	2
Neurology	3153180A0	3	3
Neurology	3153180C0	6	6
Child Neurology	3153185C0	2	2
Obstetrics-Gynecology	3153220C0	11	11
Ob-Gyn/Preliminary	3153220P0	2	0
Orthopaedic Surgery	3153260C0	6	6

Montefiore Med Ctr/Einstein-NY (Continued)

Otolaryngology	3153280C0	4	4
Pathology	3153300C0	6	6
Pediatrics	3153320C0	23	23
Pediatrics-Primary/Social	3153320M0	4	4
Phys Medicine & Rehab	3153340A0	9	9
Plastic Surgery (Integrated)	3153362C0	2	2
Psychiatry	3153400C0	12	12
Interventional Radiology (Integ)	3153416A0	2	2
Radiology-Diagnostic	3153420A0	7	7
Radiation Oncology	3153430A0	2	2
General Surgery	3153440C0	10	10
Surgery-Preliminary	3153440P3	20	12
Vascular Surgery	3153451C0	1	1
Thoracic Surgery	3153461C0	1	1

Montefiore St Lukes Cornwall-NY

Newburgh	Code	Quota	Matched
Internal Medicine	2309140C0	13	13

Montefiore-New Rochelle/Einstein-NY

New Rochelle	Code	Quota	Matched
Internal Medicine	1459140C0	13	13
Medicine-Preliminary	1459140P0	8	8

NYMC-Metropolitan Hosp Ctr-NY

Valhalla	Code	Quota	Matched
Anesthesiology	1473040C0	4	4
Dermatology	1473080A0	2	2
Emergency Medicine	1473110C0	12	12
Internal Medicine	1473140C0	20	20
Medicine-Preliminary	1473140P0	6	6
Pediatrics	1473320C0	7	7
Phys Medicine & Rehab	1473340A1	3	3
Phys Medicine & Rehab	1473340R0	1	1
Psychiatry	1473400C0	5	5
General Surgery	1473440C0	4	4
Surgery-Preliminary	1473440P0	6	5

NYMC-St Josephs Med Ctr-NY

Valhalla	Code	Quota	Matched
Family Medicine	1525120C0	10	10

NYP Brooklyn Methodist Hosp-NY

Brooklyn	Code	Quota	Matched
Emergency Medicine	1429110C0	14	14
Internal Medicine	1429140C0	34	34
Medicine-Preliminary	1429140P0	8	8
Obstetrics-Gynecology	1429220C0	4	4
Ob-Gyn/Preliminary	1429220P0	1	1
Pediatrics	1429320C0	10	10
General Surgery	1429440C0	3	3
Surgery-Preliminary	1429440P0	5	3

NYP Hosp-Columbia & Cornell-NY

New York	Code	Quota	Matched
Emergency Medicine	1409110C0	12	12
Otolaryngology	1409280C0	4	4
Phys Medicine & Rehab	1409340A0	8	8

NYP Hosp-Columbia Univ Med Ctr-NY

New York	Code	Quota	Matched
Anesthesiology	1495040C0	24	24
Anesthesiology/Apgar Research	1495040C1	2	2
Dermatology	1495080A0	4	4
Family Medicine	1495120C0	6	6
Internal Medicine	1495140C0	44	44
Neurological Surgery	1495160C0	3	3
Neurology	1495180C0	10	10
Child Neurology	1495185C0	2	2
Child Neurology	1495185R1	1	0
Obstetrics-Gynecology	1495220C0	6	6
Orthopaedic Surgery	1495260C0	5	5
Ortho Surgery/Research COR 6 yr	1495260C2	1	1
Pathology	1495300C0	7	7
Pediatrics	1495320C0	24	24
Pediatrics/Physician Scientist	1495320C2	1	1
Psychiatry	1495400C0	10	10
Psychiatry/Research	1495400C3	2	2
Interventional Radiology (Integ)	1495416A0	2	2
Radiology-Diagnostic	1495420A0	6	6
Radiation Oncology	1495430A0	1	1
General Surgery	1495440C0	7	7
Surgery-Preliminary	1495440P0	2	2
Surg-Prelim/Non-designated	1495440P2	5	0
Thoracic Surgery	1495461C0	2	2
Pediatrics-Medical Genetics	1495765C0	1	1

NYP Hosp-Weill Cornell Med Ctr-NY

New York	Code	Quota	Matched
Anesthesiology	1492040C0	18	18
Anesth/Research Scholars	1492040C1	0	0
Anesthesiology	1492040R0	2	2
Dermatology	1492080A0	4	4
Internal Medicine	1492140C0	36	36
Internal Med/Research	1492140C1	5	5
Medicine-Primary	1492140M0	4	4
Neurological Surgery	1492160C0	2	2
Neurology	1492180C0	8	8
Child Neurology	1492185C0	1	1
Obstetrics-Gynecology	1492220C0	7	7
Pathology	1492300C0	6	6
Pediatrics	1492320C0	18	18
Pediatrics/Gen Phys Sci Path	1492320C1	2	2
Plastic Surgery (Integrated)	1492362C0	2	2
Psych/Payne Whitney	1492400C0	11	11
Interventional Radiology (Integ)	1492416C0	3	3
Radiology-Diagnostic	1492420A0	6	6
General Surgery	1492440C0	8	8
Surgery-Preliminary	1492440P0	5	5

NYU Grossman School Of Medicine-NY

New York	Code	Quota	Matched
Anesthesiology/NYU Man	2978040A0	22	22
Anesthesiology/NYU Bkln	2978040A1	6	6
Anesthesiology/3-yr MD Path	2978040A2	0	0
Anesthesiology	2978040R0	2	2
Dermatology	2978080A0	8	8
Dermatology/3-yr MD Path	2978080A2	1	1

NYU Grossman School Of Medicine-NY (Continued)

Emergency Medicine	2978110C0	18	18
Internal Medicine	2978140C0	24	24
Int Med/Clin Invest Track	2978140C2	8	8
Int Med/NYU-Tisch-Kimmel	2978140C3	12	12
Int Med/3-yr MD Path	2978140C4	2	2
Medicine-Primary/NYU Man	2978140M0	8	8
Medicine-Primary/NYU Bkln	2978140M1	10	10
Med-Prelim/NYU Man	2978140P0	1	1
Med-Prelim/Neurology NYU Man	2978140P1	9	9
Med-Prelim/Anesthesia NYU Man	2978140P2	8	8
Med-Prelim/NYU Bkln	2978140P3	1	1
Med-Prelim/Neurology NYU Bkln	2978140P4	5	5
Med-Prelim/Anesthesia NYU Bkln	2978140P5	4	4
Med-Prelim/3-yr MD Path Man	2978140P6	3	3
Neurological Surgery	2978160C0	3	3
Neurology/NYU Man	2978180A0	12	12
Neurology/NYU Bkln	2978180A1	5	5
Neurology/NYU Man	2978180R0	1	1
Child Neurology	2978185C0	2	2
Obstetrics-Gynecology	2978220C0	9	9
Ob-Gyn/3-yr MD Path	2978220C1	1	1
Orthopaedic Surgery	2978260C0	11	11
Ortho Surgery/3-yr MD Path	2978260C1	3	3
Otolaryngology	2978280C0	3	3
Otolaryngology/3-yr MD Path	2978280C1	1	1
Pathology	2978300C0	7	7
Pediatrics	2978320C0	19	19
Phys Medicine & Rehab	2978340A0	12	12
Plastic Surgery (Integrated)	2978362C0	4	4
Psychiatry	2978400C0	13	13
Psychiatry/Research/MDPhD	2978400C1	3	1
Psychiatry/Child/Research	2978400C2	1	1
Interventional Radiology (Integ)	2978416A0	2	2
Radiology-Diagnostic	2978420A0	8	8
Radiology-Diag/3-Yr MD Path	2978420A1	2	2
Radiation Oncology	2978430A0	3	3
General Surgery/NYU Man	2978440C0	7	7
General Surgery/NYU Bkln	2978440C1	3	3
Gen Surgery/3-yr MD Path Man	2978440C2	1	1
Surg-Prelim/NYU Man	2978440P0	4	4
Surg-Prelim/Int Radiology	2978440P2	1	1
Vascular Surgery	2978451C0	1	1
Thoracic Surgery	2978461C0	1	1
Psychiatry-Neurology	2978755C0	1	1

NYU Long Island SOM-NY

Mineola	Code	Quota	Matched
Internal Medicine	1455140C0	18	18
Internal Medicine/LISOM Trk	1455140C1	4	4
Medicine-Preliminary	1455140P0	16	16
Obstetrics-Gynecology	1455220C0	4	4
Obstetrics-Gynecology/LISOM Trk	1455220C1	1	1
Orthopaedic Surgery	1455260C0	3	3
Pathology	1455300C0	2	2
Pediatrics	1455320C0	11	11
Pediatrics/LISOM Trk	1455320C1	1	1
General Surgery	1455440C0	5	5
Surgery-Preliminary	1455440P0	5	3

Nassau Univ Med Ctr-NY

East Meadow	Code	Quota	Matched
Emergency Medicine	1448110C0	5	5
Internal Medicine	1448140C0	26	15
Medicine-Preliminary	1448140P0	7	6
Med-Prelim/Ophthalmology	1448140P1	4	4
Obstetrics-Gynecology	1448220C0	4	3
Ob-Gyn/Preliminary	1448220P0	1	0
Orthopaedic Surgery	1448260C0	2	2
Pediatrics	1448320C0	6	6
Phys Medicine & Rehab	1448340A0	5	5
Plastic Surgery (Integrated)	1448362C0	1	1
Psychiatry	1448400C0	7	7
Psychiatry/CAP 5 yr	1448400C1	2	2
Radiology-Diagnostic	1448420A0	4	4
General Surgery	1448440C0	3	3
Surgery-Preliminary	1448440P0	7	3
Transitional	1448999P0	10	6

New York Institute Technology COM

Old Westbury	Code	Quota	Matched
Family Medicine	2314120C0	7	7

New York-Presbyterian/Queens

Flushing	Code	Quota	Matched
Emergency Medicine	1822110C0	9	9
Internal Medicine	1822140C0	18	18
Medicine-Preliminary	1822140P0	6	6
General Surgery	1822440C0	5	5
Surgery-Preliminary	1822440P0	6	0

Niagara Falls Mem Med Ctr-NY

Niagara Falls	Code	Quota	Matched
Family Medicine	2205120C0	4	4

Nuvance Health-NY

Poughkeepsie	Code	Quota	Matched
Anesthesiology	2183040C0	6	6
Emergency Medicine	2183110C0	10	5
Family Medicine	2183120C0	8	7
Internal Medicine	2183140C0	25	25
Neurology	2183180C0	5	5
Psychiatry	2183400C0	9	9
General Surgery	2183440C0	3	3
Transitional	2183999P0	4	1

OBH Brookdale Univ Hosp Med Ctr-NY

Brooklyn	Code	Quota	Matched
Emergency Medicine	1419110C0	8	8
Psychiatry	1419400C0	7	7
General Surgery	1419440C0	3	3
Surgery-Preliminary	1419440P0	9	3

OBH Interfaith Med Ctr-NY

Brooklyn	Code	Quota	Matched
Psychiatry	1425400C0	5	5

OBH Kingsbrook Jewish Med Ctr-NY

Brooklyn	Code	Quota	Matched
Phys Medicine & Rehab	1476340A0	4	4
Phys Medicine & Rehab	1476340R0	1	1

Our Lady Of Lourdes-NY

Binghamton	Code	Quota	Matched
Family Medicine	2185120C0	10	10

Richmond Univ Med Ctr-NY

Staten Island	Code	Quota	Matched
Internal Medicine	1514140C0	12	11
Medicine-Preliminary	1514140P0	14	4
Obstetrics-Gynecology	1514220C0	4	4
Pediatrics	1514320C0	6	6
Psychiatry	1514400C0	6	6
Radiology-Diagnostic	1514420A0	2	2

Rochester Gen Hosp-NY

Rochester	Code	Quota	Matched
Family Medicine	1509120C0	5	4
Internal Medicine	1509140C0	24	24
Obstetrics-Gynecology	1509220C0	5	5
Psychiatry	1509400C0	4	4
Interventional Radiology (Integ)	1509416A0	2	2
Radiology-Diagnostic	1509420A0	5	5
Radiology-Diagnostic	1509420R0	1	1

Rochester Regional Health/Unity Hosp-NY

Rochester	Code	Quota	Matched
Internal Medicine	1510140C0	16	16
Medicine-Preliminary	1510140P0	3	2
Phys Medicine & Rehab	1510340A0	3	3
Phys Medicine & Rehab	1510340R0	3	3

SUNY HSC Brooklyn-NY

Brooklyn	Code	Quota	Matched
Anesthesiology	1426040C0	13	13
Anesthesiology	1426040R0	4	4
Dermatology	1426080A0	8	8
Emergency Medicine	1426110C0	21	21
Family Medicine	1426120C0	6	6
Internal Medicine	1426140C0	47	47
Medicine-Primary	1426140M0	12	12
Medicine-Preliminary	1426140P0	8	8
Med-Prelim/Ophthalmology	1426140P3	2	2
Neurology	1426180A0	1	0
Neurology	1426180C0	11	11
Child Neurology	1426185C0	2	2
Obstetrics-Gynecology	1426220C0	6	6
Orthopaedic Surgery	1426260C0	6	6
Otolaryngology	1426280C0	3	3
Pathology	1426300C0	6	6
Pediatrics	1426320C0	26	26
Phys Medicine & Rehab	1426340A0	6	6
Psychiatry	1426400C0	13	13
Radiology-Diagnostic	1426420A0	8	8
Radiation Oncology	1426430A0	2	0
General Surgery	1426440C0	8	8
Surgery-Preliminary	1426440P0	12	10
Medicine-Emergency Med	1426705C0	4	4

SUNY Upstate Med University

Syracuse	Code	Quota	Matched
Anesthesiology	1516040C0	11	11
Anesthesiology	1516040R0	3	3
Emergency Medicine	1516110C0	11	10
Family Medicine	1516120C0	6	6
Internal Medicine	1516140C0	35	35
Medicine-Preliminary	1516140P0	18	18
Med-Prelim/PM&R	1516140P3	1	1
Med-Prelim/Radiology	1516140P4	6	6
Neurological Surgery	1516160C0	2	2
Neurology	1516180C0	9	9
Obstetrics-Gynecology	1516220C0	5	5
Orthopaedic Surgery	1516260C0	5	5
Otolaryngology	1516280C0	3	3
Pathology	1516300C0	5	5
Pediatrics	1516320C0	15	10
Phys Medicine & Rehab	1516340A0	6	6
Psychiatry	1516400C0	8	8
Psychiatry/Rural-GBHC	1516400C7	2	2
Psychiatry/Rural-HPC	1516400C8	2	2
Radiology-Diagnostic	1516420A0	7	7
Radiation Oncology	1516430A0	2	1
General Surgery	1516440C0	5	5

Samaritan Med Ctr-NY

Watertown	Code	Quota	Matched
Family Medicine	2024120C0	3	1
Internal Medicine	2024140C0	2	2

St Barnabas Hosp-NY

Bronx	Code	Quota	Matched
Dermatology	3113080A0	1	1
Emergency Medicine/Osteopathic	3113110C0	15	7
Osteo Neuromusculo Med	3113275C0	4	4
Pediatrics	3113320C0	6	6
General Surgery	3113440C0	3	3

St Elizabeth Med Ctr-NY

Utica	Code	Quota	Matched
Family Medicine	3064120C0	10	10

St Johns Riverside Hospital-NY

Yonkers	Code	Quota	Matched
Emergency Medicine	1897110C0	10	7
Internal Medicine	1897140C0	9	9
Medicine-Preliminary	1897140P0	4	4

St Josephs Health-NY

Syracuse	Code	Quota	Matched
Family Medicine	1518120C0	14	14
Transitional	1518999P0	6	5

Stony Brook Teach Hosps-NY

Stony Brook	Code	Quota	Matched
Anesthesiology	2919040C0	11	11
Dermatology	2919080A0	3	3
Emergency Medicine	2919110C0	15	15
Emergency Medicine/3-yr MD Path	2919110C1	1	1
Family Medicine	2919120C0	7	7
Internal Medicine	2919140C0	32	32
Internal Med/Southampton	2919140C2	7	7
Medicine-Primary	2919140M0	1	1
Neurological Surgery	2919160C0	1	1

Stony Brook Teach Hosps-NY (Continued)

Neurology	2919180C0	5	5
Neurology/3-yr MD Path	2919180C1	1	1
Child Neurology	2919185C0	1	0
Obstetrics-Gynecology	2919220C0	5	5
Orthopaedic Surgery	2919260C0	5	5
Otolaryngology	2919280C1	1	1
Pathology	2919300C0	4	4
Pediatrics	2919320C0	12	12
Phys Medicine & Rehab	2919340A0	3	3
Psychiatry	2919400C0	6	6
Psychiatry/Comb Adult/Child	2919400C2	2	2
Psychiatry/ELIH	2919400C3	5	5
Radiology-Diagnostic	2919420A0	7	7
Radiation Oncology	2919430A0	1	0
General Surgery/Combined	2919440C2	7	7
Surg-Prelim/Combined	2919440P3	9	9
Vascular Surgery	2919451C0	1	1
Medicine-Pediatrics	2919700C0	2	2
Medicine-Pediatrics/3-yr MD Path	2919700C1	1	1
Transitional/Southhampton	2919999P1	12	12
Transitional/Ophthalmology	2919999P2	3	3

U Rochester/Strong Memorial-NY

Rochester	Code	Quota	Matched
Anesthesiology	1511040C0	16	16
Dermatology	1511080A0	4	4
Dermatology	1511080R0	1	1
Emergency Medicine	1511110C0	14	14
Family Medicine/Urban	1511120C0	10	10
Family Med/Inner City	1511120C1	2	2
Internal Medicine	1511140C0	21	21
Int Med/Research Pathway	1511140C1	3	3
Medicine-Primary	1511140M0	3	3
Medicine-Primary/Rural	1511140M1	0	0
Medicine-Preliminary	1511140P0	3	3
Neurological Surgery	1511160C0	2	2
Neurology	1511180C0	8	8
Child Neurology	1511185C0	2	2
Obstetrics-Gynecology	1511220C0	8	8
Orthopaedic Surgery	1511260C0	7	7
Ortho Surgery/Research	1511260C1	1	1
Otolaryngology	1511280C0	3	3
Pathology	1511300C0	6	6
Pediatrics	1511320C0	14	14
Phys Medicine & Rehab	1511340C0	4	4
Plastic Surgery (Integrated)	1511362C0	2	2
Psychiatry	1511400C0	7	7
Psychiatry/Child Psych	1511400C1	1	1
Interventional Radiology (Integ)	1511416A0	2	2
Radiology-Diagnostic	1511420A0	9	9
Radiology-Diagnostic	1511420R0	1	1
Radiation Oncology	1511430A0	2	0
General Surgery	1511440C0	7	7
Surg-Prelim/Non-Designated	1511440P2	2	2
Vascular Surgery	1511451C0	1	1
Thoracic Surgery	1511461C0	1	1
Medicine-Pediatrics	1511700C0	8	8

UHS-Wilson Med Ctr-NY

Johnson City	Code	Quota	Matched
Family Medicine	1452120C0	9	5
Internal Medicine	1452140C0	12	12
Medicine-Preliminary	1452140P0	4	4

UVM Health Network CVPH-NY

Plattsburgh	Code	Quota	Matched
Family Medicine	1813120C0	6	6

University at Buffalo SOM-NY

Buffalo	Code	Quota	Matched
Anesthesiology	3099040C0	12	12
Emergency Medicine	3099110C0	16	13
Fam Med/Buffalo General	3099120C0	4	4
Fam Med/Erie County	3099120C1	5	5
Fam Med/Millard Fillmore	3099120C2	5	5
Family Med/Olean	3099120C4	2	2
Family Medicine/Sisters	3099120C5	5	4
Internal Medicine	3099140C0	33	33
Internal Med/Sisters	3099140C5	13	13
Medicine-Preliminary	3099140P1	1	1
Med-Prelim/Sisters	3099140P4	2	2
Med-Prelim/Ophthalmology	3099140P6	3	3
Neurological Surgery	3099160C0	3	3
Neurology	3099180C0	5	5
Child Neurology	3099185C0	1	1
Obstetrics-Gynecology	3099220C0	9	9
Obstetrics-Gynecology/Sisters	3099220C1	4	4
Orthopaedic Surgery	3099260C0	5	5
Otolaryngology	3099280C0	2	2
Pathology	3099300C0	3	3
Pediatrics	3099320C0	15	15
Psychiatry	3099400C0	5	5
Combined Adult/Child Psych	3099400C1	2	2
Radiology-Diagnostic	3099420A0	4	4
Radiation Oncology	3099430A0	1	0
General Surgery	3099440C0	9	9
Surgery-Preliminary	3099440P0	5	2
Vascular Surgery	3099451C0	1	1
Medicine-Pediatrics	3099700C0	4	4
Medicine-Preventive Med	3099751C0	1	1

Westchester Medical Ctr-NY

Valhalla	Code	Quota	Matched
Anesthesiology	2157040C0	10	10
Internal Medicine	2157140C0	18	18
Internal Medicine/Shabbos	2157140C1	2	2
Neurological Surgery	2157160C0	2	2
Neurology	2157180C0	4	4
Obstetrics-Gynecology	2157220C0	4	4
Ob-Gyn/Preliminary	2157220P0	1	1
Orthopaedic Surgery	2157260C0	3	3
Pathology	2157300C0	2	2
Pathology/Shabbos	2157300C1	1	1
Pediatrics	2157320C0	19	19
Pediatrics-Preliminary/2 yr	2157320P0	1	1
Pediatrics-Preliminary/1 yr	2157320P1	2	1
Psychiatry	2157400C0	11	11

Westchester Medical Ctr-NY (Continued)

Psychiatry/Shabbos	2157400C1	0	0
Radiology-Diagnostic	2157420A0	5	5
General Surgery	2157440C0	2	2
General Surgery/Research	2157440C1	2	2
Surgery-Preliminary	2157440P0	5	4

Woodhull Med Ctr-NY

Brooklyn	Code	Quota	Matched
Medicine-Primary	3116140M0	21	21
Medicine-Preliminary	3116140P0	3	0

Wyckoff Heights Med Ctr-NY

Brooklyn	Code	Quota	Matched
Emergency Medicine	1435110C0	6	6
Internal Medicine	1435140C0	20	20
Obstetrics-Gynecology	1435220C0	3	3
Pediatrics	1435320C0	3	3
General Surgery	1435440C0	3	3

Zucker SOM-Northwell Cohen Childrens-NY

New Hyde Park	Code	Quota	Matched
Child Neurology	1861185A1	2	2
Pediatrics	1861320C0	33	33
Pediatrics-Preliminary	1861320P0	2	2

Zucker SOM-Northwell Forest Hills Hosp-NY

Forest Hills	Code	Quota	Matched
Internal Medicine	2062140C0	12	11
Medicine-Preliminary	2062140P0	2	1

Zucker SOM-Northwell Glen Cove Hosp-NY

Glen Cove	Code	Quota	Matched
Family Medicine	1446120C0	7	7

Zucker SOM-Northwell Huntington Hosp-NY

Huntington	Code	Quota	Matched
Orthopaedic Surgery	2319260C0	6	6

Zucker SOM-Northwell Lenox Hill Hosp-NY

New York	Code	Quota	Matched
Internal Medicine	1483140C0	23	23
Medicine-Primary	1483140M0	3	3
Medicine-Preliminary	1483140P0	14	14
Med-Prelim/Neurology	1483140P1	2	2
Obstetrics-Gynecology	1483220C0	4	4
Orthopaedic Surgery	1483260C0	2	2
Pathology	1483300C0	3	3
Radiology-Diagnostic	1483420A0	4	4
General Surgery	1483440C0	4	4
Surgery-Preliminary	1483440P0	3	3
Vascular Surgery	1483451C0	1	1

Zucker SOM-Northwell Mather Hosp-NY

Port Jefferson	Code	Quota	Matched
Internal Medicine	2187140C0	18	18
Psychiatry	2187400C0	6	6
Interventional Radiology (Integ)	2187416A0	1	1
Radiology-Diagnostic	2187420A0	3	3
Transitional	2187999P0	9	9
Trans/Radiology Mather	2187999P1	3	3
Trans/Int Radiology Mather	2187999P2	1	1

Zucker SOM-Northwell NS/LIJ-NY

New Hyde Park	Code	Quota	Matched
Anesthesiology	1700040C0	6	6
Dermatology	1700080A0	5	5
Dermatology	1700080R0	1	1
Emergency Medicine	1700110C2	23	23
Internal Medicine	1700140C0	36	36
Medicine-Preliminary	1700140P0	19	19
Neurological Surgery	1700160C0	2	2
Neurology	1700180A0	7	7
Obstetrics-Gynecology	1700220C0	10	10
Ob-Gyn/Preliminary	1700220P0	2	0
Orthopaedic Surgery	1700260C0	4	4
Otolaryngology	1700280C0	2	2
Pathology	1700300C0	4	4
Phys Medicine & Rehab	1700340A0	4	4
Plastic Surgery (Integrated)	1700362C0	3	3
Interventional Radiology (Integ)	1700416A0	2	2
Radiology-Diagnostic	1700420A0	10	10
Radiation Oncology	1700430A0	2	2
Radiation Oncology	1700430R0	1	0
General Surgery	1700440C0	8	8
Surgery-Preliminary	1700440P0	12	0
Vascular Surgery	1700451C1	1	1
Thoracic Surgery	1700461C0	1	1
Medicine-Emergency Med	1700705C0	2	2

Zucker SOM-Northwell Peconic Bay-NY

Riverhead	Code	Quota	Matched
Family Medicine	2200120C0	6	6
Transitional	2200999P0	12	12

Zucker SOM-Northwell Phelps Hosp-NY

Sleepy Holllow	Code	Quota	Matched
Family Medicine	1453120C0	8	8

Zucker SOM-Northwell Plainview Hosp-NY

Plainview	Code	Quota	Matched
Family Medicine	1938120C0	10	10
Transitional	1938999P0	10	10

Zucker SOM-Northwell South Shore-NY

Bay Shore	Code	Quota	Matched
Emergency Medicine	1417110C0	6	6
Obstetrics-Gynecology	1417220C0	4	4
Ob-Gyn/Preliminary	1417220P0	1	1
General Surgery	1417440C0	3	3
Surgery-Preliminary	1417440P0	5	1

Zucker SOM-Northwell Staten Island Univ-NY

Staten Island	Code	Quota	Matched
Emergency Medicine	1515110C0	10	10
Internal Medicine	1515140C0	33	33
Medicine-Preliminary	1515140P0	16	16
Med-Prelim/Neurology	1515140P1	3	3
Med-Prelim/Radiology	1515140P2	1	1
Neurology	1515180A0	6	6
Obstetrics-Gynecology	1515220C0	4	4
Pathology	1515300C0	2	2
Pediatrics	1515320C0	8	8

Zucker SOM-Northwell Staten Island Univ-NY (Continued)

Psychiatry	1515400C0	4	4
Radiology-Diagnostic	1515420A0	4	4
General Surgery	1515440C0	3	3
Surgery-Preliminary	1515440P0	6	6

Zucker SOM-Northwell Zucker Hillside-NY

Glen Oaks	Code	Quota	Matched
Psychiatry	1860400C0	11	11
Psychiatry/Research	1860400C1	2	2

NORTH CAROLINA

Atrium Health Cabarrus-NC

Concord	Code	Quota	Matched
Family Med/Cabarrus	1231120C0	8	8

Campbell University-NC

Lillington	Code	Quota	Matched
Dermatology/Sampson RMC	2128080A0	2	2
Emergency Medicine/Cape Fear	2128110C0	11	5
Emergency Med/Southeastern Hlth	2128110C1	6	3
Family Medicine/Harnett Health	2128120C0	4	4
Family Medicine/Sampson RMC	2128120C1	4	0
Family Medicine/Southeastern Hlth	2128120C2	8	2
Family Medicine/Conway MC	2128120C3	8	5
Internal Medicine/Cape Fear	2128140C0	20	16
Internal Medicine/Southeastern Hlth	2128140C1	13	5
Internal Medicine/Harnett Health	2128140C2	8	8
Obstetrics-Gynecology/Cape Fear	2128220C0	4	4
Psychiatry/Cape Fear	2128400C0	9	9
General Surgery/Cape Fear	2128440C0	4	4
Transitional/Cape Fear	2128999P0	20	4
Transitional/Harnett Health	2128999P1	13	0
Transitional/Sampson RMC	2128999P2	2	2
Trans/Sampson RMC Dermatology	2128999P3	2	2
Transitional/Conway MC	2128999P4	10	3

Carolinas Med Ctr-NC

Charlotte	Code	Quota	Matched
Emergency Medicine	1527110C0	14	14
Family Med/Elizabeth/Traditional	1527120C0	6	6
Family Med/Biddle Point/Urban	1527120C1	3	2
Family Med/Union/Apprenticeship	1527120C2	3	1
Internal Medicine	1527140C0	12	12
Medicine-Preliminary	1527140P0	6	6
Med-Prelim/PM&R	1527140P1	2	2
Neurological Surgery	1527160C0	1	1
Obstetrics-Gynecology	1527220C0	6	6
Orthopaedic Surgery	1527260C0	5	5
Pediatrics	1527320C0	12	12
Phys Medicine & Rehab	1527340A0	5	5
Psychiatry	1527400C0	4	4
General Surgery	1527440C0	6	6
Surgery-Preliminary	1527440P0	1	1

Cone Health-NC

Greensboro	Code	Quota	Matched
Family Medicine	1943120C0	8	7
Internal Medicine	1943140C0	6	6
Medicine-Preliminary	1943140P0	4	4
Psychiatry	1943400C0	4	4

Duke Univ Med Ctr-NC

Durham	Code	Quota	Matched
Anesthesiology	1529040C0	15	15
Anesthesiology/ACES 60 months	1529040C1	0	0
Anesthesiology	1529040R0	0	0
Dermatology	1529080A0	3	3
Dermatology/Diversity	1529080A2	1	1
Dermatology/Research	1529080A3	1	1
Emergency Medicine	1529110C0	12	12
Family Medicine	1529120C0	6	6
Family Medicine/Rural	1529120C1	2	2
Internal Medicine	1529140C0	46	46
Medicine-Preliminary	1529140P0	4	4
Med-Prelim/Neurology	1529140P1	7	7
Neurological Surgery	1529160C0	3	3
Neurology	1529180A0	7	7
Child Neurology	1529185C0	2	2
Child Neurology	1529185R0	1	1
Obstetrics-Gynecology	1529220C0	9	9
Orthopaedic Surgery	1529260C0	8	8
Otolaryngology	1529280C0	3	3
Otolaryngology/Research	1529280C1	1	1
Pathology	1529300C0	6	6
Pediatrics	1529320C0	15	15
Pediatrics/Research Scholars	1529320C1	1	1
Plastic Surgery (Integrated)	1529362C0	3	3
Psychiatry	1529400C0	10	10
Psychiatry/Research	1529400C3	2	2
Interventional Radiology (Integ)	1529416A0	3	3
Radiology-Diagnostic	1529420A0	10	10
Radiation Oncology	1529430A0	1	1
Rad Onc/Research Scholar	1529430A1	1	1
General Surgery	1529440C0	7	7
Surgery-Preliminary	1529440P0	3	3
Surg-Prelim/Int Radiology	1529440P4	3	0
Vascular Surgery	1529451C0	1	1
Thoracic Surgery	1529461C0	1	1
Medicine-Pediatrics	1529700C0	6	6
Medicine-Psychiatry	1529715C0	2	2

Mountain AHEC-NC

Asheville	Code	Quota	Matched
Family Medicine/Asheville	3023120C0	12	5
Family Med/Hendersonville	3023120C1	6	6
Family Medicine/Boone	3023120C2	6	2
Internal Medicine	3023140C0	15	15
Obstetrics-Gynecology	3023220C0	5	5
Psychiatry	3023400C0	6	6
General Surgery	3023440C0	5	5
Transitional	3023999P0	12	10

New Hanover Reg Med Ctr-NC

Wilmington	Code	Quota	Matched
Family Medicine	1534120C0	6	6
Internal Medicine	1534140C0	7	7
Medicine-Preliminary	1534140P0	2	2

New Hanover Reg Med Ctr-NC (Continued)

Obstetrics-Gynecology	1534220C0	4	4
Ob-Gyn/Preliminary	1534220P1	1	1
General Surgery	1534440C0	4	4
Surgery-Preliminary	1534440P0	1	1

Novant Health-NC

Cornelius	Code	Quota	Matched
Family Medicine	1891120C0	6	6

Southern Regional AHEC-NC

Fayetteville	Code	Quota	Matched
Family Medicine	3046120C0	8	6

U North Carolina Hospitals

Chapel Hill	Code	Quota	Matched
Anesthesiology	1900040A0	2	2
Anesthesiology	1900040C0	12	12
Anesthesiology	1900040R0	4	4
Dermatology	1900080A0	6	6
Emergency Medicine	1900110C0	12	12
Family Medicine	1900120C0	10	10
Family Med/Rural Health	1900120C1	3	3
Family Medicine-FIRST	1900120C2	1	1
Internal Medicine	1900140C0	26	26
Internal Med/Research	1900140C1	3	3
Medicine-Preliminary	1900140P0	10	10
Neurological Surgery	1900160C0	2	2
Neurology	1900180C0	7	7
Child Neurology	1900185C0	2	1
Obstetrics-Gynecology	1900220C0	7	7
Orthopaedic Surgery	1900260C0	4	4
Ortho Surgery/Research 6 yr	1900260C1	1	1
Otolaryngology	1900280C0	3	3
Otolaryngology/Research	1900280C1	1	1
Pathology	1900300C0	5	5
Pediatrics	1900320C0	15	15
Pediatrics/Physician Scientist	1900320C2	2	2
Pediatrics-Primary	1900320M0	4	4
Pediatrics-Preliminary	1900320P0	1	1
Phys Medicine & Rehab	1900340C0	4	4
Plastic Surgery (Integrated)	1900362C0	2	2
Psychiatry	1900400C0	16	16
Psychiatry/FIRST	1900400C1	1	1
Psychiatry/PSTP	1900400C2	1	1
Interventional Radiology (Integ)	1900416A0	1	1
Radiology-Diagnostic	1900420A0	9	9
Radiation Oncology	1900430A0	2	2
Radiation Oncology	1900430R0	1	0
General Surgery	1900440C0	7	7
Surgery-Preliminary	1900440P0	7	2
Vascular Surgery	1900451C0	1	1
Thoracic Surgery	1900461C0	1	1
Medicine-Pediatrics	1900700C0	6	6

UNC Health Blue Ridge-NC

Morganton	Code	Quota	Matched
Internal Medicine	1914140C0	8	8

Vidant Med Ctr/East Carolina Univ-NC

Greenville	Code	Quota	Matched
Emergency Medicine	3057110C0	12	12
Family Medicine	3057120C0	12	12
Family Medicine/Rural-Ahoskie	3057120C1	2	2
Family Medicine/Rural-Duplin	3057120C2	2	2
Internal Medicine	3057140C0	18	18
Medicine-Preliminary	3057140P0	5	3
Obstetrics-Gynecology	3057220C0	5	5
Pathology	3057300C0	3	3
Pediatrics	3057320C0	10	10
Phys Medicine & Rehab	3057340C0	5	5
Psychiatry	3057400C0	9	9
General Surgery	3057440C0	5	5
Surgery-Preliminary	3057440P0	4	2
Medicine-Pediatrics	3057700C0	6	6
Medicine-Emergency Med	3057705C0	2	2
Medicine-Psychiatry	3057715C0	2	2

Wake Forest Baptist Med Ctr-NC

Winston Salem	Code	Quota	Matched
Anesthesiology	1537040C0	14	14
Dermatology	1537080A0	4	4
Emergency Medicine	1537110C0	15	15
Family Medicine	1537120C0	10	10
Internal Medicine	1537140C0	31	31
Medicine-Primary	1537140M0	3	3
Medicine-Preliminary	1537140P0	3	3
Neurological Surgery	1537160C0	2	2
Neurology	1537180C0	6	6
Child Neurology	1537185C0	2	2
Obstetrics-Gynecology	1537220C0	6	6
Orthopaedic Surgery	1537260C0	5	5
Otolaryngology	1537280C0	3	3
Pathology	1537300C0	5	5
Pediatrics	1537320C0	14	14
Plastic Surgery (Integrated)	1537362C0	3	3
Psychiatry	1537400C0	7	7
Interventional Radiology (Integ)	1537416C0	1	1
Radiology-Diagnostic	1537420A0	9	9
Radiation Oncology	1537430A0	1	1
General Surgery	1537440C0	7	7
Surgery-Preliminary	1537440P0	9	2

WakeMed Health and Hospitals-NC

Raleigh	Code	Quota	Matched
Internal Medicine	2275140C0	5	5

NORTH DAKOTA

Altru Health System-ND

Grand Forks	Code	Quota	Matched
Family Med/Grand Forks	1100120C0	8	8

U North Dakota SOM

Grand Forks	Code	Quota	Matched
Family Med/Bismarck	1539120C1	5	5
Family Medicine/Minot	1539120C2	6	6
Family Medicine/Hettinger	1539120C3	2	2

U North Dakota SOM (Continued)

Family Medicine/Rural Williston	1539120C4	2	2
Family Medicine/Fargo	1539120C5	6	6
Internal Medicine	1539140C0	8	8
Neurology	1539180C0	3	3
Orthopaedic Surgery	1539260C0	3	3
Psychiatry	1539400C0	6	6
General Surgery	1539440C0	3	3
General Surgery/Rural	1539440C1	2	2
Surgery-Preliminary	1539440P0	3	2
Transitional	1539999P0	5	5

OHIO

Adena Health System-OH

Chillicothe	Code	Quota	Matched
Family Medicine	2127120C0	5	4
Internal Medicine	2127140C0	7	7
Psychiatry	2127400C0	3	3

Akron Gen Med Ctr/NEOMED-OH

Akron	Code	Quota	Matched
Emergency Medicine	1542110C0	11	11
Family Medicine	1542120C0	4	4
Internal Medicine	1542140C0	12	12
Medicine-Preliminary	1542140P0	4	4
Obstetrics-Gynecology	1542220C0	5	5
Orthopaedic Surgery	1542260C0	3	3
Psychiatry	1542400C0	4	4
General Surgery	1542440C0	4	4

Aultman Hospital/NEOMED-OH

Canton	Code	Quota	Matched
Emergency Medicine	1544110C0	6	6
Family Medicine	1544120C0	7	7
Obstetrics-Gynecology	1544220C0	5	5
Radiology-Diagnostic	1544420A0	4	4

Bethesda Hospital-OH

Cincinnati	Code	Quota	Matched
Family Medicine	2689120C0	7	7

Canton Med Ed Fdn/NEOMED-OH

Canton	Code	Quota	Matched
Internal Medicine	2009140C0	13	13

Case Western/MetroHealth Med Ctr-OH

Cleveland	Code	Quota	Matched
Anesthesiology	1553040A0	4	4
Anesthesiology	1553040C0	3	3
Dermatology	1553080A0	3	3
Emergency Medicine	1553110C0	13	13
Family Medicine	1553120C0	6	6
Internal Medicine	1553140C0	22	22
Internal Med/Leadership in Med Ed	1553140C5	1	1
Med-Primary/Vulnerable Pop	1553140M1	2	2
Medicine-Preliminary	1553140P0	5	5
Med-Prelim/Anesthesiology	1553140P1	1	1
Obstetrics-Gynecology	1553220C0	5	5
Pathology	1553300C0	3	3
Pediatrics	1553320C0	8	8
Phys Medicine & Rehab	1553340C0	6	6
Psychiatry	1553400C0	8	8
Radiology-Diagnostic	1553420A0	4	4
General Surgery	1553440C0	3	3
Surgery-Preliminary	1553440P0	2	1
Medicine-Pediatrics	1553700C0	6	6

Case Western/Univ Hosps Cleveland Med Ctr-OH

Cleveland	Code	Quota	Matched
Anesthesiology	1552040C0	12	12
Anes/CCM-Periop Leadership	1552040C1	1	1
Anesthesiology/Funded	1552040C3	2	2
Dermatology	1552080A0	4	4
Dermatology/Osteopathic	1552080A1	2	2
Emergency Medicine	1552110C0	12	12
Family Medicine	1552120C0	6	6
Internal Medicine	1552140C0	23	23
Int Med/International Health	1552140C1	0	0
Int Med/Harrington Phys-Sci Path	1552140C2	2	2
Int Med/Ctr of Outpatient Ed	1552140C5	5	5
Int Med/International Scholar	1552140C6	2	2
Int Med/Leadership in Med Ed	1552140C8	2	2
Medicine-Preliminary	1552140P0	6	6
Med-Prelim/Ophthalmology	1552140P3	6	6
Neurological Surgery	1552160C0	1	1
Neurology	1552180C0	10	10
Neurology/Funded	1552180C1	2	2
Child Neurology	1552185C0	1	1
Obstetrics-Gynecology	1552220C0	6	6
Orthopaedic Surgery	1552260C0	5	5
Ortho Surgery/Research	1552260C2	1	1
Ortho Surgery/Regional	1552260C3	2	2
Otolaryngology	1552280C0	4	4
Pathology	1552300C0	7	7
Pathology/CP Research	1552300C3	0	0
Pediatrics	1552320C0	27	27
Psychiatry	1552400C0	9	9
Interventional Radiology (Integ)	1552416A0	1	1
Radiology-Diagnostic	1552420A0	9	9
Radiology-Diagnostic	1552420R0	1	1
Radiation Oncology	1552430A0	1	1
General Surgery	1552440C0	7	7
Surgery-Preliminary	1552440P0	10	7
Surg-Prelim/Int Radiology	1552440P4	0	0
Vascular Surgery	1552451C0	1	1
Medicine-Pediatrics	1552700C0	4	4
Family Med-Preventive Med	1552752C0	1	1
Pediatrics-Medical Genetics	1552765C0	1	1
Medicine-Medical Genetics	1552766C0	1	1

Childrens Hospital-NEOMED-OH

Akron	Code	Quota	Matched
Pediatrics	1895320C0	21	21

Christ Hospital-OH

Cincinnati	Code	Quota	Matched
Family Medicine	1547120C0	7	7
Internal Medicine	1547140C0	9	9
Medicine-Preliminary	1547140P0	10	10

Cincinnati Childrens Hosp Med Ctr-OH

Cincinnati	Code	Quota	Matched
Child Neurology	1808185C0	5	5
Pediatrics	1808320C0	41	41
Peds/Psych/Child Psych	1808730C0	3	3
Pediatrics-Medical Genetics	1808765C0	2	2

Cleveland Clinic Fdn-OH

Cleveland	Code	Quota	Matched
Anesthesiology	1968040C0	22	22
Anesthesiology/South Pointe	1968040C1	3	3
Dermatology	1968080C0	4	4
Family Medicine	1968120C0	4	4
Internal Medicine	1968140C0	42	42
Internal Med/Clin Ed	1968140C1	3	3
Internal Med/VA	1968140C2	6	6
Internal Med/South Pointe	1968140C3	4	4
Internal Med/Fairview	1968140C4	12	12
Medicine-Primary	1968140M0	4	4
Med-Prelim/Fairview	1968140P2	2	2
Neurological Surgery	1968160C0	3	3
Neurology	1968180C0	12	12
Child Neurology	1968185C0	2	2
Obstetrics-Gynecology	1968220C0	7	7
Orthopaedic Surgery	1968260C1	6	6
Ortho Surgery/South Pointe	1968260C2	3	3
Otolaryngology	1968280C0	4	4
Pathology	1968300C0	7	7
Pediatrics	1968320C0	13	13
Phys Medicine & Rehab	1968340A0	2	2
Plastic Surgery (Integrated)	1968362C0	3	3
Plastic Surg (Integ)/South Pointe	1968362C1	1	1
Psychiatry	1968400C0	8	8
Interventional Radiology (Integ)	1968416A0	2	2
Radiology-Diagnostic	1968420A0	8	8
Radiation Oncology	1968430A0	2	2
General Surgery	1968440C0	10	10
General Surgery/South Pointe	1968440C1	2	2
Surgery-Preliminary	1968440P0	9	9
Surg-Prelim/Int Radiology	1968440P3	0	0
Vascular Surgery	1968451C0	3	3
Thoracic Surgery	1968461C0	3	3

East Liverpool City Hosp-OH

East Liverpool	Code	Quota	Matched
Family Medicine	2199120C0	4	3
Internal Medicine	2199140C0	6	6

Fairfield Med Ctr-OH

Lancaster	Code	Quota	Matched
Family Medicine/Osteopathic	2208120C0	4	4
Internal Medicine	2208140C0	4	4

Firelands Regional Med Ctr-OH

Sandusky	Code	Quota	Matched
Family Medicine	1984120C0	4	4
Transitional	1984999P0	4	4

Good Samaritan Hosp-Cinn-OH

Cincinnati	Code	Quota	Matched
Internal Medicine	1550140C0	10	10
Ob-Gyn/GSH Bethesda	1550220C0	8	8
General Surgery	1550440C0	4	4
Surgery-Preliminary	1550440P0	1	1
Vascular Surgery	1550451C0	1	1

Jewish Hospital-OH

Cincinnati	Code	Quota	Matched
Internal Medicine	1551140C0	13	12
Medicine-Preliminary	1551140P0	11	8
General Surgery	1551440C0	2	2

Kettering Health Network-OH

Kettering	Code	Quota	Matched
Anesthesiology/Grandview	1576040C0	3	3
Emergency Med/Grandview	1576110C0	6	4
Family Medicine/Soin	1576120C0	8	8
Family Med/Grandview	1576120C1	5	3
Family Med/Soin Rural	1576120C2	2	1
Internal Medicine/Kettering	1576140C0	11	10
Internal Med/Grandview	1576140C1	6	5
Neurology/Grandview	1576180C0	3	3
Ob-Gyn/Grandview	1576220C0	3	3
Ortho Surgery/Grandview	1576260C0	3	3
Otolaryngology/Grandview	1576280C0	1	1
Radiology-Diag/Grandview	1576420A0	2	2
General Surgery/Grandview	1576440C0	2	2
Transitional/Kettering	1576999P0	10	10
Transitional/Soin	1576999P1	5	5
Trans/Soin/Ophthalmology	1576999P2	1	1
Trans/Kettering/Ophthalmology	1576999P3	1	1

Memorial Health System-OH

Marietta	Code	Quota	Matched
Emergency Medicine	1954110C0	6	4
Family Medicine	1954120C0	4	4

Mercy Health-Anderson Hosp-OH

Cincinnati	Code	Quota	Matched
Family Medicine	2302120C0	8	4

Mercy Health-St Ritas Med Ctr-OH

Lima	Code	Quota	Matched
Emergency Medicine	2203110C0	6	5
Family Medicine	2203120C0	6	3
Internal Medicine	2203140C0	12	7

Mercy St Vincent Med Ctr-OH

Toledo	Code	Quota	Matched
Emergency Medicine	1580110C0	11	11
Family Medicine	1580120C0	6	6
Internal Medicine	1580140C0	12	12
Neurology	1580180A0	4	4
Obstetrics-Gynecology	1580220C0	4	4
Orthopaedic Surgery	1580260C0	3	3
Pediatrics	1580320C0	4	2
General Surgery	1580440C0	3	3
Transitional	1580999P0	4	4
Transitional/Neurology	1580999P1	4	4

Mount Carmel Health System-OH

Grove City	Code	Quota	Matched
Family Medicine	1565120C0	7	7
Internal Medicine	1565140C0	9	5
Orthopaedic Surgery	1565260C0	2	2
General Surgery	1565440C0	3	3
Surgery-Preliminary	1565440P0	2	1
Transitional	1565999P0	4	4

Nationwide Childrens Hosp-OH

Columbus	Code	Quota	Matched
Child Neurology	1351185C0	5	5
Child Neurology/Research	1351185C1	0	0
Pediatrics	1351320C0	34	34
Pediatrics-Primary	1351320M0	4	4
Pediatrics-Medical Genetics	1351765C0	0	0

Ohio State University Med Ctr

Columbus	Code	Quota	Matched
Anest/Clinical Base Year	1566040C0	16	16
Anesthesiology	1566040R1	2	1
Dermatology	1566080A0	2	2
Dermatology	1566080C0	2	2
Emergency Medicine	1566110C0	16	16
Family Med/Rardin FPC	1566120C0	9	9
Internal Medicine	1566140C0	26	26
Internal Medicine/Research	1566140C1	3	3
Internal Medicine/Res Cardio	1566140C2	0	0
Internal Med/Intl Scholars	1566140C4	2	2
Medicine-Primary	1566140M0	4	4
Internal Medicine/Geriatrics	1566140M1	0	0
Medicine-Preliminary	1566140P0	6	6
Neurological Surgery	1566160C0	3	3
Neurology	1566180C0	8	8
Neurology	1566180R0	2	2
Obstetrics-Gynecology	1566220C0	11	11
Orthopaedic Surgery	1566260C0	6	6
Otolaryngology	1566280C0	5	5
Pathology	1566300C0	4	4
Phys Medicine & Rehab	1566340A0	4	4
Phys Medicine & Rehab	1566340C0	3	3
Plastic Surgery (Integrated)	1566362C0	4	4
Psychiatry	1566400C0	15	15
Psychiatry/Research	1566400C1	0	0
Interventional Radiology (Integ)	1566416A0	2	2
Radiology-Diagnostic	1566420A0	11	11
Radiation Oncology	1566430A0	2	2
General Surgery	1566440C0	7	7
Surgery-Preliminary	1566440P0	5	3
Vascular Surgery	1566451C0	1	1
Thoracic Surgery	1566461C0	1	1
Medicine-Pediatrics	1566700C0	10	10
Medicine-Emergency Med	1566705C0	2	2

OhioHealth-Doctors Hosp

Columbus	Code	Quota	Matched
Anesthesiology	2122040C0	2	2
Emergency Medicine	2122110C0	8	8
Family Medicine/Osteopathic	2122120C0	6	4
Internal Medicine	2122140C0	8	6
Obstetrics-Gynecology	2122220C0	6	6
Orthopaedic Surgery	2122260C0	5	5
Otolaryngology	2122280C0	1	1
General Surgery	2122440C0	4	4

OhioHealth-Dublin Methodist Hosp

Dublin	Code	Quota	Matched
Family Medicine	2100120C0	6	6

OhioHealth-Grant Med Ctr

Columbus	Code	Quota	Matched
Family Medicine	1564120C0	10	10

OhioHealth-OBleness Hosp

Athens	Code	Quota	Matched
Family Medicine	2221120C0	4	4

OhioHealth-Riverside Methodist

Columbus	Code	Quota	Matched
Dermatology	1567080C0	2	2
Family Medicine	1567120C0	6	6
Internal Medicine	1567140C0	18	18
Medicine-Preliminary	1567140P0	6	6
Obstetrics-Gynecology	1567220C0	6	6
Psychiatry	1567400C0	3	3
General Surgery	1567440C0	5	5
Surgery-Preliminary	1567440P0	4	1
Transitional	1567999P0	12	12

St Elizabeth Health Ctr-Boardman-OH

Boardman	Code	Quota	Matched
Emergency Medicine	1904110C0	9	9
Family Medicine	1904120C0	5	5
Otolaryngology	1904280C0	1	1

St Elizabeth Youngstown Hosp-OH

Youngstown	Code	Quota	Matched
Family Medicine	1584120C0	4	4
Internal Medicine	1584140C0	11	11
Orthopaedic Surgery	1584260C0	3	3
General Surgery	1584440C0	4	4
Transitional	1584999P0	4	4

St Vincent Charity Med Ctr-OH

Cleveland	Code	Quota	Matched
Internal Medicine	1560140C0	12	12

Summa Health/NEOMED-OH

Akron	Code	Quota	Matched
Emergency Medicine	1541110C0	8	8
Family Medicine	1541120C0	7	7
Family Med/Barberton Campus	1541120C1	6	6
Internal Medicine	1541140C0	20	20
Medicine-Preliminary	1541140P0	2	2
Obstetrics-Gynecology	1541220C0	6	6
Orthopaedic Surgery	1541260C0	4	4
Pathology	1541300C0	3	3
Psychiatry	1541400C0	5	5
General Surgery	1541440C0	4	4
Transitional	1541999P0	10	10

Trinity Health System-OH

Steubenville	Code	Quota	Matched
Emergency Medicine	2308110C0	7	1
Internal Medicine	2308140C0	10	8

U Cincinnati Med Ctr-OH

Cincinnati	Code	Quota	Matched
Anesthesiology	1548040C0	8	8
Dermatology	1548080A0	4	4
Emergency Medicine	1548110C0	14	14
Internal Medicine	1548140C0	31	31
Internal Med/Clinical Sci	1548140C1	1	1
Medicine-Preliminary	1548140P0	3	3
Med-Prelim/Ophthalmology	1548140P2	4	4
Neurological Surgery	1548160C0	2	2
Neurology	1548180C0	10	10
Obstetrics-Gynecology	1548220C0	7	7
Orthopaedic Surgery	1548260C0	5	5
Otolaryngology	1548280C0	4	4
Pathology	1548300C0	3	3
Phys Medicine & Rehab	1548340C0	3	3
Plastic Surgery (Integrated)	1548362C0	1	1
Psychiatry	1548400C0	6	6
Radiology-Diagnostic	1548420A0	8	8
Radiation Oncology	1548430A0	2	2
General Surgery	1548440C0	6	6
Surgery-Preliminary	1548440P1	1	0
Vascular Surgery	1548451C0	1	1
Thoracic Surgery	1548461C0	1	1
Medicine-Pediatrics	1548700C0	7	7
Psychiatry-Family Med	1548720C0	2	2
Pediatrics-PM&R	1548735C0	1	1

Univ Hosps Community Consortium-OH

Westlake	Code	Quota	Matched
Emergency Medicine/SJMC	2189110C0	6	2
Family Medicine/SJMC	2189120C0	4	4
Fam Med/Osteo/Regionals	2189120C1	4	4
Internal Medicine/Parma	2189140C0	8	2
Internal Medicine/Regionals	2189140C1	7	6
Internal Medicine/SJMC	2189140C2	6	6
PMR/Osteopathic/Regionals	2189340C0	3	3
Transitional	2189999P0	10	10

University of Toledo-OH

Toledo	Code	Quota	Matched
Anesthesiology	1579040C0	5	5
Emergency Medicine	1579110C0	8	7
Family Medicine	1579120C1	6	2
Internal Medicine	1579140C0	14	14
Medicine-Primary	1579140M0	4	4
Medicine-Preliminary	1579140P0	6	5
Neurology	1579180C0	5	5
Neurology/PG2	1579180R0	1	1
Obstetrics-Gynecology	1579220C0	5	5
Orthopaedic Surgery	1579260C0	4	4
Pathology	1579300C0	2	2
Pediatrics	1579320C0	10	5
Phys Medicine & Rehab	1579340A0	3	3
Psychiatry	1579400C0	4	4
Psychiatry/Child-Adolescent Trk	1579400C1	1	1
Radiology-Diagnostic	1579420A0	4	4
General Surgery	1579440C0	5	5
Surgery-Preliminary	1579440P0	5	3

Western Reserve Health Ed/NEOMED-OH

Warren	Code	Quota	Matched
Family Medicine	1585120C0	6	1
Internal Medicine	1585140C0	12	12
Medicine-Preliminary	1585140P0	1	1
General Surgery	1585440C0	2	2
Surgery-Preliminary	1585440P0	2	2

Western Reserve Hosp-OH

Cuyahoga Falls	Code	Quota	Matched
Family Medicine	2179120C0	2	1
Internal Medicine	2179140C0	6	6
Orthopaedic Surgery	2179260C0	2	2
Otolaryngology	2179280C0	1	1
General Surgery	2179440C0	2	2

Wright State Univ Boonshoft SOM-OH

Dayton	Code	Quota	Matched
Dermatology	2011080A0	2	2
Emergency Medicine	2011110C0	8	5
Family Medicine	2011120C0	10	10
Internal Medicine	2011140C0	11	9
Neurology	2011180C0	4	4
Obstetrics-Gynecology	2011220C0	3	3
Orthopedic Surgery	2011260C0	2	2
Ortho Surgery/Research	2011260C1	2	2
Pediatrics	2011320C0	9	9
Plastic Surgery (Integrated)	2011362C0	2	2
Psychiatry	2011400C0	5	5
General Surgery	2011440C0	3	3
Surgery-Preliminary	2011440P0	1	1

OKLAHOMA

Griffin Memorial Hospital-OK

Norman	Code	Quota	Matched
Psychiatry	1184400C0	6	6

In His Image Family Med-OK

Tulsa	Code	Quota	Matched
Family Medicine	3192120C0	10	10

Integris Health-OK

Oklahoma City	Code	Quota	Matched
Emergency Medicine	1830110C0	8	8
Family Medicine	1830120C0	5	5
Radiology-Diagnostic	1830420A0	4	4
Radiology-Diagnostic	1830420R1	1	1

OMECO-OK

Tulsa	Code	Quota	Matched
Family Medicine/Tulsa	2171120C0	5	2
Family Medicine/Talihina	2171120C1	3	3
Family Medicine/Ada	2171120C2	4	4
Internal Medicine	2171140C1	5	1
Obstetrics-Gynecology/Osteopathic	2171220C0	6	6

OMECO-OK (Continued)

Pediatrics/Osteopathic	2171320C0	6	2
Pediatrics/Osteo-Tribal	2171320C1	3	1

Oklahoma State U Ctr for Health Sci

Tulsa	Code	Quota	Matched
Anesthesiology	2162040C0	3	3
Emergency Med/Osteopathic	2162110C0	7	6
Emergency Med/Lawton	2162110C1	6	5
Emergency Med/Norman	2162110C2	6	6
Family Medicine/Tulsa	2162120C0	9	4
Family Medicine/Lawton	2162120C2	4	3
Family Medicine/Durant	2162120C4	5	1
Family Medicine/McAlester	2162120C5	4	3
Family Med/Cherokee Nation	2162120C6	6	6
Internal Medicine/Tulsa	2162140C0	13	13
Internal Medicine/Stillwater	2162140C1	5	5
Med-Prelim/Radiology	2162140P0	3	2
Orthopaedic Surgery	2162260C0	2	2
Otolaryngology	2162280C0	1	1
Pediatrics/Osteopathic	2162320C0	4	3
Psychiatry	2162400C0	6	6
Radiology-Diagnostic	2162420A0	3	3
General Surgery	2162440C0	3	3

St Anthony Hospital-OK

Oklahoma City	Code	Quota	Matched
Family Medicine	2087120C0	9	9
Obstetrics-Gynecology	2087220C0	3	3
Transitional	2087999P0	6	6

U Oklahoma COM-OK City

Oklahoma City	Code	Quota	Matched
Anesthesiology	1588040C0	12	12
Dermatology	1588080A0	3	3
Family Medicine	1588120C0	12	12
Internal Medicine	1588140C0	20	20
Medicine-Preliminary	1588140P0	6	4
Neurological Surgery	1588160C0	2	2
Neurology	1588180C0	6	6
Nuclear Medicine	1588200A0	1	0
Obstetrics-Gynecology	1588220C0	6	6
Orthopaedic Surgery	1588260C0	6	6
Otolaryngology	1588280C0	2	2
Pathology	1588300C0	4	4
Pediatrics	1588320C0	22	22
Psychiatry	1588400C0	6	6
Radiology-Diagnostic	1588420A0	6	6
Radiation Oncology	1588430A0	2	1
General Surgery	1588440C0	6	6
Surgery-Preliminary	1588440P0	6	3
Medicine-Pediatrics	1588700C0	3	3
Pediatrics-Medical Genetics	1588765C0	1	1

U Oklahoma COM-Tulsa

Tulsa	Code	Quota	Matched
Emergency Medicine	2727110C0	9	9
Family Medicine	2727120C0	8	8
Internal Medicine	2727140C0	11	11
Medicine-Preliminary	2727140P0	3	3
Obstetrics-Gynecology	2727220C0	4	4
Pediatrics	2727320C0	8	8
Psychiatry	2727400C0	5	5
General Surgery	2727440C0	4	4
Surgery-Preliminary	2727440P0	2	2

OREGON

Legacy Emanuel/Good Samaritan-OR

Portland	Code	Quota	Matched
Internal Medicine	1594140C0	18	18

Oregon Health & Science Univ

Portland	Code	Quota	Matched
Anesthesiology	1599040C0	12	12
Anesthesiology/Clin Scientist	1599040C2	0	0
Anesthesiology/CCM	1599040C3	1	1
Dermatology	1599080A0	4	4
Derm/Basic Science Research	1599080A1	1	1
Derm/Clinical Trials Research	1599080A2	0	0
Emergency Medicine	1599110C0	11	11
Family Medicine	1599120C0	12	12
Fam Med/Cascades East	1599120C2	8	8
Family Medicine/Hillsboro	1599120C3	8	8
Internal Medicine	1599140C0	35	35
Internal Medicine/Hillsboro	1599140C1	8	8
Neurological Surgery	1599160C0	3	3
Neurology	1599180C0	5	5
Child Neurology	1599185C0	1	1
Obstetrics-Gynecology	1599220C0	7	7
Orthopaedic Surgery	1599260C0	5	5
Otolaryngology	1599280C0	3	3
Pathology	1599300C0	3	3
Pediatrics	1599320C0	18	18
Plastic Surgery (Integrated)	1599362C0	3	3
Psychiatry	1599400C0	8	8
Interventional Radiology (Integ)	1599416A0	2	2
Radiology-Diagnostic	1599420A0	5	5
Radiation Oncology	1599430A0	2	2
General Surgery	1599440C0	12	12
Surgery-Preliminary	1599440P0	10	5
Surg-Prelim/Int Radiology	1599440P4	0	0
Transitional/Radiology	1599999P0	3	3
Transitional	1599999P1	1	1

Providence Health-OR

Portland	Code	Quota	Matched
Family Medicine/Milwaukie	1827120C0	7	7
Family Medicine/Hood River	1827120C1	2	2
Internal Medicine/Portland	1827140C0	9	5
Internal Medicine/St Vincent	1827140C1	8	8
Med-Prelim/Portland	1827140P0	4	4
Med-Prelim/St Vincent	1827140P1	4	4

Roseburg Family Medicine-OR

Roseburg	Code	Quota	Matched
Family Medicine	2190120C0	8	8

Samaritan Health Services-Corvallis-OR

Corvallis	Code	Quota	Matched
Dermatology	1715080A0	2	2

Samaritan Health Services-Corvallis-OR (Continued)

Family Medicine	1715120C0	9	9
Family Medicine/RTT-Newport	1715120C1	3	3
Internal Medicine	1715140C0	9	9
Medicine-Preliminary	1715140P0	2	2
Orthopaedic Surgery	1715260C0	3	3
Psychiatry	1715400C0	2	2
Psychiatry/Child Psych	1715400C1	2	2
General Surgery	1715440C0	2	2

PENNSYLVANIA

Abington Mem Hosp-PA

Abington	Code	Quota	Matched
Family Medicine	1600120C0	8	8
Internal Medicine	1600140C0	20	20
Obstetrics-Gynecology	1600220C0	6	6
General Surgery	1600440C0	5	5
Surgery-Preliminary	1600440P0	4	4

Albert Einstein Healthcare Network-PA

Philadelphia	Code	Quota	Matched
Emergency Medicine	2206110C0	8	7
Family Medicine	2206120C0	6	6
Internal Med/Montgomery	2206140C0	15	15
Radiology-Diagnostic	2206420A0	3	3
Vascular Surgery	2206451C0	1	1

Albert Einstein Med Ctr-PA

Philadelphia	Code	Quota	Matched
Emergency Medicine	1631110C0	13	13
Family Medicine	1631120C0	6	6
Internal Medicine	1631140C0	30	30
Medicine-Preliminary	1631140P0	11	11
Med-Prelim/Neurology	1631140P1	4	4
Med-Prelim/Rad-Philadelphia	1631140P2	1	1
Med-Prelim/Rad-Montgomery	1631140P3	1	1
Med-Prelim/PM&R	1631140P4	2	2
Neurology	1631180A0	4	4
Neurology	1631180R0	1	1
Obstetrics-Gynecology	1631220C0	5	5
Orthopaedic Surgery	1631260C0	3	3
Pediatrics	1631320C0	10	10
Phys Medicine & Rehab	1631340A0	7	7
Phys Medicine & Rehab	1631340R0	1	1
Psychiatry	1631400C0	10	10
Interventional Radiology (Integ)	1631416A0	1	1
Radiology-Diagnostic	1631420A0	6	6
Radiology-Diagnostic	1631420R0	3	3
General Surgery	1631440C0	4	4
Surgery-Preliminary	1631440P0	4	0
Surg-Prelim/Int Radiology	1631440P1	1	1

Allegheny Gen Hosp-PA

Pittsburgh	Code	Quota	Matched
Anesthesiology	1648040A0	3	3
Anesthesiology	1648040C0	7	7
Emergency Medicine	1648110C0	12	12
Internal Medicine	1648140C0	31	31
Medicine-Preliminary	1648140P0	5	5
Med-Prelim/Neurology	1648140P1	5	5
Neurological Surgery	1648160C0	2	2
Neurology	1648180A0	5	5
Orthopaedic Surgery	1648260C0	5	5
Otolaryngology	1648280C0	1	1
Pathology	1648300C0	3	3
Psychiatry	1648400C0	5	5
Radiology-Diagnostic	1648420A0	7	7
Radiation Oncology	1648430A0	1	0
General Surgery	1648440C0	6	6
Surgery-Preliminary	1648440P0	6	0
Vascular Surgery	1648451C0	1	1

Bryn Mawr Hospital-PA

Bryn Mawr	Code	Quota	Matched
Family Medicine	1606120C0	6	3

Childrens Hosp-Philadelphia-PA

Philadelphia	Code	Quota	Matched
Child Neurology	1863185C0	7	7
Pediatrics	1863320C0	42	42
Pediatrics/Global Health	1863320C1	2	2
Pediatrics-Medical Genetics	1863765C0	2	2

Clarion Hospital-PA

Clarion	Code	Quota	Matched
Family Medicine	2164120C0	4	1
Transitional	2164999P0	4	2

Conemaugh Memorial Med Ctr-PA

Johnstown	Code	Quota	Matched
Emergency Medicine	1616110C0	8	8
Family Medicine	1616120C0	6	5
Internal Medicine	1616140C0	7	7
Medicine-Preliminary	1616140P0	4	4
General Surgery	1616440C0	3	3
Surgery-Preliminary	1616440P0	2	2

Cornerstone Care THC-PA

Mount Morris	Code	Quota	Matched
Family Medicine	2310120C0	4	3

Crozer-Chester Med Ctr-PA

Upland	Code	Quota	Matched
Emergency Medicine	3185110C0	8	8
Family Medicine	3185120C0	10	10
Internal Medicine	3185140C0	8	8
Obstetrics-Gynecology	3185220C0	3	3
General Surgery	3185440C0	3	3
Transitional	3185999P0	14	12

Excela Health Latrobe Hosp-PA

Latrobe	Code	Quota	Matched
Family Medicine	2965120C0	8	8

Forbes Family Medicine-PA

Monroeville	Code	Quota	Matched
Family Medicine	3087120C0	8	8

Geisinger Health System-PA

Danville	Code	Quota	Matched
Anesthesiology	1608040C0	6	6
Dermatology	1608080A0	4	4
Emergency Medicine	1608110C0	9	9
Family Medicine/Wilkes-Barre	1608120C1	6	3
Family Medicine/Lewistown	1608120C2	6	6
Internal Medicine/Danville	1608140C0	17	17
Internal Medicine/Wilkes-Barre	1608140C1	13	13
Neurological Surgery	1608160C0	1	1
Neurology	1608180C0	4	4
Obstetrics-Gynecology	1608220C0	4	4
Orthopaedic Surgery	1608260C0	4	4
Ortho Surgery/Wilkes-Barre	1608260C1	4	4
Otolaryngology	1608280C0	2	2
Pathology	1608300C0	2	2
Pediatrics	1608320C0	11	4
Pediatrics-Preliminary	1608320P0	2	1
Phys Medicine & Rehab	1608340C0	3	3
Plastic Surgery (Integrated)	1608362C0	1	1
Interventional Radiology (Integ)	1608416A0	2	2
Radiology-Diagnostic	1608420A0	5	5
General Surgery	1608440C0	5	5
General Surgery/Wilkes Barre	1608440C1	5	5
Surg-Prelim/Non-Designated	1608440P0	2	1
Medicine-Pediatrics	1608700C0	5	5
Transitional	1608999P0	8	8

Guthrie/Robert Packer Hosp-PA

Sayre	Code	Quota	Matched
Anesthesiology	1664040A0	3	3
Emergency Medicine	1664110C0	6	3
Family Medicine	1664120C0	6	6
Internal Medicine	1664140C0	12	12
Orthopaedic Surgery	1664260C0	3	3
General Surgery	1664440C0	4	4
Surgery-Preliminary	1664440P0	4	2
Surg-Prelim/Anesthesiology	1664440P1	0	0

Heritage Valley Beaver-PA

Beaver Falls	Code	Quota	Matched
Family Medicine	2044120C0	6	6

Hosp of the Univ of PA

Philadelphia	Code	Quota	Matched
Anesthesiology	1628040A0	4	4
Anesthesiology	1628040C0	20	20
Anesthesiology	1628040R0	4	4
Dermatology/3 yr	1628080A0	3	3
Derm Res & Cut Onc Fell/4 yr	1628080A1	1	1
Dermatology/Research	1628080A4	2	2
Dermatology/Diversity&Comm	1628080A5	1	1
Emergency Medicine	1628110C0	14	14
Family Medicine	1628120C0	12	12
Internal Medicine	1628140C0	44	44
Int Med/ABIM Research Pathway	1628140C1	6	6
Medicine-Primary	1628140M0	6	6
Neurological Surgery	1628160C0	3	3
Neurology	1628180A0	4	4
Neurology	1628180C0	10	10
Obstetrics-Gynecology	1628220C0	8	8
Ortho Surgery/Clinical-5 yr	1628260C0	6	6
Ortho Surgery/Research-6 yr	1628260C1	2	2
Otolaryngology	1628280C0	5	5
Pathology-AP/CP	1628300C0	9	9
Pathology-AP/NP	1628300C1	1	1
Pathology-AP Only	1628300C2	0	0
Pathology-CP Only	1628300C3	1	1
Phys Medicine & Rehab	1628340A0	2	2
Phys Medicine & Rehab	1628340C0	4	4
Plastic Surgery (Integrated)	1628362C0	3	3
Psychiatry	1628400C0	12	12
Interventional Radiology (Integ)	1628416A0	4	4
Radiology-Diag/Clin-4 yr	1628420A0	10	10
Radiology-Diag/Research-4 yr	1628420A1	3	3
Radiation Oncology	1628430C0	4	4
General Surgery	1628440C0	9	9
Surgery-Preliminary	1628440P0	10	10
Vascular Surgery	1628451C0	1	1
Thoracic Surgery	1628461C0	2	2
Medicine-Pediatrics	1628700C0	6	6
Medicine-Dermatology	1628785C0	2	2

Indiana Regional Med Ctr

Indiana	Code	Quota	Matched
Family Medicine	2322120C0	6	6

Jefferson Health-Northeast-PA

Philadelphia	Code	Quota	Matched
Emergency Medicine	2103110C0	8	8
Emergency Med/Military Track	2103110C1	1	1
Family Medicine	2103120C0	8	8
Internal Medicine	2103140C0	9	9
Medicine-Emergency Med	2103705C0	5	5
Emergency Med-Family Med	2103795C0	2	2

Jefferson Med Coll/duPont Childrens-PA

Philadelphia	Code	Quota	Matched
Child Neurology	1654185C0	2	1
Pediatrics	1654320C0	22	22
Pediatrics-PM&R	1654735C0	1	1

LECOM Health-PA

Erie	Code	Quota	Matched
Family Medicine	2031120C0	4	2
Internal Medicine	2031140C0	5	1
Orthopaedic Surgery	2031260C0	3	3
Psychiatry	2031400C0	5	4
Transitional	2031999P0	4	4

Lancaster Gen Hosp-PA

Lancaster	Code	Quota	Matched
Family Medicine	1618120C0	13	13

Lankenau Med Ctr-PA

Wynnewood	Code	Quota	Matched
Internal Medicine	1632140C0	16	16
Medicine-Preliminary	1632140P0	16	16
Obstetrics-Gynecology	1632220C0	4	4
General Surgery	1632440C0	4	4

Lankenau Med Ctr-PA (Continued)

Surgery-Preliminary	1632440P0	2	0

Lehigh Valley Hosp-PA

Allentown	Code	Quota	Matched
Dermatology	1601080A0	2	2
Emergency Medicine	1601110C0	16	15
Family Medicine/USF	1601120C0	6	6
Family Medicine/USF Osteopathic	1601120C1	2	2
Family Medicine/Pottsville	1601120C2	4	4
Internal Medicine	1601140C0	18	18
Neurology	1601180A0	5	5
Neurology	1601180R0	1	1
Obstetrics-Gynecology	1601220C0	6	6
Pediatrics	1601320C0	6	6
Plastic Surgery (Integrated)	1601362C0	1	1
Psychiatry	1601400C0	6	6
General Surgery	1601440C0	6	6
Surgery-Preliminary	1601440P1	2	1
Transitional	1601999P0	10	10
Transitional/Neurology	1601999P1	5	5
Transitional/Dermatology	1601999P2	1	1

Lower Bucks Hosp-PA

Bristol	Code	Quota	Matched
Family Medicine	2229120C0	5	5
Internal Medicine	2229140C0	6	6

Meadville Med Ctr-PA

Meadville	Code	Quota	Matched
Family Medicine	2446120C0	4	4

Mercy Catholic Med Ctr-PA

Darby	Code	Quota	Matched
Internal Medicine	1636140C0	21	21
Medicine-Preliminary	1636140P0	6	6
Radiology-Diagnostic	1636420C0	2	2
General Surgery	1636440C0	2	2
Surgery-Preliminary	1636440P0	2	1
Transitional	1636999P0	10	6

Nazareth Hospital-PA

Philadelphia	Code	Quota	Matched
Emergency Medicine	1932110C0	6	6
Internal Medicine	1932140C0	11	11
Transitional	1932999P0	6	6

Penn Highlands Healthcare-PA

Dubois	Code	Quota	Matched
Family Medicine	2226120C0	6	4
Psychiatry	2226400C0	4	4

Penn State Hershey Med Ctr-PA

Hershey	Code	Quota	Matched
Anesthesiology	1617040C0	19	19
Anesthesiology	1617040R0	1	1
Dermatology	1617080A0	4	4
Emergency Medicine	1617110C0	11	9
Family Medicine	1617120C0	9	9
Family Med/State College	1617120C1	6	6
Family Med/St Joseph	1617120C2	7	7
Internal Medicine	1617140C0	21	21
Internal Med/Research	1617140C1	2	2
Medicine-Preliminary	1617140P0	7	7
Neurological Surgery	1617160C0	3	3
Neurology	1617180C0	5	5
Obstetrics-Gynecology	1617220C0	5	5
Orthopaedic Surgery	1617260C0	5	5
Otolaryngology	1617280C0	2	2
Otolaryngology/Research	1617280C1	1	1
Pathology	1617300C0	3	3
Pediatrics	1617320C0	16	16
Phys Medicine & Rehab	1617340A0	4	4
Plastic Surgery (Integrated)	1617362C0	2	2
Psychiatry	1617400C0	6	6
Interventional Radiology (Integ)	1617416A0	1	1
Radiology-Diagnostic	1617420A0	6	6
General Surgery	1617440C0	4	4
Surgery-Preliminary	1617440P0	10	0
Surg-Prelim/Int Radiology	1617440P2	0	0
Vascular Surgery	1617451C0	1	1
Medicine-Pediatrics	1617700C0	4	4

Pennsylvania Hospital

Philadelphia	Code	Quota	Matched
Internal Medicine	1639140C0	14	14
Medicine-Preliminary	1639140P0	11	11
Med-Prelim/Neurology HUP	1639140P1	3	3
Obstetrics-Gynecology	1639220C0	6	6
Pathology	1639300C0	2	2

Philadelphia Coll of Osteo Med-PA

Philadelphia	Code	Quota	Matched
Dermatology	2158080A0	1	1
Dermatology	2158080R0	2	2
Internal Medicine	2158140C1	2	0
Internal Medicine/Osteopathic	2158140C2	8	1
Medicine-Preliminary	2158140P0	4	0
Neurological Surgery	2158160C0	1	1
Orthopaedic Surgery	2158260C0	4	4
Otolaryngology	2158280C0	3	3
General Surgery	2158440C0	6	6

St Lukes Hosp-Anderson-PA

Easton	Code	Quota	Matched
Dermatology	2176080A0	2	2
Emergency Medicine	2176110C0	10	10
Family Medicine	2176120C0	6	6
Internal Medicine	2176140C0	13	13
Neurology	2176180C0	4	4
Otolaryngology	2176280C0	2	2
Psychiatry	2176400C0	6	6
Transitional	2176999P0	6	6
Transitional/Dermatology	2176999P1	0	0

St Lukes Hosp-Bethlehem-PA

Bethlehem	Code	Quota	Matched
Emergency Medicine	1605110C0	12	11

St Lukes Hosp-Bethlehem-PA (Continued)

Family Medicine	1605120C0	6	6
Family Medicine/Rural	1605120C1	4	4
Internal Medicine	1605140C0	11	11
Internal Medicine/Cardiology	1605140C1	1	1
Obstetrics-Gynecology	1605220C0	6	6
Orthopaedic Surgery	1605260C0	3	3
Psychiatry/Rural Program	1605400C0	2	2
General Surgery	1605440C0	5	5
Transitional	1605999P0	6	6

St Mary Med Ctr-Langhorne-PA

Philadelphia	Code	Quota	Matched
Internal Medicine	2139140C0	11	11

St Vincent Hlth Ctr-PA

Erie	Code	Quota	Matched
Emergency Medicine	1612110C0	6	5
Family Medicine	1612120C0	6	6

Suburban Community Hosp-PA

East Norriton	Code	Quota	Matched
Family Medicine/Osteopathic	1970120C0	4	4
Internal Medicine	1970140C0	5	5
Transitional/Osteopathic	1970999P0	4	4

Temple Univ Hosp-PA

Philadelphia	Code	Quota	Matched
Anesthesiology	1646040A0	3	3
Anesthesiology	1646040C0	8	8
Dermatology	1646080A0	3	3
Emergency Medicine	1646110C0	14	14
Family Medicine	1646120C0	4	2
Internal Medicine	1646140C0	41	41
Int Med/Sabbath Observed	1646140C2	1	1
Medicine-Preliminary	1646140P0	5	5
Neurological Surgery	1646160C0	1	1
Neurology	1646180C0	6	6
Obstetrics-Gynecology	1646220C0	6	6
Ob-Gyn/Preliminary	1646220P0	1	1
Orthopaedic Surgery	1646260C0	4	4
Otolaryngology	1646280C0	2	2
Pathology	1646300C0	4	4
Phys Medicine & Rehab	1646340A0	9	7
Phys Medicine & Rehab	1646340R0	1	1
Psychiatry	1646400C0	12	12
Interventional Radiology (Integ)	1646416A0	2	2
Radiology-Diagnostic	1646420A0	5	5
Radiology-Diagnostic	1646420R0	1	1
General Surgery	1646440C0	6	6
Surgery-Preliminary	1646440P0	11	0

Temple Univ/Fox Chase Cancer Ctr-PA

Philadelphia	Code	Quota	Matched
Radiation Oncology	1638430A0	2	2

Thomas Jefferson Univ-PA

Philadelphia	Code	Quota	Matched
Anesthesiology	1630040A0	5	5
Anesthesiology	1630040C0	10	10
Dermatology	1630080A0	4	4
Emergency Medicine	1630110C0	17	17
Family Medicine	1630120C0	10	10
Internal Medicine	1630140C0	33	33
Medicine-Primary	1630140M0	4	4
Med-Prelim/Ophthalmology	1630140P2	8	8
Neurological Surgery	1630160C0	4	4
Neurology	1630180C0	10	10
Obstetrics-Gynecology	1630220C0	7	7
Orthopaedic Surgery	1630260C0	6	6
Otolaryngology	1630280C0	5	5
Pathology	1630300C0	4	4
Phys Medicine & Rehab	1630340A0	7	7
Psychiatry	1630400C0	10	10
Interventional Radiology (Integ)	1630416A0	2	2
Radiology-Diagnostic	1630420A0	7	7
Radiation Oncology	1630430A0	1	0
General Surgery	1630440C0	7	7
Surgery-Preliminary	1630440P0	3	3
Surg-Prelim/Int Radiology	1630440P1	2	1

Tower Health/Chestnut Hill Hosp-PA

Philadelphia	Code	Quota	Matched
Family Medicine	2966120C0	6	6

Tower Health/Drexel Univ COM-PA

Philadelphia	Code	Quota	Matched
Family Medicine	2225120C0	7	7

Tower Health/Phoenixville Hosp-PA

West Reading	Code	Quota	Matched
Psychiatry	2290400C0	8	8

Tower Health/Reading Hospital-PA

Reading	Code	Quota	Matched
Anesthesiology	1661040C0	6	6
Emergency Medicine	1661110C0	9	9
Family Medicine	1661120C0	8	8
Internal Medicine	1661140C0	10	10
Internal Medicine/Osteopathic	1661140C1	2	2
Medicine-Primary	1661140M0	3	3
Neurology	1661180C0	4	4
Obstetrics-Gynecology	1661220C0	5	5
Phys Medicine & Rehab	1661340C0	4	4
Psychiatry	1661400C0	4	4
General Surgery	1661440C0	4	4

Tower Health/St Christophers Hosp-PA

Philadelphia	Code	Quota	Matched
Child Neurology	1653185C0	2	2
Child Neurology	1653185R0	1	0
Pediatrics	1653320C0	24	14

UPMC Altoona Hospital-PA

Altoona	Code	Quota	Matched
Family Medicine	1603120C0	8	8
Transitional	1603999P0	4	4

UPMC Hamot Med Ctr-PA

Erie	Code	Quota	Matched
Emergency Medicine	1611110C0	6	5
Neurology	1611180C0	2	1
Orthopaedic Surgery	1611260C0	3	3
Otolaryngology	1611280C0	1	1

UPMC Harrisburg-PA

Harrisburg	Code	Quota	Matched
Emergency Medicine	1615110C0	6	2
Family Medicine/Osteopathic	1615120C0	4	3
Internal Medicine	1615140C0	16	16
Internal Medicine/Osteopathic	1615140C1	6	6
Obstetrics-Gynecology	1615220C0	4	4
Orthopaedic Surgery	1615260C0	5	5
General Surgery	1615440C0	4	4
General Surgery/Community	1615440C1	3	3
Surgery-Preliminary	1615440P0	2	0

UPMC Lititz-PA

Lititz	Code	Quota	Matched
Anesthesiology/Osteopathic	2173040C0	2	2
Family Medicine/Osteopathic	2173120C0	4	4
Internal Medicine/Osteopathic	2173140C0	3	3

UPMC McKeesport-PA

Mckeesport	Code	Quota	Matched
Family Medicine	1620120C0	7	7
Internal Medicine	1620140C0	12	12

UPMC Medical Education-PA

Pittsburgh	Code	Quota	Matched
Anesthesiology	1652040A0	2	2
Anesthesiology	1652040C0	16	16
Anesthesiology/Research	1652040C1	1	1
Dermatology	1652080A0	6	6
Dermatology	1652080R0	1	1
Emergency Medicine	1652110C0	16	16
Family Medicine/Horizon	1652120C0	4	4
Family Med/Susquehanna	1652120C1	7	7
Internal Medicine	1652140C0	33	33
Int Med/Womens Health	1652140C1	5	5
Int Med/Intl Scholars	1652140C2	7	7
Int Med/Global Health	1652140C3	4	4
Int Med/ABIM Research Path	1652140C4	4	4
Medicine-Preliminary	1652140P0	8	8
Neurological Surgery	1652160C0	4	4
Neurology	1652180C0	8	8
Child Neurology	1652185C0	3	3
Neurodevelopmental Disabilities	1652186C0	1	1
Obstetrics-Gynecology	1652220C0	9	9
Orthopaedic Surgery	1652260C0	4	4
Ortho Surgery/Research	1652260C1	4	4
Otolaryngology	1652280C0	5	5
Pathology	1652300C0	8	8
Pediatrics	1652320C0	24	24
Peds/Scientist Development	1652320C2	4	4
Pediatrics-Primary	1652320M0	2	2
Phys Medicine & Rehab	1652340A0	4	4
Phys Medicine & Rehab	1652340C0	5	5
Plastic Surgery (Integrated)	1652362C0	3	3
Psychiatry/General	1652400C0	9	9
Psychiatry/General/Child	1652400C1	4	4
Interventional Radiology (Integ)	1652416A0	2	2
Radiology-Diagnostic	1652420A0	10	10
Radiation Oncology	1652430A0	2	2
General Surgery	1652440C0	7	7
General Surgery/Horizon	1652440C1	2	2
Surgery-Preliminary	1652440P0	4	4
Surg-Prelim/Non-Designated	1652440P1	1	1
Vascular Surgery	1652451C0	2	2
Thoracic Surgery	1652461C0	1	1
Cardiothoracic Surgery	1652461C1	1	1
Medicine-Pediatrics	1652700C0	4	4
Psych-Fam Med/McKeesport	1652720C2	1	1
Psych-Fam Med/St Margaret	1652720C3	1	1
Pediatrics-Anesthesiology	1652726C0	1	1
Peds/Psych/Child Psych	1652730C0	2	2
Transitional	1652999P0	3	3
Transitional/Radiology	1652999P2	1	1
Transitional/PM&R	1652999P3	0	0
Transitional/Ophthalmology	1652999P4	6	6

UPMC Mercy Hospital-PA

Pittsburgh	Code	Quota	Matched
Internal Medicine	1649140C0	21	21
General Surgery	1649440C0	4	4
Surgery-Preliminary	1649440P0	5	3

UPMC Presbyterian Shadyside-PA

Pittsburgh	Code	Quota	Matched
Family Medicine	1657120C0	6	6
Family Medicine/Osteopathic	1657120C1	4	4

UPMC St Margaret-PA

Pittsburgh	Code	Quota	Matched
Family Medicine	1656120C0	13	13

Washington Hospital-PA

Washington	Code	Quota	Matched
Family Medicine	1669120C0	8	4

Wellspan Health Good Sam Hosp-PA

York	Code	Quota	Matched
Family Medicine	2181120C0	7	7

Wellspan Health York Hosp-PA

York	Code	Quota	Matched
Emergency Medicine	1674110C0	13	9
Family Medicine	1674120C0	8	8
Internal Medicine	1674140C0	12	12
Obstetrics-Gynecology	1674220C0	5	5
Ortho Surgery/Osteopathic	1674260C0	3	3
General Surgery	1674440C0	4	4
Surgery-Preliminary	1674440P0	2	1

Western Pennsylvania Hosp

Pittsburgh	Code	Quota	Matched
Obstetrics-Gynecology	1659220C0	5	5

Wright Center for GME-PA

Scranton	Code	Quota	Matched
Family Medicine	3056120C0	12	12
Family Medicine/Arizona	3056120C1	4	4
Family Medicine/DC	3056120C2	6	6
Family Medicine/Washington	3056120C3	4	2
Family Medicine/Ohio	3056120C4	3	2
Medicine-Primary	3056140M0	34	34
Phys Medicine & Rehab	3056340C0	5	5
Psychiatry	3056400C0	7	7

PUERTO RICO

Damas Hospital-PR

Ponce	Code	Quota	Matched
Internal Medicine	2039140C0	7	7
Transitional	2039999P0	12	12

Hosp Episcopal San Lucas-PR

Ponce	Code	Quota	Matched
Emergency Medicine	2101110C0	7	7
Internal Medicine	2101140C0	7	7
Obstetrics-Gynecology	2101220C0	4	4
Pediatrics	2101320C0	6	6
General Surgery	2101440C0	3	3
Surgery-Preliminary	2101440P0	2	1
Transitional	2101999P0	9	9

Hospital de la Concepcion-PR

San German	Code	Quota	Matched
Internal Medicine	1202140C0	7	7

Ponce Health Sciences Univ SOM-PR

Ponce	Code	Quota	Matched
Psychiatry	1433400C0	6	6

San Juan VA Med Ctr-PR

San Juan	Code	Quota	Matched
Internal Medicine	3012140C0	20	20
Medicine-Preliminary	3012140P0	5	5
Phys Medicine & Rehab	3012340C0	3	3

Univ Central del Caribe SOM-PR

Bayamon	Code	Quota	Matched
Internal Medicine	1775140C0	9	9
Medicine-Preliminary	1775140P0	8	8

Univ of Puerto Rico

San Juan	Code	Quota	Matched
Anesthesiology	1116040C0	3	3
Dermatology	1116080A0	3	3
Emergency Medicine	1116110C0	10	10
Family Medicine	1116120C0	8	8
Internal Medicine	1116140C0	14	14
Medicine-Preliminary	1116140P0	2	0
Neurology	1116180C0	3	3
Child Neurology	1116185C0	1	0
Obstetrics-Gynecology	1116220C0	5	5
Orthopaedic Surgery	1116260C0	4	4
Otolaryngology	1116280C0	2	2
Pathology	1116300C0	3	3
Pediatrics	1116320C0	13	13
Phys Medicine & Rehab	1116340C0	3	3
Psychiatry	1116400C0	6	6
Radiology-Diagnostic	1116420A0	4	4
General Surgery	1116440C0	5	5
Surgery-Preliminary	1116440P0	6	3
Medicine-Pediatrics	1116700C0	2	2
Transitional	1116999P0	4	4

RHODE ISLAND

Brown Univ/Butler Hospital-RI

Providence	Code	Quota	Matched
Psychiatry	3170400C0	10	10

Brown Univ/Kent Hospital

Warwick	Code	Quota	Matched
Family Medicine/Pawtucket	2270120C0	12	12
Family Medicine/Warwick	2270120C1	4	4
Internal Medicine	2270140C0	13	13

Brown Univ/Rhode Island Hosp

Providence	Code	Quota	Matched
Anesthesiology	1677040A0	16	16
Anesthesiology	1677040R0	4	4
Dermatology	1677080A0	4	4
Emergency Medicine	1677110C0	14	14
Internal Medicine	1677140C0	29	29
Medicine-Primary	1677140M0	10	10
Medicine-Preliminary	1677140P0	5	5
Med-Prelim/Neurology	1677140P1	6	6
Med-Prelim/Anesthesiology	1677140P2	2	2
Neurological Surgery	1677160C0	2	2
Neurology	1677180A0	6	6
Orthopaedic Surgery	1677260C0	6	6
Pathology	1677300C0	4	4
Pediatrics	1677320C0	16	16
Plastic Surgery (Integrated)	1677362C0	2	2
Interventional Radiology (Integ)	1677416A0	2	2
Radiology-Diagnostic	1677420A0	6	6
General Surgery	1677440C0	7	7
Surgery-Preliminary	1677440P0	6	1
Medicine-Pediatrics	1677700C0	4	4
Peds/Psych/Child Psych	1677730C0	3	3

Brown Univ/Women & Infants Hosp of RI

Providence	Code	Quota	Matched
Obstetrics-Gynecology	2793220C0	8	8

Kent Hospital-RI

Warwick	Code	Quota	Matched
Emergency Medicine	1936110C0	8	8

NYMC-Landmark Med Ctr-RI

Woonsocket	Code	Quota	Matched
Internal Medicine	2307140C0	7	7
Medicine-Preliminary	2307140P0	5	1

Roger Williams Med Ctr-RI

Providence	Code	Quota	Matched
Internal Medicine	1678140C0	12	12

Roger Williams Med Ctr-RI (Continued)

Med-Prelim/Brown Anesthesiology	1678140P0	4	2
Medicine-Preliminary	1678140P1	1	1

SOUTH CAROLINA

Aiken Regional Med Ctrs-SC

Aiken	Code	Quota	Matched
Family Medicine	2321120C0	6	6

AnMed Health-SC

Anderson	Code	Quota	Matched
Family Medicine	3017120C0	11	9

Grand Strand Reg Med Ctr-SC

Myrtle Beach	Code	Quota	Matched
Anesthesiology	1761040C0	6	6
Emergency Medicine	1761110C0	12	12
Family Medicine	1761120C0	6	3
Internal Medicine	1761140C0	13	13
General Surgery	1761440C0	3	3
Transitional	1761999P0	12	12

McLeod Reg Med Ctr-SC

Florence	Code	Quota	Matched
Family Med/Urban Florence	2032120C0	8	4
Family Med/Rural Cheraw	2032120C1	4	4
Family Med/Rural Clarendon	2032120C2	4	1

Medical University of SC

Charleston	Code	Quota	Matched
Anesthesiology	1680040C0	15	15
Dermatology	1680080A0	4	4
Dermatology/International	1680080C0	1	1
Emergency Medicine	1680110C0	10	10
Family Medicine	1680120C1	10	10
Internal Medicine	1680140C0	26	26
Internal Medicine/PSTP	1680140C1	0	0
Medicine-Preliminary	1680140P0	2	2
Med-Prelim/Ophthalmology	1680140P1	2	2
Neurological Surgery	1680160C0	2	2
Neurology	1680180C0	8	8
Child Neurology	1680185C0	1	0
Obstetrics-Gynecology	1680220C0	6	6
Orthopaedic Surgery	1680260C0	4	4
Otolaryngology	1680280C0	4	4
Pathology	1680300C0	5	5
Pediatrics	1680320C0	14	14
Pediatrics-Primary	1680320M0	3	3
Plastic Surgery (Integrated)	1680362C0	1	1
Psychiatry	1680400C0	14	14
Interventional Radiology (Integ)	1680416A0	2	2
Radiology-Diagnostic	1680420A0	11	11
Radiation Oncology	1680430A0	2	0
General Surgery	1680440C0	8	8
Surgery-Preliminary	1680440P0	12	12
Surg-Prelim/Int Radiology	1680440P1	2	2
Vascular Surgery	1680451C0	2	2
Thoracic Surgery	1680461C0	2	2
Medicine-Pediatrics	1680700C0	4	4
Medicine-Psychiatry	1680715C0	2	2
Psychiatry-Neurology	1680755C0	1	0
Transitional	1680999P0	4	4
Transitional/Ophthalmology	1680999P1	2	2

Prisma Health-U of SC SOM Columbia

Columbia	Code	Quota	Matched
Emergency Medicine	1681110C0	13	13
Family Medicine/Columbia	1681120C0	10	10
Family Medicine/Sumter	1681120C1	4	4
Family Med/Winnsboro Rural	1681120C2	1	0
Internal Medicine	1681140C0	11	11
Medicine-Primary	1681140M0	3	3
Medicine-Preliminary	1681140P0	3	3
Neurology	1681180C0	6	6
Obstetrics-Gynecology	1681220C0	4	4
Orthopaedic Surgery	1681260C0	4	4
Pediatrics	1681320C0	13	12
Plastic Surgery (Integrated)	1681362C0	1	1
Psychiatry	1681400C0	8	8
General Surgery	1681440C0	4	4
Surgery-Preliminary	1681440P0	2	1

Prisma Health-U of SC SOM Greenville

Greenville	Code	Quota	Matched
Emergency Medicine	1683110C0	10	10
Family Medicine/Greenville	1683120C0	6	6
Family Medicine/Seneca	1683120C2	6	6
Family Medicine/Greer	1683120C3	6	6
Internal Medicine	1683140C0	12	12
Neurology	1683180C0	6	6
Obstetrics-Gynecology	1683220C0	6	6
Orthopaedic Surgery	1683260C0	4	4
Pediatrics	1683320C0	11	11
Psychiatry	1683400C0	5	5
Psychiatry/Greer	1683400C1	8	8
General Surgery	1683440C0	6	6
Surgery-Preliminary	1683440P0	2	0
Medicine-Pediatrics	1683700C0	5	5

Self Regional Healthcare-SC

Greenwood	Code	Quota	Matched
Family Medicine	2033120C0	10	10

Spartanburg Reg Healthcare-SC

Spartanburg	Code	Quota	Matched
Family Medicine	1685120C0	12	11
General Surgery	1685440C0	3	3
Surgery-Preliminary	1685440P0	3	1
Transitional	1685999P0	6	6

Summerville Med Ctr-SC

Summerville	Code	Quota	Matched
Obstetrics-Gynecology	2329220C0	3	2

Tidelands Health-SC

Myrtle Beach	Code	Quota	Matched
Family Medicine	1979120C0	8	8

Trident Medical Center-SC

Charleston	Code	Quota	Matched
Emergency Medicine	2056110C0	10	10
Internal Medicine	2056140C0	10	1

Trident Medical Center-SC (Continued)

General Surgery	2056440C0	4	4
Surgery-Preliminary	2056440P0	4	4

SOUTH DAKOTA

Center for Family Medicine-SD

Sioux Falls	Code	Quota	Matched
Family Medicine	2979120C0	9	6
Family Medicine/Pierre	2979120C1	2	0

Rapid City Hospital-SD

Rapid City	Code	Quota	Matched
Family Medicine	1177120C0	6	6

Univ of South Dakota SSOM

Sioux Falls	Code	Quota	Matched
Internal Medicine	2805140C0	8	8
Medicine-Preliminary	2805140P0	2	2
Pathology	2805300C0	2	1
Pediatrics	2805320C0	6	3
Psychiatry	2805400C0	7	7
General Surgery	2805440C0	4	4
Transitional	2805999P0	6	6

TENNESSEE

Baptist Mem Med Education-TN

Memphis	Code	Quota	Matched
Family Medicine	1694120C0	6	3
Obstetrics-Gynecology	1694220C0	4	4
Radiology-Diagnostic	1694420A0	6	6
General Surgery	1694440C0	3	3

East Tennessee St Univ

Johnson City	Code	Quota	Matched
Family Med/Johnson City	2066120C1	6	6
Family Med/Bristol	2066120C2	8	8
Family Med/Kingsport	2066120C3	6	6
Internal Medicine	2066140C0	13	13
Medicine-Preliminary	2066140P0	1	1
Obstetrics-Gynecology	2066220C0	3	3
Orthopaedic Surgery	2066260C0	2	2
Pathology	2066300C0	2	2
Pediatrics	2066320C0	8	8
Psychiatry	2066400C0	7	7
General Surgery	2066440C0	6	6
Surgery-Preliminary	2066440P0	2	0

HCA Healthcare/TriStar Nashville-TN

Brentwood	Code	Quota	Matched
Internal Medicine	2252140C0	10	2
Psychiatry	2252400C0	8	8

HCA Healthcare/TriStar Southern Hills-TN

Nashville	Code	Quota	Matched
Family Medicine	2263120C0	9	3

Meharry/Metro General Hosp-TN

Nashville	Code	Quota	Matched
Family Medicine	1028120C0	6	6
Internal Medicine	1028140C0	14	14
Medicine-Preliminary	1028140P0	2	2
Obstetrics-Gynecology	1028220C0	3	3
Psychiatry	1028400C0	6	6

U Tennessee COM-Chattanooga

Chattanooga	Code	Quota	Matched
Emergency Medicine	1689110C0	7	7
Family Medicine	1689120C0	7	7
Internal Medicine	1689140C0	10	10
Obstetrics-Gynecology	1689220C0	4	4
Orthopaedic Surgery	1689260C0	3	3
Pediatrics	1689320C0	9	9
General Surgery	1689440C0	5	5

U Tennessee Grad SOM-Knoxville

Knoxville	Code	Quota	Matched
Anesthesiology	1839040C0	10	10
Anesthesiology	1839040R0	2	2
Family Medicine	1839120C0	9	9
Internal Medicine	1839140C0	12	12
Obstetrics-Gynecology	1839220C0	4	4
Pathology	1839300C0	3	1
Radiology-Diagnostic	1839420A0	6	6
General Surgery	1839440C0	6	6
Surgery-Preliminary	1839440P0	5	2
Transitional	1839999P0	2	2
Transitional/Radiology	1839999P2	4	4

U Tennessee Health Sci Ctr-Memphis

Memphis	Code	Quota	Matched
Anesthesiology	1844040C0	3	3
Dermatology	1844080A0	3	3
Emergency Medicine	1844110C0	8	8
Family Med/St Francis	1844120C0	5	4
Family Med/Jackson	1844120C1	12	12
Internal Medicine	1844140C0	20	20
Medicine-Preliminary	1844140P0	6	6
Med-Prelim/Neurology	1844140P1	3	3
Med-Prelim/Radiology	1844140P2	3	3
Med-Prelim/Radiation Onc	1844140P3	0	0
Med-Prelim/Dermatology	1844140P4	3	3
Neurological Surgery	1844160C0	3	3
Neurology	1844180A0	3	3
Child Neurology	1844185C0	2	1
Obstetrics-Gynecology	1844220C0	7	7
Orthopaedic Surgery	1844260C0	8	8
Otolaryngology	1844280C0	4	4
Pathology	1844300C0	2	2
Pediatrics	1844320C0	23	23
Psychiatry	1844400C0	8	8
Radiology-Diagostic	1844420A1	3	3
Radiation Oncology	1844430A0	1	0
General Surgery	1844440C0	8	8
Surgery-Preliminary	1844440P0	5	0
Medicine-Pediatrics	1844700C0	14	14

UT Ascension St Thomas-TN

Nashville	Code	Quota	Matched
Emergency Med/Murfreesboro	1699110C0	8	8
Family Med/Murfreesboro	1699120C0	8	8
Internal Med/Midtown	1699140C0	8	8

UT Ascension St Thomas-TN (Continued)

Med-Prelim/Midtown	1699140P0	2	2
Obstetrics-Gynecology/Midtown	1699220C0	3	3
General Surgery/West	1699440C0	3	3

Vanderbilt Univ Med Ctr-TN

Nashville	Code	Quota	Matched
Anesthesiology	1702040C0	18	18
Dermatology	1702080A0	5	5
Emergency Medicine	1702110C0	13	13
Internal Medicine	1702140C0	42	42
Int Med/ABIM Research Path	1702140C1	5	5
Medicine-Preliminary	1702140P0	5	5
Neurological Surgery	1702160C0	3	3
Neurology	1702180C0	7	7
Child Neurology	1702185C0	4	4
Child Neurology	1702185R0	1	1
Obstetrics-Gynecology	1702220C0	6	6
Orthopaedic Surgery	1702260C0	5	5
Otolaryngology	1702280C0	5	5
Pathology	1702300C0	6	6
PathologyPSTP	1702300C1	0	0
Pediatrics	1702320C0	24	24
Phys Medicine & Rehab	1702340C0	4	4
Plastic Surgery (Integrated)	1702362C0	1	1
Psychiatry	1702400C0	5	5
Psychiatry/Child Fast Track	1702400C1	3	3
Psychiatry/Research	1702400C2	1	1
Interventional Radiology (Integ)	1702416A0	3	3
Radiology-Diagnostic	1702420A0	6	6
Radiation Oncology	1702430A0	2	2
General Surgery	1702440C0	8	8
Surgery-Preliminary	1702440P0	13	1
Surg-Prelim/Int Radiology	1702440P1	3	3
Surg-Prelim/Ophthalmology	1702440P2	5	5
Medicine-Pediatrics	1702700C0	6	6
Pediatrics-Medical Genetics	1702765C0	1	1

TEXAS

Baptist Hosps of Southeast Texas

Beaumont	Code	Quota	Matched
Internal Medicine	2312140C0	13	13

Baylor Coll Med-Houston-TX

Houston	Code	Quota	Matched
Anesthesiology	1716040A0	3	3
Anesthesiology	1716040C0	14	14
Anesthesiology	1716040R0	5	5
Dermatology	1716080A0	3	3
Emergency Medicine	1716110C0	15	15
Emergency Medicine/SACM	1716110C1	1	1
Family Med/Comm Hlth Ctr	1716120C0	8	8
Family Med/St Lukes Lufkin	1716120C6	3	3
Internal Medicine	1716140C0	48	48
Internal Medicine/Research	1716140C1	2	2
Internal Medicine/MDACC	1716140C2	5	5
Medicine-Preliminary	1716140P0	4	4
Med-Prelim/Ophthalmology	1716140P1	6	6
Med-Prelim/PM&R	1716140P2	2	2
Med-Prelim/Dermatology	1716140P3	2	2
Neurological Surgery	1716160C0	4	4
Neurology	1716180C0	10	10
Child Neurology/Neuroscience	1716185C0	2	1
Child Neurology	1716185C1	3	3
Child Neurology	1716185R0	1	1
Neurodevelopmental Disabilities	1716186C0	2	2
Obstetrics-Gynecology	1716220C0	12	12
Orthopaedic Surgery	1716260C0	6	6
Otolaryngology	1716280C0	5	5
Pathology	1716300C0	8	8
Pediatrics	1716320C0	36	36
Pediatrics/Global Health	1716320C1	5	5
Pediatrics/San Antonio	1716320C2	13	13
Peds/Scientist Development Prog	1716320C3	1	1
Peds/PC Leadership Prog	1716320C4	4	4
Phys Medicine & Rehab	1716340A0	8	8
Plastic Surgery (Integrated)	1716362C0	3	3
Psychiatry	1716400C0	12	12
Psychiatry/Research	1716400C1	1	1
Radiology-Diagnostic	1716420A0	8	8
Radiology-Diagnostic/ESIR	1716420A1	4	4
Radiation Oncology	1716430A0	2	0
General Surgery	1716440C0	4	4
General Surgery/Academic	1716440C1	4	4
General Surgery/Global	1716440C2	1	1
Surgery-Preliminary	1716440P0	17	1
Vascular Surgery	1716451C0	1	1
Thoracic Surgery	1716461C0	1	1
Medicine-Pediatrics	1716700C0	9	9
Pediatrics-Medical Genetics	1716765C0	2	2
Medicine-Medical Genetics	1716766C0	1	1

Baylor S&W All Saints Med Ctr-TX

Fort Worth	Code	Quota	Matched
Emergency Medicine	2259110C0	6	6
Internal Medicine	2259140C0	15	15
Obstetrics-Gynecology	2259220C0	6	6
Transitional	2259999P0	13	13
Transitional/PM&R	2259999P1	2	2

Baylor S&W Med Ctr-Round Rock-TX

Round Rock	Code	Quota	Matched
Family Medicine	2318120C0	6	4
Internal Medicine	2318140C0	8	6

Baylor Scott & White Med Ctr-TX

Temple	Code	Quota	Matched
Anesthesiology	1725040C0	10	10
Dermatology	1725080A0	3	3
Emergency Medicine	1725110C0	14	13
Family Medicine	1725120C0	6	6
Internal Medicine	1725140C0	22	22
Medicine-Preliminary	1725140P0	8	8
Med-Prelim/Radiology	1725140P2	4	4
Med-Prelim/Dermatology	1725140P3	1	1
Neurological Surgery	1725160C0	1	1
Neurology	1725180C0	3	3
Obstetrics-Gynecology	1725220C0	4	4
Orthopaedic Surgery	1725260C0	4	4

Baylor Scott & White Med Ctr-TX (Continued)

Otolaryngology	1725280C0	1	1
Pathology	1725300C0	2	2
Pediatrics	1725320C0	7	6
Plastic Surgery (Integrated)	1725362C0	2	2
Psychiatry	1725400C0	5	5
Radiology-Diagnostic	1725420A0	7	7
General Surgery	1725440C0	6	6

Baylor Univ Med Ctr-Dallas-TX

Dallas	Code	Quota	Matched
Emergency Medicine	1706110C0	8	8
Family Medicine	1706120C0	4	4
Internal Medicine	1706140C0	13	13
Medicine-Preliminary	1706140P0	3	3
Obstetrics-Gynecology	1706220C0	5	5
Orthopaedic Surgery	1706260C0	3	3
Pathology	1706300C0	5	5
Phys Medicine & Rehab	1706340A0	3	3
Radiology-Diagnostic	1706420A0	2	2
Radiology-Diagnostic	1706420C0	5	5
General Surgery	1706440C0	9	9
Surgery-Preliminary	1706440P0	2	2

CHRISTUS Health-TX

Irving	Code	Quota	Matched
Emergency Medicine/Spohn	2116110C0	12	12
Family Medicine/Spohn	2116120C0	14	9
Family Med/Santa Rosa	2116120C1	10	10
Internal Medicine/GSMC	2116140C0	12	12

Conroe Reg Med Ctr-TX

Conroe	Code	Quota	Matched
Family Medicine	1502120C0	12	12

Corpus Christi Med Ctr-TX

Corpus Christi	Code	Quota	Matched
Dermatology	2110080R0	2	2
Internal Medicine	2110140C0	6	1

DeTar Healthcare System-TX

Victoria	Code	Quota	Matched
Family Medicine	1797120C0	8	8

Driscoll Childrens Hosp-TX

Corpus Christi	Code	Quota	Matched
Pediatrics	1703320C0	16	16

HCA Houston Healthcare/U Houston-TX

Houston	Code	Quota	Matched
Emergency Medicine	2211110C0	13	3
Family Medicine	2211120C0	10	1
Internal Medicine	2211140C0	25	23
Obstetrics-Gynecology	2211220C0	3	3
General Surgery	2211440C0	4	4
Transitional/West	2211999P0	13	10
Transitional/Kingwood	2211999P1	13	13

HCA Las Palmas del Sol Healthcare-TX

El Paso	Code	Quota	Matched
Internal Medicine	2188140C0	15	7
Obstetrics-Gynecology	2188220C0	6	6
Transitional	2188999P0	13	8

HCA Medical City Healthcare-TX

Dallas	Code	Quota	Matched
Dermatology/Fort Worth	2244080A0	1	1
Emergency Medicine	2244110C0	8	8
Family Medicine/Arlington	2244120C0	18	13
Family Medicine/Fort Worth	2244120C1	6	6
Internal Medicine/Arlington	2244140C0	30	10
Internal Medicine/Fort Worth	2244140C1	10	6
Internal Medicine/Weatherford	2244140C2	8	1
Med-Prelim/Weatherford	2244140P0	12	10
Ob-Gyn/Arlington	2244220C0	5	5
General Surgery/Arlington	2244440C0	7	7

John Peter Smith Hosp-TX

Fort Worth	Code	Quota	Matched
Emergency Medicine	1711110C0	15	15
Family Medicine	1711120C0	24	24
Obstetrics-Gynecology	1711220C0	4	4
Orthopaedic Surgery	1711260C0	4	4
Psychiatry	1711400C0	8	8
Transitional	1711999P1	12	12

Memorial Hermann Hosp-TX

Sugar Land	Code	Quota	Matched
Family Medicine	1785120C0	14	14

Methodist Health System Dallas-TX

Dallas	Code	Quota	Matched
Family Medicine	1707120C0	6	6
Internal Medicine	1707140C0	13	13
Obstetrics-Gynecology	1707220C0	3	3
General Surgery	1707440C0	3	3
Surgery-Preliminary	1707440P0	3	3

Methodist Hospital-Houston-TX

Houston	Code	Quota	Matched
Anesthesiology	1167040C0	6	6
Family Medicine	1167120C0	8	8
Internal Medicine	1167140C0	17	17
Neurological Surgery	1167160C0	2	2
Neurology	1167180C0	7	7
Obstetrics-Gynecology	1167220C0	5	5
Orthopaedic Surgery	1167260C0	3	3
Pathology	1167300C0	5	5
Pathology/Clinical	1167300C1	0	0
Radiology-Diagnostic	1167420A0	4	4
General Surgery	1167440C0	6	6
Surgery-Preliminary	1167440P0	1	1
Vascular Surgery	1167451C0	2	2

Presbyterian Hosp-Dallas-TX

Dallas	Code	Quota	Matched
Internal Medicine	1719140C0	6	6
Medicine-Preliminary	1719140P0	6	6

St Davids Healthcare GME-TX

Austin	Code	Quota	Matched
Obstetrics-Gynecology	2285220C0	5	5
General Surgery	2285440C0	5	5

TIGMER-TX

San Antonio	Code	Quota	Matched
Family Medicine/San Antonio	2169120C0	8	5
Family Medicine/Laredo	2169120C1	8	3
Internal Medicine/San Antonio	2169140C0	14	14
Medicine-Primary/Laredo	2169140M0	8	5
Psychiatry	2169400C0	12	12

Texas A&M-Bryan/College Station

Bryan	Code	Quota	Matched
Family Medicine	1713120C0	10	10
Psychiatry	1713400C0	4	4

Texas Health Resources

Fort Worth	Code	Quota	Matched
Internal Med/Harris Methodist	2279140C0	10	10
Internal Medicine/HEB Denton	2279140C1	20	20
General Surgery	2279440C0	3	3

Texas Tech U Affil-Amarillo

Amarillo	Code	Quota	Matched
Family Medicine	2993120C0	3	3
Internal Medicine	2993140C0	13	13
Obstetrics-Gynecology	2993220C0	3	3
Pediatrics	2993320C0	7	7

Texas Tech U Affil-El Paso

El Paso	Code	Quota	Matched
Emergency Medicine	1710110C0	12	8
Family Medicine	1710120C0	8	4
Family Medicine/Transmountain	1710120C1	6	6
Internal Medicine	1710140C0	15	15
Internal Med/Transmountain	1710140C2	10	10
Neurology	1710180A0	3	3
Obstetrics-Gynecology	1710220C0	5	5
Pediatrics	1710320C0	15	15
Psychiatry	1710400C0	8	8
Psychiatry/Transmountain	1710400C1	4	4
Radiology-Diagnostic	1710420A0	3	3
General Surgery	1710440C0	4	4
Surgery-Preliminary	1710440P0	2	2

Texas Tech U Affil-Lubbock

Lubbock	Code	Quota	Matched
Anesthesiology	2973040C0	4	4
Anesthesiology	2973040R0	1	1
Dermatology	2973080A0	3	3
Emergency Medicine	2973110C0	8	8
Family Medicine	2973120C0	6	4
Internal Medicine	2973140C0	14	14
Medicine-Preliminary	2973140P0	2	2
Neurology	2973180C0	4	4
Obstetrics-Gynecology	2973220C0	3	3
Orthopaedic Surgery	2973260C0	4	4
Otolaryngology	2973280C0	1	1
Pediatrics	2973320C0	8	8
Psychiatry	2973400C0	4	4
Psychiatry/CAP	2973400C1	2	2
General Surgery	2973440C0	5	5
Surgery-Preliminary	2973440P0	5	2

Texas Tech U Affil-Permian Basin

Odessa	Code	Quota	Matched
Family Medicine/Odessa	3124120C0	12	12
Family Med/Rural-Ft Stockton	3124120C2	1	0
Family Med/Rural-Sweetwater	3124120C3	1	1
Family Med/Rural-Alpine	3124120C4	1	1
Family Med/Rural-Pecos	3124120C5	1	1
Family Med/Rural-Carlsbad	3124120C6	1	1
Family Med/Rural-Hobbs	3124120C7	1	1
Family Medicine/Midland	3124120C8	1	1
Internal Medicine	3124140C0	13	13
Obstetrics-Gynecology	3124220C0	4	4
Psychiatry	3124400C0	2	1

Texoma Med Ctr-TX

Denison	Code	Quota	Matched
Family Medicine	2234120C0	8	7

U Texas HSC-San Antonio

San Antonio	Code	Quota	Matched
Anesthesiology	1722040C0	16	16
Anesthesiology	1722040R0	1	1
Dermatology	1722080A0	3	3
Emergency Medicine	1722110C0	10	9
Emergency Medicine/Military	1722110C1	1	0
Family Medicine	1722120C0	14	14
Internal Medicine	1722140C0	30	30
Internal Med/Adv IM Skill	1722140C4	4	4
Medicine-Preliminary	1722140P0	3	3
Med-Prelim/Ophthalmology	1722140P4	4	4
Neurological Surgery	1722160C0	1	1
Neurology	1722180C0	7	7
Obstetrics-Gynecology	1722220C0	7	7
Orthopaedic Surgery	1722260C0	7	7
Otolaryngology	1722280C0	2	2
Pathology	1722300C0	5	5
Pediatrics	1722320C0	15	15
Phys Medicine & Rehab	1722340C0	8	8
Psychiatry	1722400C0	11	11
Interventional Radiology (Integ)	1722416A0	2	2
Radiology-Diagnostic	1722420A0	11	11
Radiology-Diagnostic	1722420R0	2	2
Radiation Oncology	1722430A0	2	1
Radiation Oncology	1722430R0	1	0
General Surgery	1722440C0	7	7
Surgery-Preliminary	1722440P0	14	14
Thoracic Surgery	1722461C0	1	1

U Texas HSC-Tyler

Tyler	Code	Quota	Matched
Family Medicine	3626120C0	8	8
Family Medicine/Rural	3626120C1	2	2
Family Medicine/Athens	3626120C2	4	4
Internal Medicine/Tyler	3626140C1	20	11
Psychiatry	3626400C0	6	6
Psychiatry/Pittsburg	3626400C1	4	4
General Surgery	3626440C0	3	3

U Texas MD Anderson Cancer Ctr

Houston	Code	Quota	Matched
Radiation Oncology	1004430A0	6	6

U Texas Med Branch-Galveston

Galveston	Code	Quota	Matched
Anesthesiology	1714040C0	16	16
Anesthesiology	1714040R0	4	4
Dermatology	1714080A0	6	6
Dermatology	1714080R1	1	1
Family Medicine	1714120C0	12	10
Internal Medicine	1714140C0	27	27
Medicine-Preliminary	1714140P0	6	5
Med-Prelim/Ophthalmology	1714140P4	4	4
Neurological Surgery	1714160C0	2	2
Neurology	1714180C0	6	6
Obstetrics-Gynecology	1714220C0	8	8
Orthopaedic Surgery	1714260C0	5	5
Otolaryngology	1714280C0	3	3
Pathology	1714300C0	5	5
Pediatrics	1714320C0	14	14
Plastic Surgery (Integrated)	1714362C0	4	4
Psychiatry	1714400C0	7	7
Psychiatry/Child Psych	1714400C1	2	2
Interventional Radiology (Integ)	1714416A0	1	1
Radiology-Diagnostic	1714420A0	6	6
Radiation Oncology	1714430A0	1	0
Radiation Oncology	1714430R0	1	1
General Surgery	1714440C0	7	7
Surgery-Preliminary	1714440P2	3	2
Vascular Surgery	1714451C0	1	1
Medicine-Prev Med/Aerospace	1714751C0	2	2

U Texas Med Sch-Houston

Houston	Code	Quota	Matched
Anesthesiology	2923040C0	25	25
Anesthesiology/Research	2923040C1	1	1
Anesthesiology	2923040R0	1	1
Dermatology	2923080A0	7	7
Emergency Medicine	2923110C0	20	20
Family Medicine/HH/LBJ	2923120C0	12	9
Internal Medicine	2923140C0	40	40
Medicine-Preliminary	2923140P0	11	11
Med-Prelim/Radiation Onc	2923140P1	2	2
Neurological Surgery	2923160C0	3	3
Neurology	2923180C0	10	10
Child Neurology	2923185C0	3	1
Obstetrics-Gynecology	2923220C0	12	12
Orthopaedic Surgery	2923260C0	6	6
Otolaryngology	2923280C0	3	3
Pathology	2923300C0	7	7
Pediatrics	2923320C0	24	24
Phys Medicine & Rehab	2923340C0	4	4
Psychiatry	2923400C0	13	13
Psychiatry/Child Psych	2923400C1	2	2
Psychiatry/Research	2923400C2	2	2
Interventional Radiology (Integ)	2923416A0	3	3
Radiology-Diagnostic	2923420A0	10	10
General Surgery	2923440C0	6	6
Surg-Prelim/Non-designated	2923440P0	9	5
Surg-Prelim/OMFS	2923440P2	3	3
Vascular Surgery	2923451C0	1	1
Medicine-Pediatrics	2923700C0	8	8
Pediatrics-Medical Genetics	2923765C0	1	1

U Texas Rio Grande Valley

Harlingen	Code	Quota	Matched
Family Medicine/McAllen Med Ctr	1825120C0	6	6
Family MedicineDHR-Edinburg	1825120C1	8	8
Family Medicine/Knapp	1825120C2	5	5
Internal Medicine/VBMC-Harlingen	1825140C0	5	5
Internal Medicine/DHR-Edinburg	1825140C1	16	16
Internal Medicine/Knapp	1825140C2	12	12
Ob-Gyn/DHR-Edinburg	1825220C0	4	4
Obstetrics-Gynecology/BOLD	1825220C1	1	1
Psychiatry	1825400C0	6	6
General Surgery/DHR-Edinburg	1825440C0	4	4
General Surgery/Valley Baptist MC	1825440C1	2	2
Surgery-Prelimary/DHR-Edinburg	1825440P0	4	4
Transitional	1825999P0	4	4

U Texas Southwestern Med Sch-Dallas

Dallas	Code	Quota	Matched
Anesthesiology	2835040C0	17	17
Anesthesiology	2835040R0	5	5
Dermatology	2835080A0	8	8
Emergency Medicine	2835110C0	26	26
Family Medicine	2835120C0	14	14
Internal Medicine	2835140C0	51	51
Internal Medicine/PSTP	2835140C3	4	4
Medicine-Preliminary	2835140P0	6	6
Neurological Surgery	2835160C0	3	3
Neurology	2835180C0	9	9
Child Neurology/Neuroscience	2835185C0	1	1
Child Neurology	2835185C1	4	4
Child Neurology	2835185R0	1	1
Neurodevelopmental Disabilities	2835186C0	0	0
Obstetrics-Gynecology	2835220C0	18	18
Orthopaedic Surgery	2835260C0	6	6
Otolaryngology	2835280C0	4	4
Pathology	2835300C0	9	9
Pediatrics	2835320C0	32	32
Pediatrics/PSTP2	2835320C2	1	1
Phys Medicine & Rehab	2835340A0	3	3
Phys Medicine & Rehab	2835340C0	6	6
Plastic Surgery (Integrated)	2835362C0	5	5
Psychiatry	2835400C0	11	11
Psychiatry/Research	2835400C2	2	2
Psychiatry/ChildPsych	2835400C3	3	3
Psychiatry/Rural Pub Mental Hlth	2835400C4	2	2
Interventional Radiology (Integ)	2835416A0	3	3
Radiology-Diagnostic	2835420A0	10	10
Radiology-Diag/Research	2835420A1	3	3
Radiology-Diagnostic R	2835420R0	2	2
Radiation Oncology	2835430A0	3	3
General Surgery	2835440C0	13	13
Surgery-Preliminary	2835440P0	12	12
Surg-Prelim/Rad Research	2835440P3	1	1
Vascular Surgery	2835451C0	1	1

U Texas Southwestern Med Sch-Dallas (Continued)

Medicine-Pediatrics	2835700C0	4	4
Medicine-Psychiatry	2835715C0	2	2
Psychiatry-Neurology	2835755C0	1	1

U Texas at Austin Dell Medical School

Austin	Code	Quota	Matched
Dermatology	1793080A0	4	4
Dermatology	1793080R0	1	1
Emergency Medicine	1793110C0	8	8
Family Medicine	1793120C0	7	7
Internal Medicine	1793140C0	12	12
Internal Med/Distinction	1793140C1	5	5
Medicine-Primary	1793140M0	4	4
Medicine-Preliminary	1793140P0	5	5
Neurological Surgery	1793160C0	1	1
Neurology	1793180C0	6	6
Neurology/Ascension	1793180C1	4	4
Child Neurology	1793185C0	1	1
Child Neurology	1793185R0	1	0
Obstetrics-Gynecology	1793220C0	5	5
Orthopaedic Surgery	1793260C0	4	4
Pediatrics	1793320C0	21	21
Phys Medicine & Rehab	1793340A0	2	2
Psychiatry	1793400C0	9	9
Radiology-Diagnostic	1793420A0	4	4
Radiology-Diagnostic	1793420R0	4	4
General Surgery	1793440C0	4	4
Surgery-Preliminary	1793440P0	4	3
Transitional	1793999P0	6	6

Waco Family Medicne Institute-TX

Waco	Code	Quota	Matched
Family Medicine	1735120C0	12	12

William Beaumont Army Med Ctr-TX

El Paso	Code	Quota	Matched
Internal Medicine/El Paso VA	1717140C0	3	1
Orthopaedic Surgery	1717260C0	1	1

UTAH

Intermountain Med Ctr-UT

Murray	Code	Quota	Matched
Transitional	1729999P0	8	8

McKay-Dee Hospital Ctr-UT

Ogden	Code	Quota	Matched
Family Medicine	1736120C0	7	7

University of Utah Health

Salt Lake City	Code	Quota	Matched
Anesthesiology	1732040A0	4	4
Anesthesiology/Trans	1732040C0	5	5
Anesthesiology/IM	1732040C1	5	5
Anesthesiology	1732040R0	1	1
Dermatology	1732080A0	3	3
Dermatology/IM	1732080C0	1	1
Emergency Medicine	1732110C0	12	12
Family Medicine	1732120C0	10	8
Family Med/StARR Research	1732120C1	0	0
Internal Medicine	1732140C0	27	27
Internal Med/Research	1732140C1	2	2
Internal Med/Intl Partnership	1732140C2	4	4
Internal Med/Med-Geri Pathway	1732140C3	0	0
Internal Medicine/Research-A	1732140C4	0	0
Internal Medicine/Research-B	1732140C5	1	1
Med-Prelim/Ophthalmology	1732140P1	4	4
Neurological Surgery	1732160C0	3	3
Neurology	1732180C0	8	8
Child Neurology	1732185C0	3	3
Obstetrics-Gynecology	1732220C0	7	7
Orthopaedic Surgery	1732260C0	6	6
Otolaryngology	1732280C0	3	3
Pathology-AP/CP Comb	1732300C0	4	4
Pathology-AP/NP Comb	1732300C3	0	0
Pathology/Physician Scientist	1732300C4	1	1
Pediatrics	1732320C0	23	23
Phys Medicine & Rehab	1732340C0	7	7
Plastic Surgery (Integrated)	1732362C0	3	3
Psychiatry	1732400C0	9	9
Psychiatry/Research	1732400C1	2	2
Psychiatry/Rural Idaho Track	1732400C2	3	3
Radiology-Diagnostic	1732420A0	7	7
Radiology-Diagnostic	1732420C0	1	1
Radiation Oncology	1732430A0	2	2
General Surgery	1732440C0	6	6
Thoracic Surgery	1732461C0	1	1
Medicine-Pediatrics	1732700C0	3	3
Peds/Psych/Child Psych	1732730C0	3	3
Pediatrics-Medical Genetics	1732765C0	1	1

Utah HealthCare Inst/St Marks

Salt Lake City	Code	Quota	Matched
Family Medicine	1730120C0	4	4

Utah Valley Reg Med Ctr

Provo	Code	Quota	Matched
Family Medicine	1215120C0	8	8

VERMONT

Univ of Vermont Medical Center

Burlington	Code	Quota	Matched
Anesthesiology	1734040C0	6	6
Dermatology	1734080A0	2	2
Emergency Medicine	1734110C0	6	6
Family Medicine	1734120C0	6	6
Internal Medicine	1734140C0	12	12
Medicine-Primary	1734140M0	3	3
Medicine-Preliminary	1734140P0	1	1
Medicine-Preliminary/FAP	1734140P2	2	2
Neurological Surgery	1734160C0	1	1
Neurology	1734180C0	5	5
Obstetrics-Gynecology	1734220C0	3	3
Orthopaedic Surgery	1734260C0	3	3
Otolaryngology	1734280C0	1	1
Pathology	1734300C0	4	4
Pediatrics	1734320C0	7	7
Psychiatry	1734400C0	3	3
Combined Adult/Child Psych	1734400C1	2	2
Radiology-Diagnostic	1734420A0	6	6

Univ of Vermont Medical Center (Continued)

General Surgery	1734440C0	4	4
Surgery-Preliminary	1734440P0	1	1

VIRGINIA

Bon Secours Health System-VA

Midlothian	Code	Quota	Matched
Family Medicine/St Francis	2530120C0	8	8
Family Medicine/Blackstone	2530120C1	2	2

Carilion Clinic-Virginia Tech Carilion SOM

Roanoke	Code	Quota	Matched
Dermatology	1748080A0	2	2
Dermatology	1748080R1	1	1
Emergency Medicine	1748110C0	12	12
Family Medicine	1748120C0	10	10
Internal Medicine	1748140C0	21	21
Medicine-Preliminary	1748140P0	3	3
Neurological Surgery	1748160C0	1	1
Neurology	1748180C0	3	3
Obstetrics-Gynecology	1748220C0	4	4
Pediatrics	1748320C0	6	2
Plastic Surgery (Integrated)	1748362C0	2	2
Psychiatry	1748400C0	8	8
General Surgery	1748440C0	5	5
Surgery-Preliminary	1748440P0	4	4

Eastern Virginia Med School

Norfolk	Code	Quota	Matched
Dermatology	2980080A0	3	3
Dermatology/Ext Funded	2980080R1	1	1
Emergency Medicine	2980110C0	10	10
Family Medicine	2980120C1	16	16
Internal Medicine	2980140C0	13	13
Internal Medicine/Geriatrics	2980140C1	1	0
Medicine-Preliminary	2980140P0	11	11
Obstetrics-Gynecology	2980220C0	5	5
Otolaryngology	2980280C0	3	3
Pediatrics	2980320C0	28	28
Phys Medicine & Rehab	2980340A0	3	3
Physl Medicine & Rehab	2980340R0	3	3
Plastic Surgery (Integrated)	2980362C0	1	1
Psychiatry	2980400C0	6	6
Radiology-Diagnostic	2980420A0	4	4
Radiology-Diagnostic	2980420R1	1	1
General Surgery	2980440C0	5	5
Vascular Surgery	2980451C0	1	1

HCA Healthcare LGH-Montgomery/VCOM-VA

Blacksburg	Code	Quota	Matched
Dermatology	2192080A0	2	2
Family Medicine	2192120C0	6	6
Internal Medicine	2192140C0	7	2
Transitional/Dermatology	2192999P0	2	2
Transitional	2192999P1	2	2

Inova Fairfax Hospital-VA

Falls Church	Code	Quota	Matched
Family Medicine	3199120C0	9	9
Internal Medicine	3199140C0	11	11
Neurological Surgery	3199160C0	1	1
Obstetrics-Gynecology	3199220C0	6	6
Pediatrics	3199320C0	13	13
General Surgery	3199440C0	7	7

Johnston Memorial Hosp-VA

Abingdon	Code	Quota	Matched
Family Medicine	2178120C0	5	1
Internal Medicine	2178140C0	7	3

LewisGale Med Ctr-VA

Salem	Code	Quota	Matched
Emergency Medicine	2129110C0	8	4
Family Medicine	2129120C0	8	0
Internal Medicine	2129140C0	20	5
Psychiatry	2129400C0	9	5
Transitional Year	2129999P0	15	3

Liberty Univ COM-VA

Lynchburg	Code	Quota	Matched
Osteo Neuromusculo Med	2204275C0	2	0

Lynchburg Fam Med Res-VA

Lynchburg	Code	Quota	Matched
Family Medicine	3065120C0	9	7

Riverside Reg Med Ctr-VA

Newport News	Code	Quota	Matched
Emergency Medicine	1739110C0	8	8
Family Medicine	1739120C0	13	13
Obstetrics-Gynecology	1739220C0	3	3
Transitional	1739999P0	12	12

Sovah Health-Danville-VA

Danville	Code	Quota	Matched
Family Medicine	2145120C0	6	6
Internal Medicine	2145140C0	10	10

University of Virginia

Charlottesville	Code	Quota	Matched
Anesthesiology	1737040A0	2	2
Anesthesiology	1737040C0	12	12
Anesthesiology	1737040R0	2	2
Dermatology	1737080A0	3	3
Dermatology	1737080R1	1	1
Emergency Medicine	1737110C0	12	12
Family Medicine	1737120C0	8	8
Internal Medicine	1737140C0	30	30
Medicine-Primary	1737140M0	3	3
Medicine-Preliminary	1737140P0	3	3
Neurological Surgery	1737160C0	3	3
Neurology	1737180C0	6	6
Child Neurology	1737185C0	1	1
Obstetrics-Gynecology	1737220C0	5	5
Orthopaedic Surgery/5 Yr	1737260C0	5	5
Otolaryngology	1737280C0	3	3
Pathology	1737300C0	6	6
Pediatrics	1737320C0	11	11
Phys Medicine & Rehab	1737340A0	2	2

University of Virginia (Continued)

Phys Medicine & Rehab	1737340C0	2	2
Plastic Surgery (Integrated)	1737362C0	2	2
Psychiatry	1737400C0	10	10
Interventional Radiology (Integ)	1737416C0	2	2
Radiology-Diagnostic	1737420A0	8	8
Radiation Oncology	1737430A0	2	2
Radiation Oncology	1737430R0	2	2
General Surgery	1737440C0	5	5
Surgery-Preliminary	1737440P1	8	2
Thoracic Surgery	1737461C0	1	1

VCU-Shenandoah Valley-VA

Front Royal	Code	Quota	Matched
Family Medicine	1742120C0	5	4

Virginia Commonwealth U Hlth Sys

Richmond	Code	Quota	Matched
Anesthesiology	1743040C0	8	8
Anesthesiology	1743040R0	4	4
Dermatology	1743080A0	2	2
Emergency Medicine	1743110C0	12	12
Internal Medicine	1743140C0	33	33
Internal Medicine/Geriatrics	1743140C3	0	0
Medicine-Preliminary	1743140P0	5	5
Med-Prelim/Neurology	1743140P1	8	8
Med-Prelim/PM&R	1743140P2	3	3
Med-Prelim/Ophthalmology	1743140P3	4	4
Neurological Surgery	1743160C0	2	2
Neurology	1743180A0	8	8
Child Neurology	1743185C0	1	1
Obstetrics-Gynecology	1743220C0	6	6
Orthopaedic Surgery	1743260C0	5	5
Otolaryngology	1743280C0	3	3
Pathology	1743300C0	4	4
Pediatrics	1743320C0	16	16
Phys Medicine & Rehab	1743340A0	6	6
Plastic Surgery (Integrated)	1743362C0	2	2
Psychiatry	1743400C0	11	11
Psychiatry/Research Trk	1743400C1	0	0
Interventional Radiology (Integ)	1743416A0	2	2
Radiology-Diagnostic	1743420A0	7	7
Radiation Oncology	1743430A0	1	1
Radiation Oncology	1743430R0	2	2
General Surgery	1743440C0	6	6
Surgery-Preliminary	1743440P0	7	7
Medicine-Pediatrics	1743700C0	4	4
Medicine-Emergency Med	1743705C0	2	2

Wellmont Health System-VA

Big Stone Gap	Code	Quota	Matched
Family Medicine	2216120C0	6	4
Internal Medicine	2216140C0	9	9

WASHINGTON

Central WA Family Med

Yakima	Code	Quota	Matched
Family Medicine	3059120C0	9	4
Family Med/Ellensburg Rural	3059120C1	2	2

Community Health Care-WA

Tacoma	Code	Quota	Matched
Family Medicine	1731120C0	8	3

Elson S Floyd COM WSU-WA

Spokane	Code	Quota	Matched
Internal Medicine	2276140C0	12	12
Medicine-Preliminary	2276140P0	4	4

Harrison Med Ctr-WA

Bremerton	Code	Quota	Matched
Family Medicine	2059120C0	8	8

Kadlec Regional Med Ctr-WA

Richland	Code	Quota	Matched
Family Medicine	1721120C0	8	8

Kaiser Permanente Washington

Seattle	Code	Quota	Matched
Family Medicine/Capitol Hill	1811120C0	4	4
Family Medicine/Burien	1811120C1	2	2

Legacy Salmon Creek Med Ctr-WA

Vancouver	Code	Quota	Matched
Internal Medicine	2301140C0	12	12

MultiCare Good Samaritan Hosp-WA

Puyallup	Code	Quota	Matched
Family Medicine	1574120C0	6	6

PeaceHealth Southwest Med Ctr-WA

Vancouver	Code	Quota	Matched
Family Medicine	1143120C0	8	8

Providence Sacred Heart Med Ctr-WA

Spokane	Code	Quota	Matched
Family Medicine	1758120C0	10	10
Family Med/Rural	1758120C1	2	2
Internal Medicine	1758140C0	10	8
Phys Medicine & Rehab	1758340A0	6	6
Psychiatry	1758400C0	4	4
Transitional	1758999P0	18	18

Providence St Peter Hospital-WA

Olympia	Code	Quota	Matched
Family Medicine	3198120C0	7	7
Family Medicine/Chehalis	3198120C1	3	3
Family Med/Summit Pacific	3198120C2	2	2

Puyallup Tribal Health Authority-WA

Tacoma	Code	Quota	Matched
Family Medicine	2209120C0	4	3

Sea Mar Community Health Ctrs-WA

Seattle	Code	Quota	Matched
Family Medicine	1912120C0	10	9

Skagit Regional Health-WA

Mount Vernon	Code	Quota	Matched
Family Medicine	2159120C0	4	2
Internal Medicine	2159140C0	8	8

St Josephs Hospital-WA

Tacoma	Code	Quota	Matched
General Surgery	2210440C0	2	2

Swedish Med Ctr-WA

Seattle	Code	Quota	Matched
Family Med/First Hill	1755120C0	6	6
Family Med/Downtown	1755120C1	3	3
Family Med/Ballard	1755120C2	2	2
Family Med/Cherry Hill	1755120C3	4	4
Family Med/SeaMar	1755120C4	2	0
Family Med/SIHB	1755120C5	2	2
Family Med/Carolyn Downs	1755120C7	2	2
Family Med/ID Clinic	1755120C8	2	2
Family Medicine/Rural	1755120C9	3	3
Obstetrics-Gynecology	1755220C0	6	6
General Surgery	1755440C0	5	5
Surgery-Preliminary	1755440P0	5	4

Tacoma Family Med-WA

Tacoma	Code	Quota	Matched
Family Medicine	3086120C0	8	8

Trios Health-WA

Kennewick	Code	Quota	Matched
Family Medicine	2167120C0	4	1
Internal Medicine	2167140C0	6	3

U Washington Affil Hosps

Seattle	Code	Quota	Matched
Anesthesiology	1918040A0	1	1
Anesthesiology/Clin Base Yr	1918040C0	24	24
Anesthesiology/Crit Care Comb	1918040C1	1	1
Anesthesiology/Bonica Scholar	1918040C2	1	1
Anesthesiology	1918040R0	1	1
Dermatology	1918080A0	4	4
Dermatology	1918080R0	1	1
Emergency Medicine	1918110C0	13	13
Family Medicine	1918120C0	6	6
Family Med/Harborview	1918120C1	2	2
Family Medicine/Chelan Rural	1918120C2	2	2
Internal Medicine	1918140C0	41	41
Medicine-Primary	1918140M0	11	11
Med-Prelim/Ophthalmology	1918140P2	5	5
Neurological Surgery	1918160C0	3	3
Neurology	1918180C0	8	8
Child Neurology	1918185C0	3	3
Obstetrics-Gynecology	1918220C0	7	7
Orthopaedic Surgery	1918260C0	8	8
Otolaryngology	1918280C0	3	3
Oto + 2 yrs research	1918280C1	1	1
Pathology-AP & CP	1918300C0	5	5
Pathology-AP only	1918300C1	1	1
Pathology-CP only	1918300C2	1	0
Pathology-AP & NP	1918300C3	1	1
Pediatrics	1918320C0	31	31
Pediatrics/Alaska	1918320C1	4	4
Pediatrics/Research	1918320C2	2	2
Pediatrics/Health Equity	1918320C3	4	4
Phys Medicine & Rehab	1918340A0	5	5
Phys Medicine & Rehab	1918340C0	3	3
Plastic Surgery (Integrated)	1918362C0	5	5
Psychiatry	1918400C0	12	12
Psychiatry/Research	1918400C4	4	4
Psychiatry/UW Montana	1918400C5	3	3
Interventional Radiology (Integ)	1918416A0	3	3
Radiology-Diagnostic	1918420A0	10	10
Radiation Oncology	1918430A0	2	2
General Surgery	1918440C0	3	3
General Surgery/Research	1918440C1	4	4
Surg-Prelim/2yr	1918440P0	3	1
Surg-Prelim/1yr	1918440P3	13	6
Vascular Surgery	1918451C0	2	2
Thoracic Surgery	1918461C0	1	1
Pediatrics-Medical Genetics	1918765C0	1	1

Valley Med Ctr-WA

Renton	Code	Quota	Matched
Family Medicine	3132120C0	8	8

Virginia Mason Med Ctr-WA

Seattle	Code	Quota	Matched
Anesthesiology	1756040A0	3	3
Anesthesiology	1756040C0	6	6
Internal Medicine	1756140C0	6	6
Medicine-Primary	1756140M0	4	4
Medicine-Preliminary	1756140P0	3	3
Radiology-Diagnostic	1756420A0	1	1
Radiology-Diagnostic	1756420C0	2	2
General Surgery	1756440C0	5	5
Surgery-Preliminary	1756440P0	6	5
Transitional	1756999P0	5	5

Yakima Valley Farm Workers Clinic-WA

Toppenish	Code	Quota	Matched
Family Medicine	2168120C0	4	1

WEST VIRGINIA

AccessHealth-WV

Beckley	Code	Quota	Matched
Family Medicine	2304120C0	4	2

Charleston Area Med Ctr-WV

Charleston	Code	Quota	Matched
Emergency Medicine	1902110C0	6	5
Family Medicine	1902120C0	2	2
Internal Medicine	1902140C0	11	11
Medicine-Preliminary	1902140P0	5	3
Obstetrics-Gynecology	1902220C0	3	3
Pediatrics	1902320C0	7	7
Psychiatry	1902400C0	4	4
General Surgery	1902440C0	4	4
Surgery-Preliminary	1902440P0	2	0
Vascular Surgery	1902451C0	1	1
Medicine-Psychiatry	1902715C0	2	2

Greenbrier Valley Med Ctr-WV

Ronceverte	Code	Quota	Matched
Family Medicine	2305120C0	4	1
Osteo Neuromusculo Med	2305275C0	3	3

Marshall Community Health-WV

Huntington	Code	Quota	Matched
Family Medicine	2191120C0	4	3

Marshall University SOM-WV

Huntington	Code	Quota	Matched
Family Medicine	3066120C0	8	8
Internal Medicine	3066140C0	17	17
Medicine-Preliminary	3066140P0	9	6
Neurology	3066180C0	4	4
Obstetrics-Gynecology	3066220C0	3	3
Orthopaedic Surgery	3066260C0	3	3
Pediatrics	3066320C0	6	5
Psychiatry	3066400C0	6	6
General Surgery	3066440C0	4	4
Surgery-Preliminary	3066440P0	3	0
Medicine-Pediatrics	3066700C0	2	2

United Hospital Ctr-WV

Bridgeport	Code	Quota	Matched
Family Medicine	2985120C0	7	7

West Virginia University SOM

Morgantown	Code	Quota	Matched
Anesthesiology	1837040C0	9	9
Dermatology	1837080A0	2	2
Emergency Medicine	1837110C0	10	10
Family Medicine	1837120C0	1	1
Family Med/Harpers Ferry	1837120C1	5	2
Internal Medicine	1837140C0	22	22
Internal Med/Funded Intl	1837140C1	3	3
Internal Med/Camden Clark	1837140C2	6	6
Neurological Surgery	1837160C0	1	1
Neurology	1837180C0	8	8
Obstetrics-Gynecology	1837220C0	3	3
Orthopaedic Surgery	1837260C0	3	3
Ortho Surgery/Research	1837260C1	1	1
Otolaryngology	1837280C0	3	3
Pathology	1837300C0	3	3
Pediatrics	1837320C0	6	5
Plastic Surgery (Integrated)	1837362C0	1	1
Psychiatry	1837400C0	9	9
Psychiatry/Funded Intl	1837400C1	1	1
Radiology-Diagnostic	1837420A0	6	6
Radiation Oncology	1837430A0	1	0
General Surgery	1837440C0	5	5
Surgery-Preliminary	1837440P1	3	0
Medicine-Pediatrics	1837700C0	3	3
Transitional	1837999P0	12	12
Trans/Dermatology	1837999P2	1	1

Wheeling Hospital-WV

Wheeling	Code	Quota	Matched
Family Medicine	1770120C0	8	8

WISCONSIN

Aurora Health Care/ASMC-WI

Milwaukee	Code	Quota	Matched
Family Med/Lakeland	1787120C1	4	3
Internal Medicine	1787140C0	13	13
Obstetrics-Gynecology	1787220C0	3	3

Aurora St Lukes Medical Ctr-WI

Millwaukee	Code	Quota	Matched
Family Medicine	1789120C0	12	12
Interventional Radiology (Integ)	1789416C0	1	1
Radiology-Diagnostic	1789420C0	4	4
Transitional	1789999P0	9	9

Gundersen Lutheran Med Fdn-WI

La Crosse	Code	Quota	Matched
Family Medicine	1774120C0	6	6
Internal Medicine	1774140C0	8	8
General Surgery	1774440C0	4	4
Transitional	1774999P0	12	12

Marshfield Clinic-WI

Marshfield	Code	Quota	Matched
Dermatology	1780080A1	2	2
Internal Medicine	1780140C0	10	10
Pediatrics	1780320C0	6	6
General Surgery	1780440C0	3	3
Medicine-Pediatrics	1780700C0	2	2

Med Coll Wisconsin Affil Hosps

Milwaukee	Code	Quota	Matched
Anesthesiology	1784040C0	19	19
Anesthesiology	1784040R0	2	2
Dermatology	1784080A0	5	5
Emergency Medicine	1784110C0	12	12
Family Med/All Saints	1784120C1	6	6
Fam Med/Columbia-St Marys	1784120C2	8	8
Family Med/Fox Valley	1784120C4	7	7
Fam Med/Froedtert Menom Falls	1784120C5	6	6
Internal Medicine	1784140C0	26	26
Internal Medicine/Geriatrics	1784140C1	1	1
Int Med/Research Path	1784140C2	2	2
Medicine-Primary	1784140M0	1	1
Medicine-Preliminary	1784140P0	10	10
Neurological Surgery	1784160C0	2	2
Neurology	1784180C0	6	6
Child Neurology	1784185C0	2	2
Obstetrics-Gynecology	1784220C0	9	9
Orthopaedic Surgery	1784260C0	5	5
Otolaryngology	1784280C0	3	3
Pathology	1784300C0	4	4
Pediatrics	1784320C0	23	23
Pediatrics-Preliminary	1784320P0	1	1
Phys Medicine & Rehab	1784340A0	6	6
Plastic Surgery (Integrated)	1784362C0	2	2
Psychiatry/Milwaukee	1784400C0	8	8
Psychiatry/Northeastern WI	1784400C1	4	4
Psychiatry/Central WI	1784400C2	3	3

Med Coll Wisconsin Affil Hosps (Continued)

Interventional Radiology (Integ)	1784416C0	2	2
Radiology-Diagnostic	1784420A0	7	7
Radiation Oncology	1784430A0	2	2
General Surgery	1784440C0	7	7
General Surgery/Rural	1784440C1	1	1
Surgery-Preliminary	1784440P0	3	1
Medicine-Pediatrics	1784700C0	6	6
Pediatrics-Anesthesiology	1784726C0	1	1
Transitional/St Joseph	1784999P0	14	14

Mercy Health System-WI

Janesville	Code	Quota	Matched
Family Medicine	3722120C0	7	6

ProHealth Waukesha Mem Hosp-WI

Waukesha	Code	Quota	Matched
Family Medicine	2280120C0	6	4

U Wisconsin Hospital and Clinics

Madison	Code	Quota	Matched
Anesthesiology	1779040A0	1	1
Anesthesiology	1779040C0	15	15
Anesthesiology	1779040R0	1	1
Dermatology	1779080A0	5	5
Dermatology	1779080R0	1	1
Emergency Medicine	1779110C0	13	13
Internal Medicine	1779140C0	29	29
Medicine-Primary	1779140M0	3	3
Med-Prelim/Radiation Onc	1779140P1	1	1
Med-Prelim/Radiology	1779140P2	2	2
Med-Prelim/Ophthalmology	1779140P3	3	3
Neurological Surgery	1779160C0	2	2
Neurology	1779180C0	5	5
Child Neurology	1779185C0	1	0
Obstetrics-Gynecology	1779220C0	6	6
Obstetrics-Gynecology/Rural	1779220C1	1	1
Orthopaedic Surgery	1779260C0	6	6
Otolaryngology	1779280C0	3	3
Pathology/AP and CP	1779300C0	6	6
Pathology/AP-only or CP-only	1779300C1	1	0
Pediatrics	1779320C0	15	15
Phys Medicine & Rehab	1779340A0	3	3
Plastic Surgery (Integrated)	1779362C0	3	3
Psychiatry	1779400C0	10	10
Interventional Radiology (Integ)	1779416A0	1	1
Radiology-Diagnostic	1779420A0	8	8
Radiation Oncology	1779430A0	1	1
General Surgery/Academic	1779440C0	6	6
General Surgery/Community	1779440C1	1	1
Surgery-Preliminary	1779440P3	6	0
Surg-Prelim/Radiology	1779440P4	1	1
Surg-Prelim/Int Radiology	1779440P5	1	1
Vascular Surgery	1779451C0	1	1

U Wisconsin SOM and Public Health

Madison	Code	Quota	Matched
Family Med/Madison	3001120C0	16	16
Family Med/Baraboo	3001120C1	2	0

WiNC GME Consortium-WI

Wausau	Code	Quota	Matched
Family Medicine/Prevea-Eau Claire	2262120C0	5	5
Family Medicine/Prevea-EC-Augusta	2262120C1	1	1
Family Medicine/Aspirus-Wausau	2262120C2	4	3
Family Med/MCW-Prevea-Green Ba	2262120C3	4	4

WYOMING

Univ of Wyoming-Casper

Casper	Code	Quota	Matched
Family Medicine	3089120C0	8	8
Family Medicine/Rural	3089120C1	1	1

Univ of Wyoming-Cheyenne

Cheyenne	Code	Quota	Matched
Family Medicine	2034120C0	6	4

Exhibit 17:
SJC-AMA-000000476
May 22, 2024 Response to AMA CME Report

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May 22, 2024

AMA – Reference Committee C
Email: [redacted]@ama-assn.org)

RE: Response to AMA CME Report 02-A-24 ("The Current Match Process and Alternatives")

Dear Reference Committee C:

The National Resident Matching Program® ("NRMP") has reviewed the American Medical Association's CME Report 02-A-24 ("The Current Match Process and Alternatives") (hereinafter "the Report") and now provides the following corrections, comments, and recommendations.

Though NRMP values the opportunity to raise these issues and appreciates your consideration of this feedback, NRMP's submission does not imply its support or agreement with the Report. To the contrary, NRMP remains deeply concerned that the authors of the original resolution (Resolution 302-A-23) were motivated by a desire to disparage NRMP and mischaracterize The Match processes.

As a general matter, the Report gives unwarranted deference to the presumptions and unfounded opinions of those authors within the Resident and Fellow Section ("RFS"), especially given the indisputable fact that NRMP and the processes and procedures of The Match are not involved in the determinations of residents' salaries and benefits, nor limit the ability of residents to negotiate those terms. We appreciate the Report's efforts to provide some clarification on these issues and the benefits that NRMP provides as one part of a much broader medical education community. We also look forward to working with the AMA on more collaborative and productive means for further improvements in the resident and fellowship experience of our nation's future physicians.

Corrections

NRMP identifies the following corrections that should be resolved in the final draft of the Report.

- **Page 2, Line 20:** Shapley and colleague Gayle developed a deferred acceptance algorithm in the 1960's. Years later, Roth engaged in extensive study of the algorithm and its application to matching markets. Their pioneering work resulted in the Nobel Prize in Economics. Their respective research did not lead "*to the development of the algorithm used for the Match*." As noted on line 23, the current algorithm has been in use since 1998.
- **Page 2, Lines 28-30:** In 2015, the AOA and ACGME initiated the process of a "Single Accreditation System" ("SAS"). To state that SAS combined "*…the AOA and*

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NRMP match programs" is incorrect. SAS was a unification of the residency program accreditation process by two independent accrediting organizations. The Report likely intended to comment on the transition of osteopathic seniors from the AOA match to a single match under the NRMP, which occurred because of SAS, but was independent from the AOA and ACGME. Furthermore, substantial numbers (approximately half) of osteopathic seniors had for decades, entered The Match before the transition to a single match, which was completed in 2020.

- **Page 3, Line 3:** Appendix A is the infographic of the matching process for the National Matching Program ("NMP"), a subsidiary of the NRMP that provides matching services to government, education organizations, and other non-profit organizations. In 2022, the proceeds from NMP were directed to reduce the cost of match registration to all applicants in the Main Residency Match and the Specialties Matching Service. The correct infographic may be found here: https://www.nrmp.org/intro-to-the-match/.

- **Page 4, Lines 14-20:** Plastic surgery fellowship programs use the SF Match; however, Integrated Plastic Surgery residency programs participate in the NRMP's Main Residency Match (hereinafter "The Match"). Ophthalmology residency applicants may enter The Match while attempting to secure a position through the SF Match to obtain a PGY-1 position or seek and rank programs of a different specialty. Applicants who match into ophthalmology, and who have registered for The Match, are withdrawn from The Match in advance of the algorithm being run and are reimbursed the registration fees paid to the NRMP. In addition, the NRMP and AUPO facilitate match placement into "joint" programs to further streamline ophthalmology match placement using the All In exception if requested by the preliminary program. The NRMP also oversees the Specialties Matching Service® (SMS®), which executes 22 fellowship matches each year serving more than 70 subspecialties and more than 13,000 applicants.

- **Page 6, Line 17:** The UGRC released 34 recommendations, not 28. The NRMP was an active participant in the UGRC workgroup and other workgroups formed during the pandemic. The Report's reference to recommendation #23 is acknowledged; however, the final recommendation is specific to the number of applications, the application processes that lead to selection, and a call for pilot projects across the transition to residency.

- **Page 7, Lines 4-11; Page 9, Lines 26-30:** The Report acknowledges the efforts of the AMA MSS and RFS to submit nominees for the NRMP Board of Directors every year for the last ten years and noted that NRMP no longer has designated AMA seats as of 2017. This was also brought to the NRMP's attention in a phone call from the AMA staff office before receiving the report. In 2012, the NRMP modified its bylaws to eliminate reference(s) to sponsoring organizations and their dedicated

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seats on the NRMP board at the behest of partner organizations, including the AMA. Since that time, no partner organization has had a designated seat. However, in 2023, one of the student director nominees submitted by the AMA MSS was appointed to the NRMP's board for a two-year term.

The council's inference (in the report and in the recommendations) that the AMA's nomination to the NRMP board will serve as an agent for the concerns of the RFS or other elements of the AMA is troublesome. The NRMP's independence from other organizations is a necessary component of our 501(c)3 designation and is paramount to the NRMP maintaining its transparent and equitable posture across all organizations and interest groups, i.e., no organization or group gains favor or advantage simply because they agree to serve on the NRMP's board. The NRMP conducts an open call for nominations in addition to requesting nominations from other organizations to recruit a diverse pool of candidates, to provide opportunity more broadly, and to avoid engaging in nepotistic practices that appoint the same leaders to multiple boards across the continuum of medical education and physician workforce. The NRMP has worked diligently to avoid the 'echo chamber' and to ensure that directors on the board represent a cross section of student and resident learners, practicing physicians and educators, and non-physician members. Directors appointed to the NRMP board are holistically reviewed for their qualifications, interest, and ability to assist the NRMP achieve its strategic goals through an appropriate governance framework that actively works to prevent conflicts and duality of interest. As the NRMP respects the AMA's legal right to independently determine the governance of its organization, we expect the same from the AMA.

- **Page 9, Lines 21-24:** This recommendation echoes the Report's earlier discussion pertaining to the business interests of the AMA through the Change MedEd initiatives and the RR grants. While NRMP appreciates that the council seeks to promote the business initiatives of the AMA, labeling this as "National Resident Matching Program Reform" is wholly inappropriate and should be corrected.

Comments

NRMP provides the following comments on sections of the Report, which are intended to aid and inform your use of the Report:

- **Page 5, Line 51 – Page 6, Line 1:** "*It seems that further analysis of what works well and what does not work well is warranted in order to improve The Match process.*"

  This sentiment is expressed multiple times in the Report without any objective statement about any purported problem with The Match. To clarify, "The Match" is a registered trademark of the NRMP, an independent 501(c)3. The Match is not a colloquial term for the whole of the transition to residency nor does it extend to the services and offerings of other organizations and should not be used in this context

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by the AMA or any other organization. If the Report meant to convey that the transition to residency needs to be analyzed for improvement, e.g., how programs recruit and make employment decisions, application numbers, etc., then the Report should state that clearly to identify a problem and advocate for learners. If the AMA is concerned that programs are making salary decisions based on antiquated Medicare rules or hospital budget constraints, or market restrictions of supply versus demand, then the Report should again state that clearly to identify a problem and advocate for appropriate solutions. Using "The Match" as shorthand to critique aspects of the transition to residency outside the control of NRMP is inappropriate, does a disservice to the community in need of advocacy, and intentionally causes injury to the NRMP, its reputation, and its services.

- **Page 7, Lines 35-50:** This section identifies past reports by the Council on Medical Education that purport to "address residency and the Match." The NRMP has repeatedly voiced substantial concern about the lack of communication, lack of transparency, and lack of input pertaining to the development of AMA reports and policy, especially when internal AMA policy appears to impose obligations on other organizations and is published as if it were authoritative. Separately, greater internal controls are required by the AMA to prevent uninformed accusations, such as those made against NRMP, its leadership, and its governance in multiple resolutions and recommendations published on the AMA website and using the AMA moniker.

- **Page 8, Lines 1-47 (Relevant AMA Policy):** The NRMP reiterates its objection to any statement or suggestion that AMA has the authority to review, monitor, or oversee any of the NRMP's business practices or services. The NRMP does welcome collaborative discussion intended to address processes that benefit the medical education community, provided that AMA proactively communicates with NRMP in an open and transparent manner.

- **Page 9, Lines 1-2:** The Report perpetuates a false narrative that residents face a "*lack of control over their own destinies*." While the NRMP understands the anxiety applicants feel at the time of transition to residency, we object to the characterization that applicants lack control. Perpetuating statements such as these marginalize learner agency and contributes to the perception of a lack of control. The NRMP believes the AMA should serve to support and educate learners on productive means to better exert their own agency throughout the transition to residency.

- **Page 9, Line 6-7:** "*This report illuminates the importance of ongoing communication and transparency by the NRMP as well as collaboration among all invested parties*."

  The NRMP became aware of the original RFS resolution and its allegations because of a social media post in 2022 by a member of the RFS, not because of any communication or transparency by the RFS or the leadership of the AMA. NRMP has made several requests to meet with the RFS and others engaged in the

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decision/policy-making processes of the AMA House of Delegates. Those requests were denied, including requests made of this committee in 2023. After the 2023 HOD meeting, the NRMP was asked to rebut the 2006 working paper used as the basis for the RFS's recommendations and the HOD directive to study alternatives to The Match. The NRMP's ability to engage in direct communication with those expressing concern was limited and did not encourage or facilitate "ongoing" communication nor is it in any way transparent. Furthermore, while advised that NRMP can provide in-person testimony to the Reference Committee in Chicago, IL in June 2024 (that request was denied in 2023), we were also advised that testimony would be limited to 60-90 seconds. Those actions do not align with the Report's words on the importance of productive dialogue.

- **Page 9, Lines 10-12:** "*Accordingly, attention should be focused on what can be done to improve The Match and other specialty matches rather than focusing on its replacement, as a match process continues to be the best solution for trainees at this time.*"

  The Report should clearly state its recommendation to "Rescind AMA policy D-130.944," which was specifically focused on the NRMP and the processes and procedures of The Match. For other recommendations that deal with application processes, those matters should not be incorrectly attributed to NRMP or The Match. Similarly, the Report should also not presume to include "other specialty matches" which implies that any concerns about another organization's services extend to The Match; especially since the accusations made were not extended to the "other specialty matches," nor were they asked to respond to the HOD directive for study.

Recommendations:

Based on the foregoing corrections and comments, NRMP makes the following requests and recommendations to the AMA, the Council, and the HOD:

1. NRMP requests the Report clearly state its recommendation to "Rescind AMA policy D-130.944," as the first recommendation rather than the last.
2. NRMP requests the title of AMA policy D-310.977 be amended to reflect the intent of the AMA (to contribute to the conversation and advocate for learners) and not imply authority over the NRMP or indicate the AMA is engaged in "reform" of the National Resident Matching Program, an independent 501(c)3 corporation.
3. NRMP requests that section 21 of AMA Policy D-310.977, "National Resident Matching Program Reform," be amended to state" *"Continues to engage the National Resident Matching Program® (NRMP®) and other matching organizations on behalf of residents and medical students to further develop ongoing relationships, improve communications, and seek additional opportunities to collaborate ~~including the submission of suitable nominees for their governing bodies as appropriate~~."*

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4. NRMP recommends the AMA study its processes and activities for developing and promoting its policies and overseeing the appropriate activities of its members. As directed toward NRMP, this process has created substantial and intentional barriers to any external input and has consumed countless hours and resources trying to understand the AMA's processes, trying to understand how we might provide information to those leveling unfounded serious accusations against the NRMP and hospital organizations engaged in residency training, and developing a response to a theoretical working paper that was never a legitimate basis of real-world findings. Significant changes by AMA are required to repair the loss of trust and credibility resulting from those purporting to act on its behalf to attack NRMP and other members of the medical education community.

5. NRMP recommends the AMA incorporate a framework of consultation between AMA leadership, its advisory groups, and the HOD to ensure that all parties have accurate information before posting damaging reports and policies to the AMA website and disseminating inaccurate information and accusations throughout the medical education community. These actions have caused harm to the NRMP, to other medical education organizations, and to the stakeholders of the AMA who rely on the information provided through the AMA's advocacy work and GME division.

6. NRMP recommends the AMA pilot a process that allows for early direct communication with organizations whose processes are deemed to contribute to concerns by AMA leadership, an AMA advisory group(s), or HOD before publishing disparaging reports, recommendations, or policies. The NRMP also recommends the AMA collaborate with those organizations to identify the (actual) issue(s) and potential solutions before moving forward with a recommendation for policy change to the HOD. Furthermore, the NRMP recommends the AMA permit meaningful opportunities for response and testimony and not subject organizations to an online response or a 60-90 second period of testimony.

Thank you for this opportunity to address the NRMP's concerns about the Report of the Council on Medical Education.

Regards,

[redacted]

Cc. [redacted], MD, [redacted], MD, [redacted], MD

NRMP Board of Directors

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Exhibit 18:
SJC-AMA-000000708
Which Factors Do Applicants Weight Most When Picking Residency Programs

www.ama-assn.org /medical-students/preparing-residency/which-factors-do-applicants-weigh-most-when-picking-residency

Which factors do applicants weigh most when picking residency programs?

Preparing for Residency

Which are the top factors you are considering in your Match rank-order list? Learn how they compare with what your colleagues are seeking.

By
Brendan Murphy , Senior News Writer

Jan 8, 2025 | 5 Min Read

AMA News Wire

Jan 8, 2025

Medicine is a calling, many people feel. You don't choose it. It chooses you. As far as which programs physicians train in, that comes down to a rank-order list.

What factors do medical students consider most—and least—when choosing residency programs? Data recently released by the National Resident Matching Program (NRMP) shed some light on that question.

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Get ready for Match Week

Access timely resources from the AMA to help you successfully navigate Match Week and beyond.

Start Reading

Among the data, reports and research produced by the NRMP is a survey that aims to weigh the factors to which applicants give strongest consideration when applying to and ranking programs. The 2024 version of the survey featured responses from about 12,000 applicants, representing roughly 25% of the applicant pool in the most recent residency-selection cycle.

NRMP asked survey respondents to list the factors that influenced both application and ranking choices and the relative importance of each of those factors on a scale of one to five. These factors may be worth keeping on a medical student's radar in advance of the March 5 deadline for fourth-year medical students to submit their Match rank-order list.

The AMA helps medical students master the residency-application process so you can make the right decisions about your career, prepare for a knockout interview, explore residency opportunities—all so you can successfully match.

Most important factors

Most important factors

Among active U.S. allopathic senior medical students ranking residency programs across all specialties, these were the top five considerations.

- Overall goodness of fit—cited by 91%.
- Desired geographic location—90%.
- Interview day experience—88%.
- Reputation of program—83%.
- Quality of residents in program—83%.

The top five factors listed by applicants who were active U.S. osteopathic senior medical students ranking programs—on their final Match rank-order list—were as follows:

- Overall goodness of fit—88%.
- Desired geographic location—85%.
- Interview day experience—84%.
- Quality of residents in program—80%.
- Work-life balance—77%.

For MD applicants, work-life balance was a factor that dropped out of the top five while program reputation took on increased importance. DO applicants had the same top five factors as the previous application cycle.

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SJC-AMA-000000709

Dive deeper:

- So you wrapped up the residency interview. Do this next.
- What I wish I knew in medical school about Match rank-order lists
- Creating a Match rank-order list? Avoid these 4 common missteps
- Match ranking advice: Trust your gut
- An intern's rank-order list do's and don'ts
- Tips to help medical students fight rank-list uncertainty
- Meet Your Match: Composing a rank-order list

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Ranking strategy and application statistics

Ranking strategy and application statistics

Here are some other interesting nuggets from the survey.

U.S. MD seniors most commonly ranked the programs in order of their preference, with 95% citing that as a strategy for ranking programs, compared with 93% for U.S. DO seniors (also the most common strategy among that applicant type). Of U.S. MD seniors ranked, 79% ranked all the programs they were willing to attend (75% for DOs), and 74% ranked all programs with which they interviewed, regardless of preference.A smaller share of DO applicants, 63%, ranked all the programs with which they interviewed.

The median number of applications submitted by U.S. seniors who matched was 37, down from 40 in 2024 and 45 in 2023. The median number of interviews offered to matched U.S. seniors was 15, with those applicants attending a median of 14 interviews. Matched U.S. seniors typically ranked 14 programs.

Matched DO applicants applied to more programs, with a median of 49—down from 54 in 2023 and 60 in 2022. Their median number of interview invitations was 17, with those applicants attending 14 interviews and ranking 14 programs.

The median number of applications submitted by U.S. MD seniors who did not match was 50, down from 57 last year. The median number of interviews offered to applicants who did not match was 14, with those applicants typically attending 13 interviews and ranking a median of 13 programs.

The median number of applications submitted by unmatched DO applicants was 62 programs, down nine from 2023. Those applicants received a median of 13 interview invitations and typically attended 13

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interviews and ranked 12.

Dive deeper:

Follow the road to residency

Get tips and insider advice from the AMA on how to successfully Match to a residency program—delivered to your inbox.

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Declining application totals

Declining application totals

Many physician specialties saw significant drops in application totals in 2024. That can, at least in part, be attributed to the expansion of program signaling—a system that allows applicants to indicate interest in a limited number of residency programs when they submit their applications.At least 20 specialties used signaling in the current residency selection cycle.

In an interview on "AMA Update" at the beginning of the 2024–2025 residency application cycle, NRMP Board Chair Deborah Clements, MD, highlighted the aim of signaling, and how it addresses application saturation that had become a burden on program directors. Dr. Clements speaks from experience—in addition to her role at the NRMP, Dr. Clements is program director for the McGaw Northwestern Family Medicine Residency at Lake Forest.

"Regardless of specialty, the number of applications that we receive exceeds our capacity to interview—even many qualified candidates," said Dr. Clements, an AMA member. "So we make assumptions based on applications as to who might come to our programs.

In speaking of the utility of signals for applicants and programs, Dr. Clements said it might not always be obvious on paper that an applicant has ties to or deep interest in a program. Signals remedy that.

"The ability to signal programs prior to an interview has really given us the opportunity to potentially invite candidates we may not have previously considered," she said. "If you're from California and you tell me

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you're interested in Chicago, in February, you worry. But maybe not. Unless I have a reason to believe that you are. And so, signals can help with that."

FREIDA™, the AMA's comprehensive residency and fellowship database, includes more than 13,000 Accreditation Council for Graduate Medical Education-accredited residency programs and offers a streamlined user experience.

Find the perfect Match

Podcast: Meet your Match step-by-step residency selection guide

Video: How to choose the best residency program for you

Specialty guide: Simplify your specialty selection for residency

Video playlist: Members-only access to professional development from AMA Ed Hub™

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Exhibit 19:
NRMP_00004565
Applicant Match History

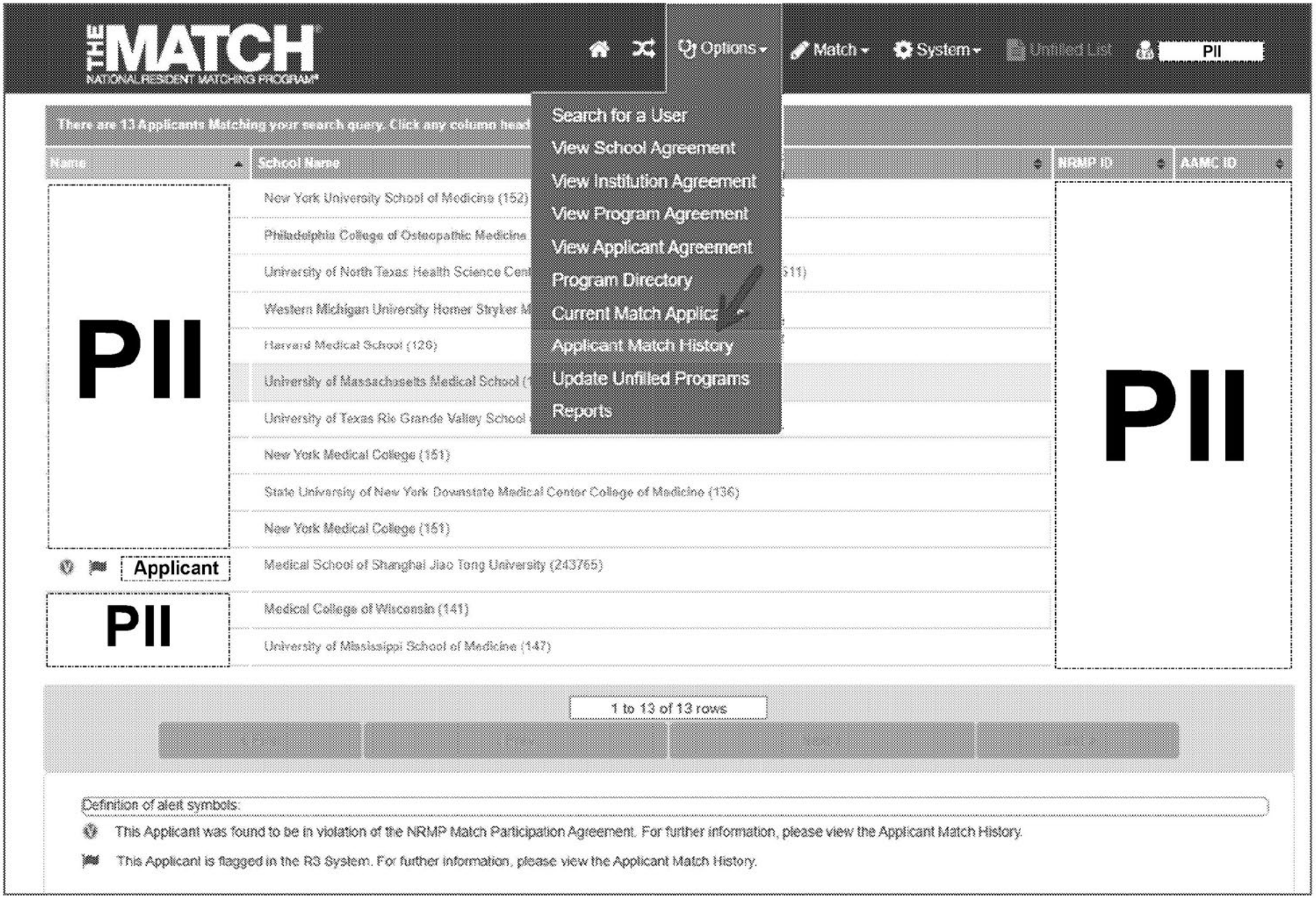
THE MATCH
NATIONAL RESIDENT MATCHING PROGRAM
Options
Match
System
Unfilled List
PII
Search for a User
View School Agreement
View Institution Agreement
View Program Agreement
View Applicant Agreement
Program Directory
Current Match Applica
Applicant Match History
Update Unfilled Programs
Reports
There are 13 Applicants Matching your search query. Click any column head
Name
School Name
NRMP ID
AAMC ID
New York University School of Medicine (152)
Philadelphia College of Osteopathic Medicine
University of North Texas Health Science Cen
Western Michigan University Homer Stryker M
Harvard Medical School (126)
University of Massachusetts Medical School
University of Texas Rio Grande Valley School
New York Medical College (151)
State University of New York Downstate Medical Center College of Medicine (136)
New York Medical College (151)
Medical School of Shanghai Jiao Tong University (243765)
Medical College of Wisconsin (141)
University of Mississippi School of Medicine (147)
PII
Applicant
1 to 13 of 13 rows
Definition of alert symbols:
This Applicant was found to be in violation of the NRMP Match Participation Agreement. For further information, please view the Applicant Match History.
This Applicant is flagged in the R3 System. For further information, please view the Applicant Match History.

Exhibit 20:
NRMP_00004566
Match Violator Message

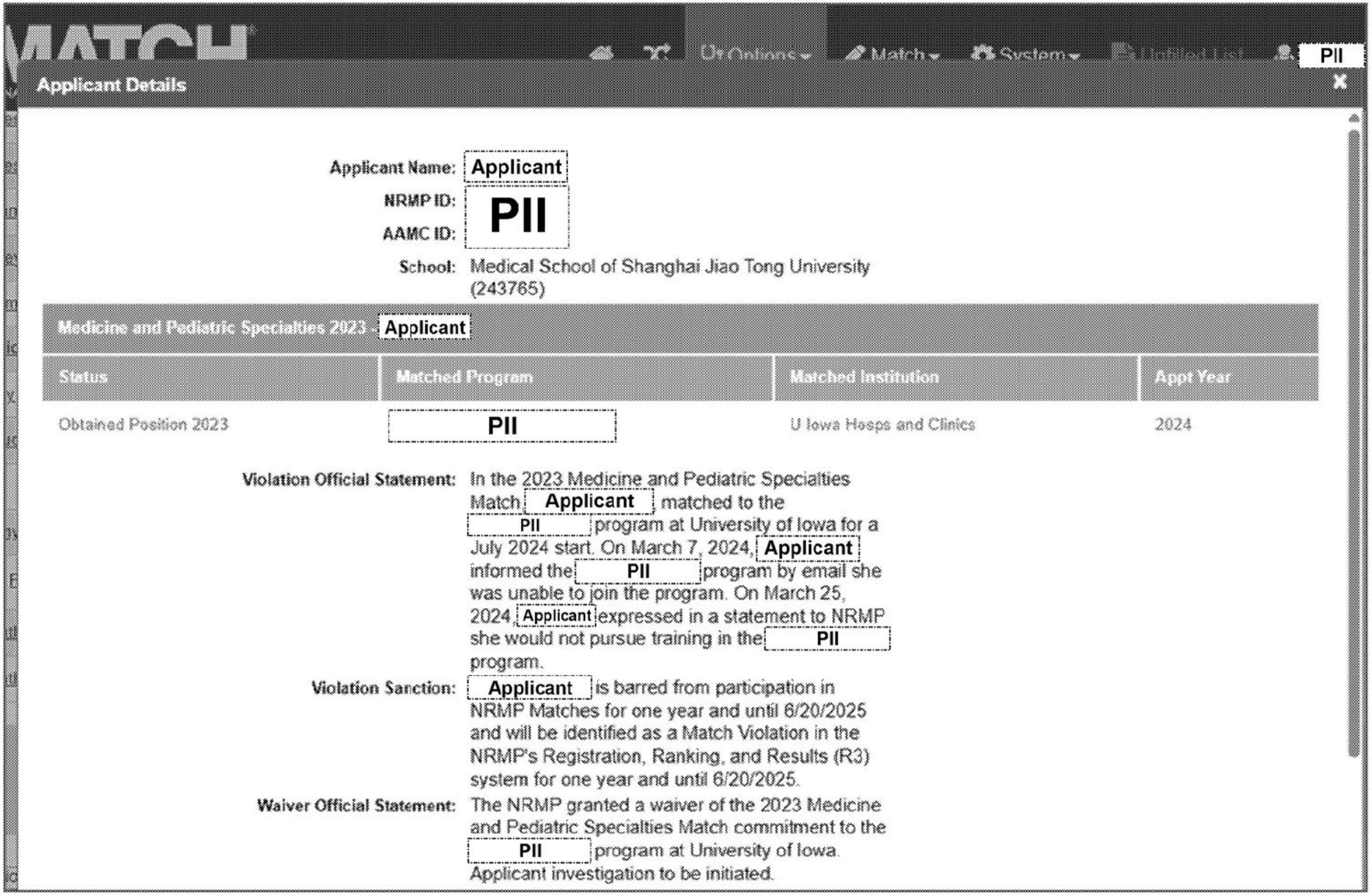
MATCH
Applicant Details
Applicant Name: Applicant
NRMP ID:
AAMC ID:
PII
School: Medical School of Shanghai Jiao Tong University (243765)
Medicine and Pediatric Specialties 2023 - Applicant
Status
Matched Program
Matched Institution
Appt Year
Obtained Position 2023
PII
U Iowa Hosps and Clinics
2024
Violation Official Statement: In the 2023 Medicine and Pediatric Specialties Match, Applicant, matched to the PII program at University of Iowa for a July 2024 start. On March 7, 2024, Applicant informed the PII program by email she was unable to join the program. On March 25, 2024, Applicant expressed in a statement to NRMP she would not pursue training in the PII program.
Violation Sanction: Applicant is barred from participation in NRMP Matches for one year and until 6/20/2025 and will be identified as a Match Violation in the NRMP's Registration, Ranking, and Results (R3) system for one year and until 6/20/2025.
Waiver Official Statement: The NRMP granted a waiver of the 2023 Medicine and Pediatric Specialties Match commitment to the PII program at University of Iowa. Applicant investigation to be initiated.

Exhibit 21:
SJC-AMA-000000749
What to Know About SOAP's Last-Minute Match Options

www.ama-assn.org /medical-students/preparing-residency/what-know-about-soaps-last-minute-match-options

What to know about SOAP's last-minute Match options

AMA News Wire

Feb 26, 2025

Monday of Match Week can bring disappointing news for some medical students participating in the 2025 Main Residency Match®. A small percentage of residency applicants will find out on that date—March 17—that they did not match. While time and space are limited, there is hope for those students who do not match.

The Supplemental Offer and Acceptance Program® (SOAP®) is a vehicle through which eligible unmatched and partially matched applicants in the Main Residency Match apply for and are offered positions that were not filled when the matching algorithm was initially processed. On Monday morning of Match Week, applicants learn whether, but not where, they matched. Match status notifications will be sent by email. To apply to an unfilled position through SOAP, applications are submitted through the Association of American Medical Colleges (AAMC) Electronic Residency Application Service® (ERAS®).

Get ready for Match Week

Access timely resources from the AMA to help you successfully navigate Match Week and beyond.

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Start Reading

In 2025, SOAP runs March 17–20. There are multiple SOAP Offer Rounds. In each Offer Round, applicants have two hours to accept or reject offers in the system. Offers not accepted or rejected expire automatically. As has been the case since the 2021 application cycle, a fourth offer round has been added to SOAP. The rationale behind that decision, according to the National Resident Matching Program (NRMP), is that there has been an increase in the number of unfilled positions remaining after the SOAP process.

FREIDA™, the AMA Residency & Fellowship Database® , enables unmatched students to research residencies from more than 13,000 programs both during and following SOAP. Access is free, but extra benefits—such as a dashboard that helps users save, rank and keep notes on each program—are available to AMA members.

Veterans of the Match process offered guidance for medical students who may have to enter SOAP. Here are some of the most relevant nuggets of advice.

Should I use SOAP to find a position in a specialty that's not my first choice?

Should I use SOAP to find a position in a specialty that's not my first choice?

"As an applicant, you have to decide whether the specialty you aspired to match into is something you will try for again or whether you will be happy in something else as well," said AMA member Christopher Libby, MD, MPH, "You can't begin to form a strategy if you don't answer that first."

Dr. Libby advised that applicants who are at risk of not Matching assess their application.

"Most, not all, U.S. applicants who did not match have a weakness in their application," he said. If it is a board score or some disciplinary action, then some competitive specialties may not be realistic, especially in the SOAP."

One method to determine is to do a modified SWOT (strengths, weaknesses, opportunities, threats) analysis.

Ask yourself "What are the strengths of practicing this specialty? What are the weaknesses that I would not enjoy, said Dr. Libby an emergency medicine physician at Cedars-Sinai in Los Angeles.

"What about this clinically would I not like? What are the opportunities available in the specialty that would appeal to what I liked about emergency medicine? What are the threats to the other aspects of my life based on this specialty?"

If you are certain you want to reapply to the specialty in which you did not match, Dr. Libby offered that medical students might want to pursue a preliminary residency.

Dive deeper:

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- If you don’t match, take these 5 tips from a SOAP survivor
- Match: Which specialties place most residents through SOAP
- “Meet Your Match”: How to find a position through SOAP
- What to know about preliminary, advanced GME positions

Get residency-ready with AMA benefits

- Find your perfect match using full features of FREIDA™, the AMA Residency & Fellowship Database®
- Distinguish yourself with AMA leadership opportunities

Supporting you today as a medical student. Protecting your future as a physician.

Join the AMA Today

If I get an offer through SOAP, should I take it?

If I get an offer through SOAP, should I take it?

“I definitely recommend a student take the first offer they receive, rather than wait for the second round” of SOAP, said Nicole Deiorio, MD, professor and associate dean, student affairs in undergraduate medical education at Virginia Commonwealth University. “The availability of openings goes down dramatically for the second round, so it doesn't make [strategic] sense to “hold out for something better.”

“In general, I also recommend applicants use all 45 applications in the first round [of SOAP], although this should be discussed on a case-by-case basis with an adviser.”

The AMA Road to Residency series provides medical students, international medical graduates and others with guidance on preparing for residency application, acing your residency interview, putting together your rank-order list and more.

Dive deeper:

How should you decide where to apply?

How should you decide where to apply?

After not matching in orthopaedic surgery, AMA member Victoria Gordon, DO, was able to find an emergency medicine position through SOAP. While acting quickly is key, she said you should still consider your personal preferences where you can.

“SOAP applicants are given 45 tokens,” Dr. Gordon said during a recording “Meet Your Match” series, as part of the “AMA Making the Rounds” podcast. “You might as well put all your chances out there.”

“I didn't apply anywhere I didn't want to live because if I was going to be changing specialties and changing my life, I wanted to have at least a benefit in location or type of program.”

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Follow the road to residency

Get tips and insider advice from the AMA on how to successfully Match to a residency program—delivered to your inbox.

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Exhibit 22:
AAMC Exhibit 52
Navigating Match Week and SOAP

Navigating Match Week and SOAP

March 3, 2023

[redacted] NRMP Chief of Match Operations
[redacted] ERAS Senior Training Specialist

Agenda

- What is SOAP?
- SOAP Policies/Communication
- Preparing for SOAP
- ERAS PDWS
- Creating a Preference List
- How SOAP Rounds Work
- Monitoring & Updating Preference Lists
- Updating the List of Unfilled Programs
- Post SOAP and Match Day!

WHAT IS SOAP®

- Supplemental Offer and Acceptance Program® (SOAP®)
- Programs review ERAS® applications, contact applicants, and express preferences with lists created in the R3® system.
- Unfilled positions are offered to eligible applicants on the program's preference list in a series of four rounds.
- It is NOT another Match.
- Positions offered and accepted constitute a binding commitment under the Match Participation Agreement.

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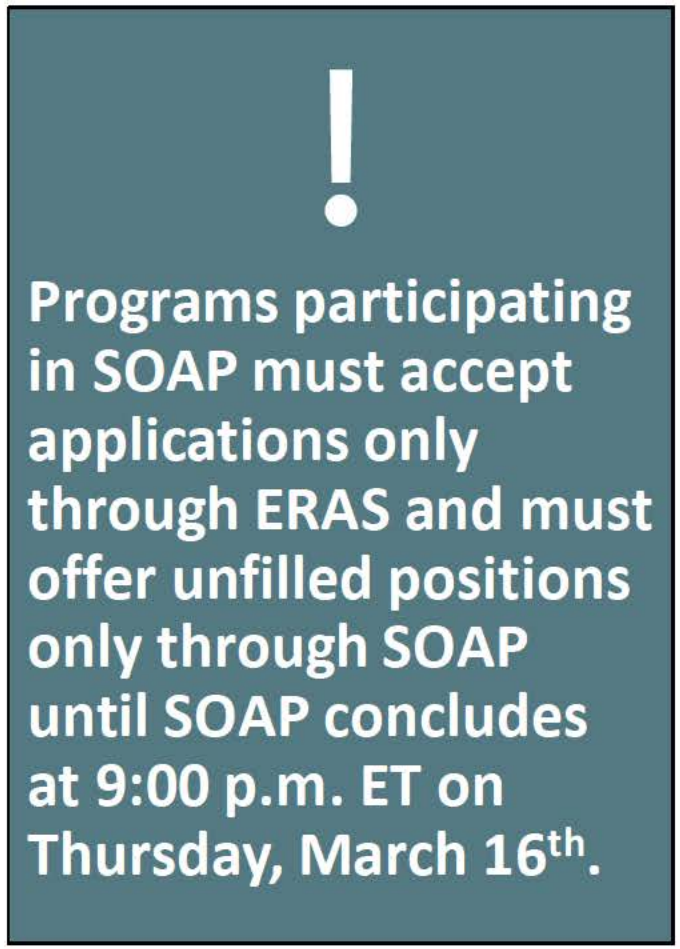
SOAP POLICIES



- Programs cannot contact applicants or their representatives until an application is received.
- Programs cannot ask applicants to indicate whether they will accept an offer if one is extended through SOAP.
- Programs cannot contact SOAP-ineligible applicants until SOAP concludes.
- Programs that opt out of SOAP participation CANNOT extend offers until after SOAP concludes.
- Programs can create positions for partially-matched applicants after SOAP concludes.

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APPLICANT COMMUNICATION DURING SOAP

SOAP-eligible applicants:

- Can access the *List of Unfilled Programs* only for positions for which they are eligible.
- Can apply only to unfilled Match-participating programs that are participating in SOAP.
- Are prohibited from using any means other than an ERAS application to apply to and contact programs.
- Must refrain from communicating with programs until the program contacts the applicant
- Can receive multiple offers in a SOAP round.

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PREPARING FOR SOAP

- ✓ View the videos and SOAP resources on the NRMP web site so you fully understand SOAP policy and functionality.
- ✓ Update Public Contact Information for your program in the R3 system.
- ✓ Identify staff to participate, if necessary, and ensure that those staff understand SOAP policies and procedures.
- ✓ Subscribe to the NRMP & ERAS SOAP and Match Week Listserv.

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MATCH WEEK AND SOAP SCHEDULE

Monday, March 13

10:00 A.M. ET	Programs learn if they filled Applicants learn if they matched
11:00 A.M. ET	SOAP applicants can start preparing and sending applications via ERAS

Tuesday, March 14

8:00 A.M. ET	Programs can begin viewing SOAP applications in ERAS and can contact applicants upon receipt of an application
11:30 A.M. ET	Programs can begin creating preference lists in the R3 system

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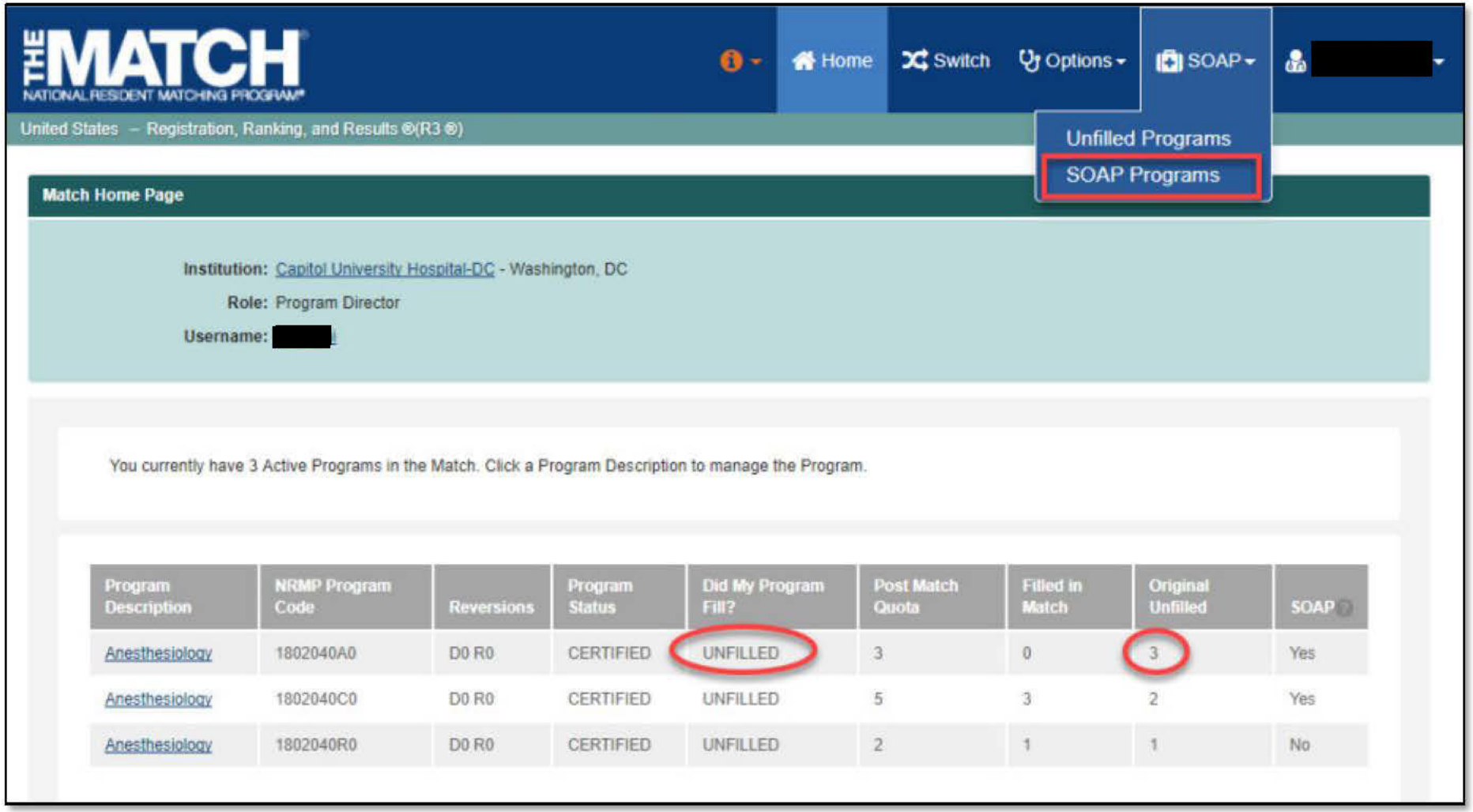
VIEWING UNFILLED STATUS



Program Description	NRMP Program Code	Reversions	Program Status	Did My Program Fill?	Post Match Quota	Filled in Match	Original Unfilled	SOAP
Anesthesiology	1802040A0	D0 R0	CERTIFIED	UNFILLED	3	0	3	Yes
Anesthesiology	1802040C0	D0 R0	CERTIFIED	UNFILLED	5	3	2	Yes
Anesthesiology	1802040R0	D0 R0	CERTIFIED	UNFILLED	2	1	1	No

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Using the PDWS during 2023 Supplemental Offer and Acceptance Program® (SOAP®)

[redacted]
ERAS Senior Training Specialist

SOAP Preparation in ERAS

The Supplemental Offer and Acceptance Program (SOAP) is a collaborative effort managed by the National Residency Matching Program® (NRMP®) during Match week.

To participate in SOAP your program must:

In ERAS®:	In NRMP:
Within ERAS Account Maintenance (EAM), • Program is listed as *Participating* for ERAS 2023 • Entered the NRMP ID for all training track(s) for the NRMP Match	• Registered with the NRMP • Unfilled positions in the NRMP's Main Residency Match
Contact the ERAS Client Technical Support at 202-828-0413 or using the *ERAS Support Contact Form*	Contact the NRMP Support at 866-653-6767 or *support@nrmp.org*

SOAP Schedule as of March 10, 2023

Monday

March 13

7:30 a.m. ET
Applicants: MyERAS closes
Programs: PDWS closes
Schools: DWS closes

11 a.m. ET
Applicants: MyERAS opens for SOAP (SOAP applicants have 45 applications starting now through Thursday 9 pm ET)
Schools: DWS opens

Tuesday

March 14

8 a.m. ET
Programs: PDWS opens (Except ACGME Residency programs that filled in the Main Match or elected to not participate in SOAP)

11:30 a.m. ET
Programs: Can begin creating preference list in NRMP® R3 system

Wednesday

March 15

All Day
Applicants continue to apply to programs.

Programs continue to review applications in the PDWS and update preference lists in the NRMP R3 system.

Thursday

March 16

9-11 a.m. ET
NRMP SOAP Round 1

12-2 p.m. ET
NRMP SOAP Round 2

3-5 p.m. ET
NRMP SOAP Round 3

6-8 p.m. ET
NRMP SOAP Round 4

9 p.m. ET
SOAP Ends; ERAS resumes normal operations
Programs: PDWS is opened for all programs

NRMP Releases unfilled program list to applicants

NRMP Releases Confidential Roster of Matched Applicants to Programs

Friday

Match Day—March 17

12 p.m. ET
School ceremonies begin

12 p.m. ET
Applicants: Find out where they matched through the NRMP R3 system and email

Note: *Fully matched programs participating in the Main Residency Match® will not have access to the PDWS until after SOAP (Thursday, March 16, 9 pm ET).*

SOAP Indicator in the PDWS

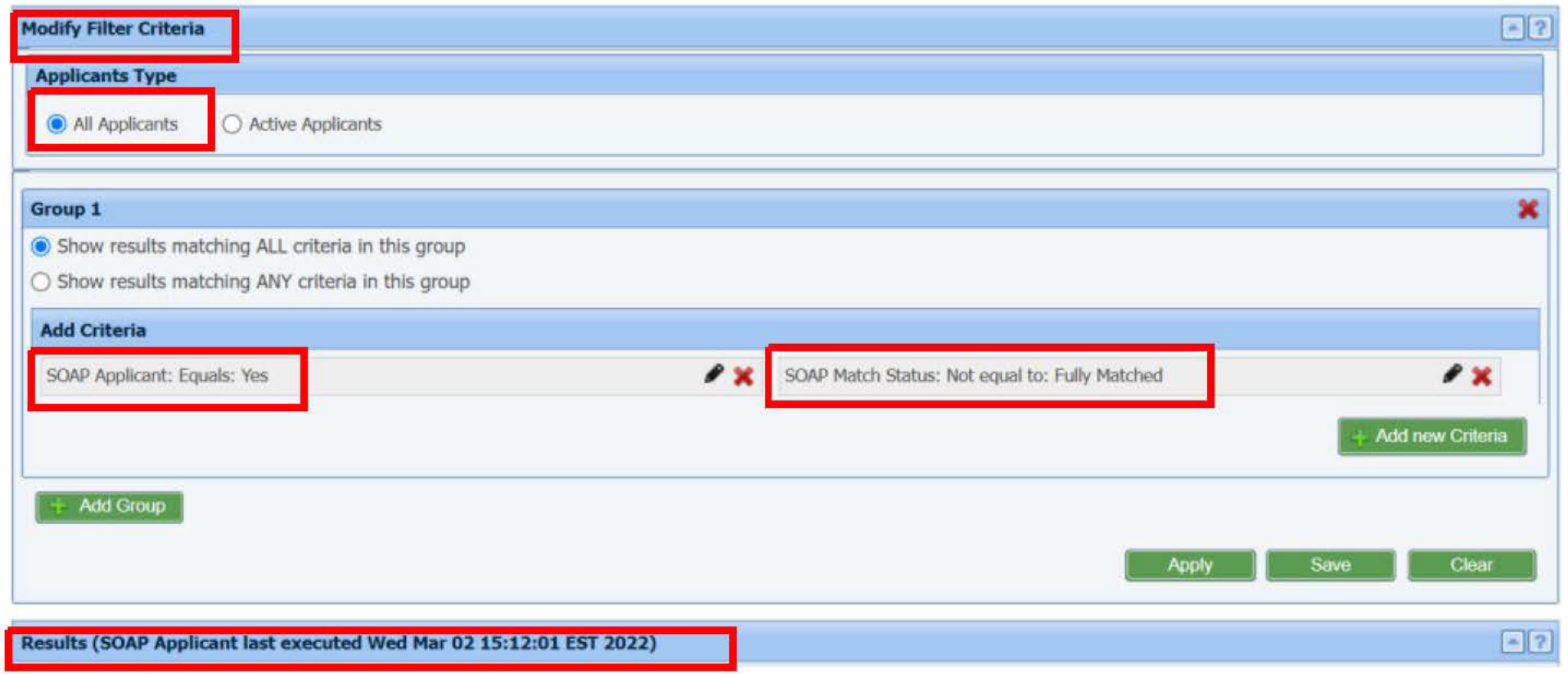
The SOAP indicator (a light bulb) will appear next to applicants that applied to your program during SOAP in View Current Results, View Applications, Scheduler, and Rankings.

System-Defined Filters in the PDWS

Use SOAP System-Defined Filters to limit your applicant pool to SOAP applicants

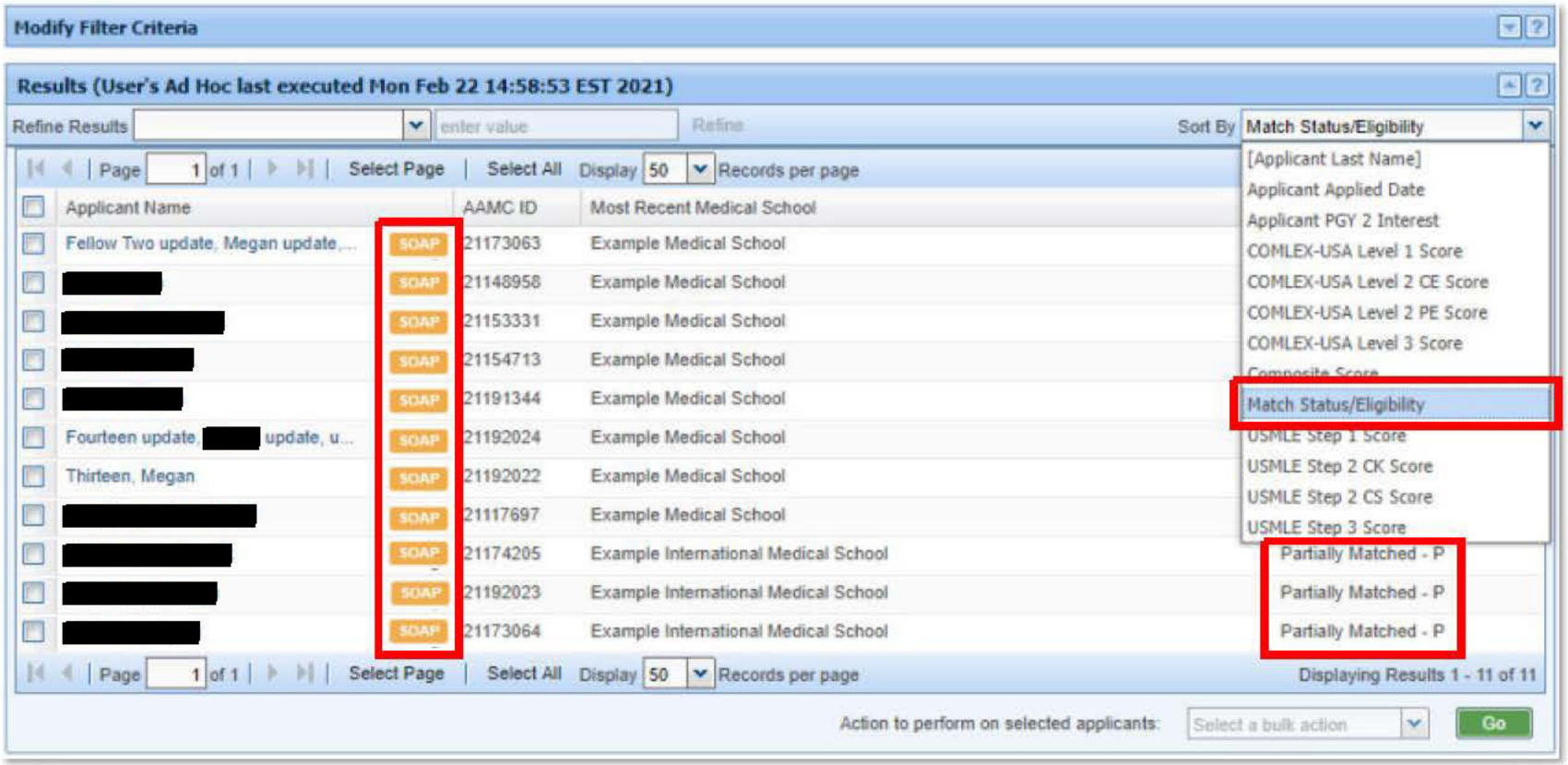
Review Filter Criteria

Review the filter criteria to understand your applicant pool



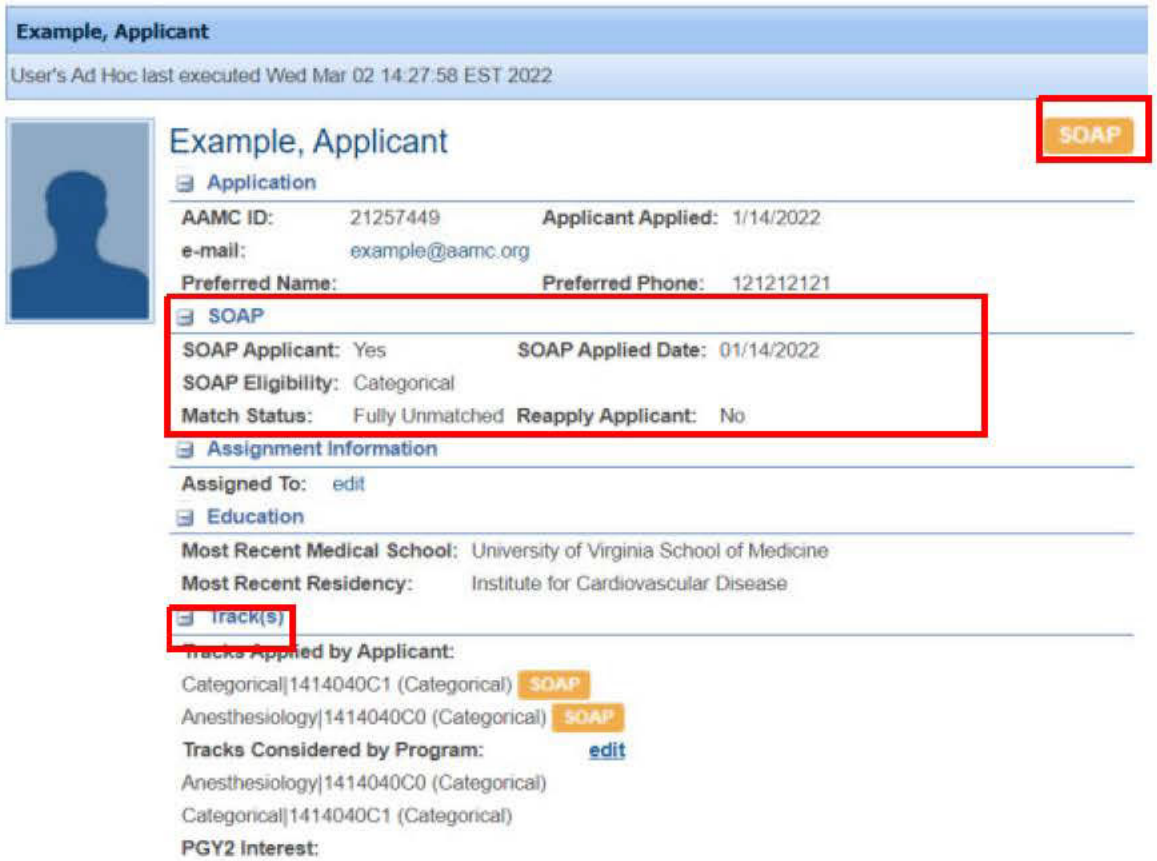
Filter Applicants in the PDWS

After you run a filter, you can sort applicants by their Match Status/Eligibility. The SOAP indicator will display next to SOAP applicants



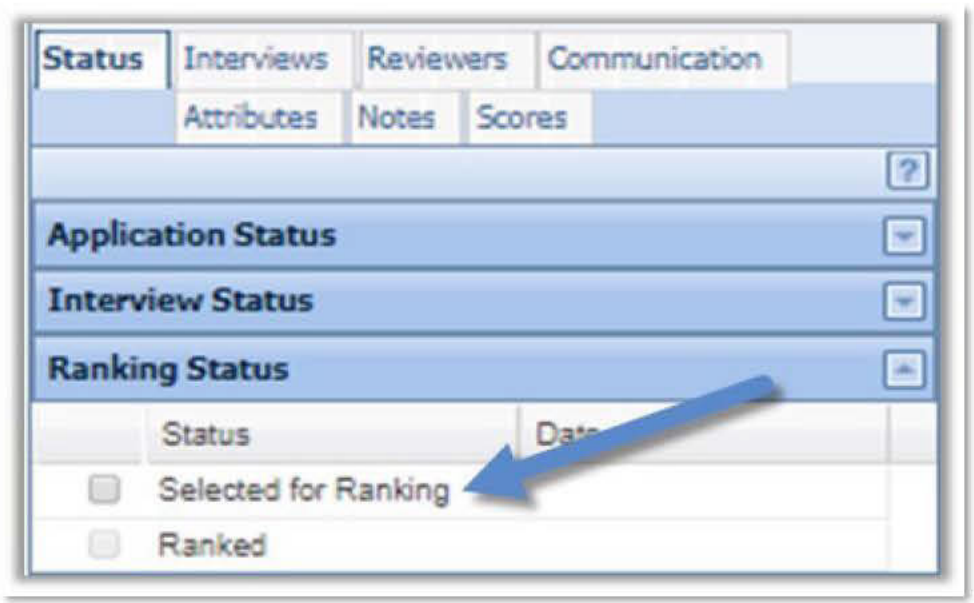
View Applications in the PDWS

- The SOAP header displays the applicant's SOAP Eligibility and Match Status.
- The Track(s) header displays specific tracks the applicant applied to during SOAP



Rank Applicants in the PDWS

As you evaluate applicants, check the Selected for Ranking status for applicants you are interested in offering a position. In Rankings, you can easily drag applicants up and down the rank list to order the applicants



Next Steps after SOAP

EAM Participating Status

- If applicable, change status to No Longer Accepting

Residency Management System (RMS)

- Authorize vendor at institution level
- Will Start status

End of the season on Wednesday, May 31 at 5 p.m. ET

https://connect.aamc.org/resourcelibraries/resourcelibraries

Need Assistance?

- (202) 828-0413
- Monday, Wednesday, Friday: 8 a.m. – 6 p.m.ET
- **Tuesday: 7 a.m. – 6 p.m. ET**
- Thursday: 8 a.m. – 9 p.m. ET

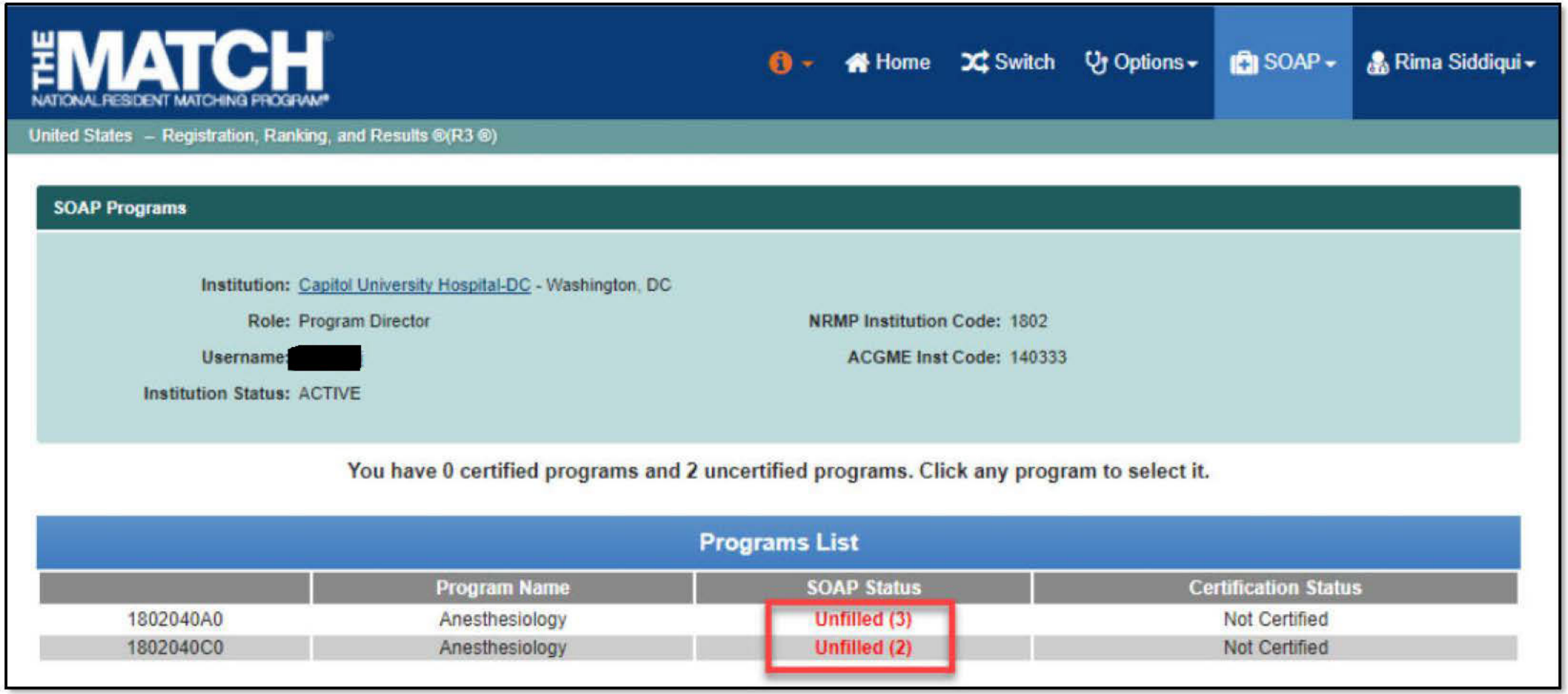
For additional resources and support

- *ERAS Community Site*
- *Joint ERAS NRMP SOAP Guide for Programs*
- *ERAS Communications by Email*
- *NRMP/ERAS SOAP Listserv*

https://www.aamc.org/contact-eras

AAMC

CREATING A PREFERENCE LIST



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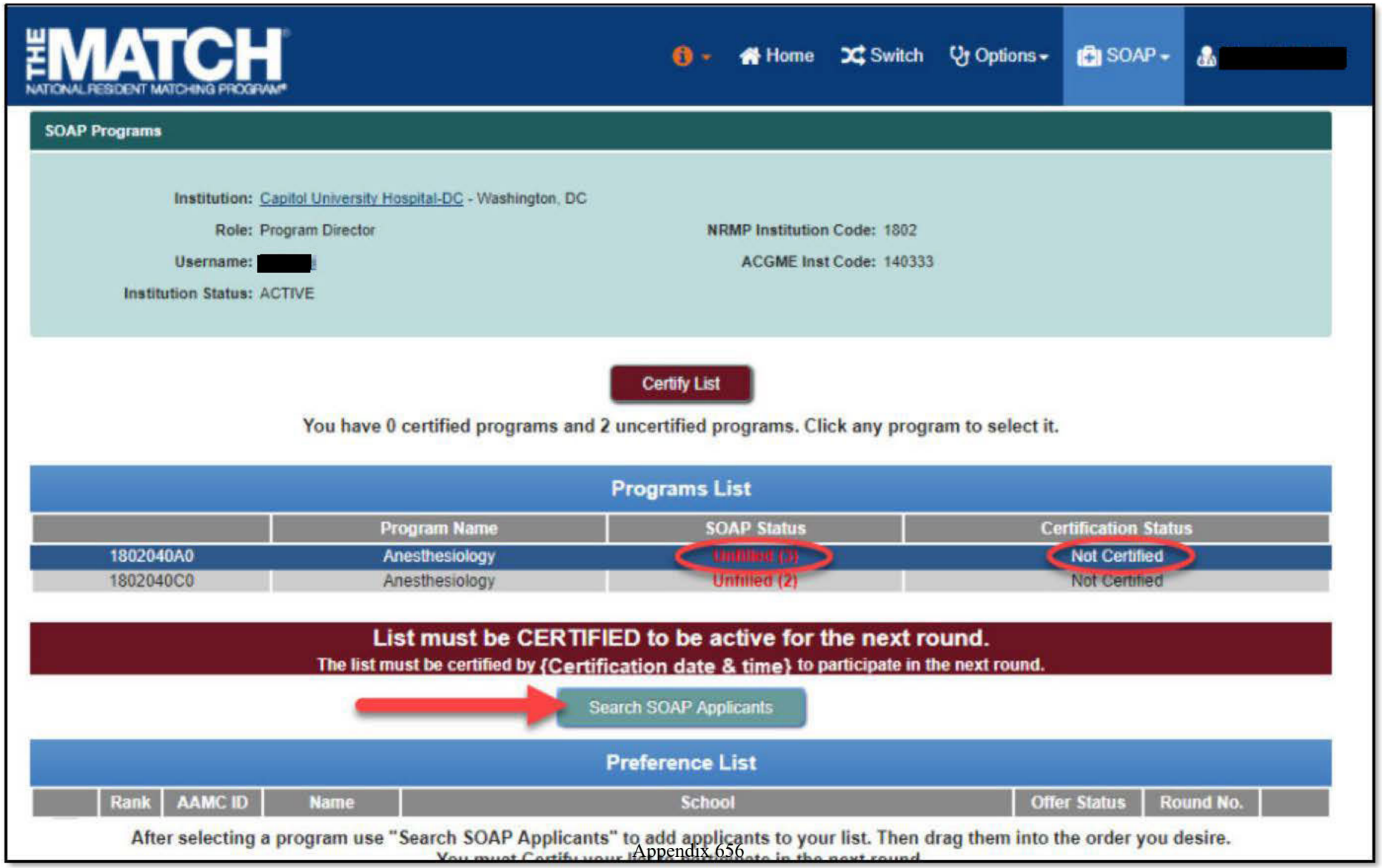
CREATING A PREFERENCE LIST



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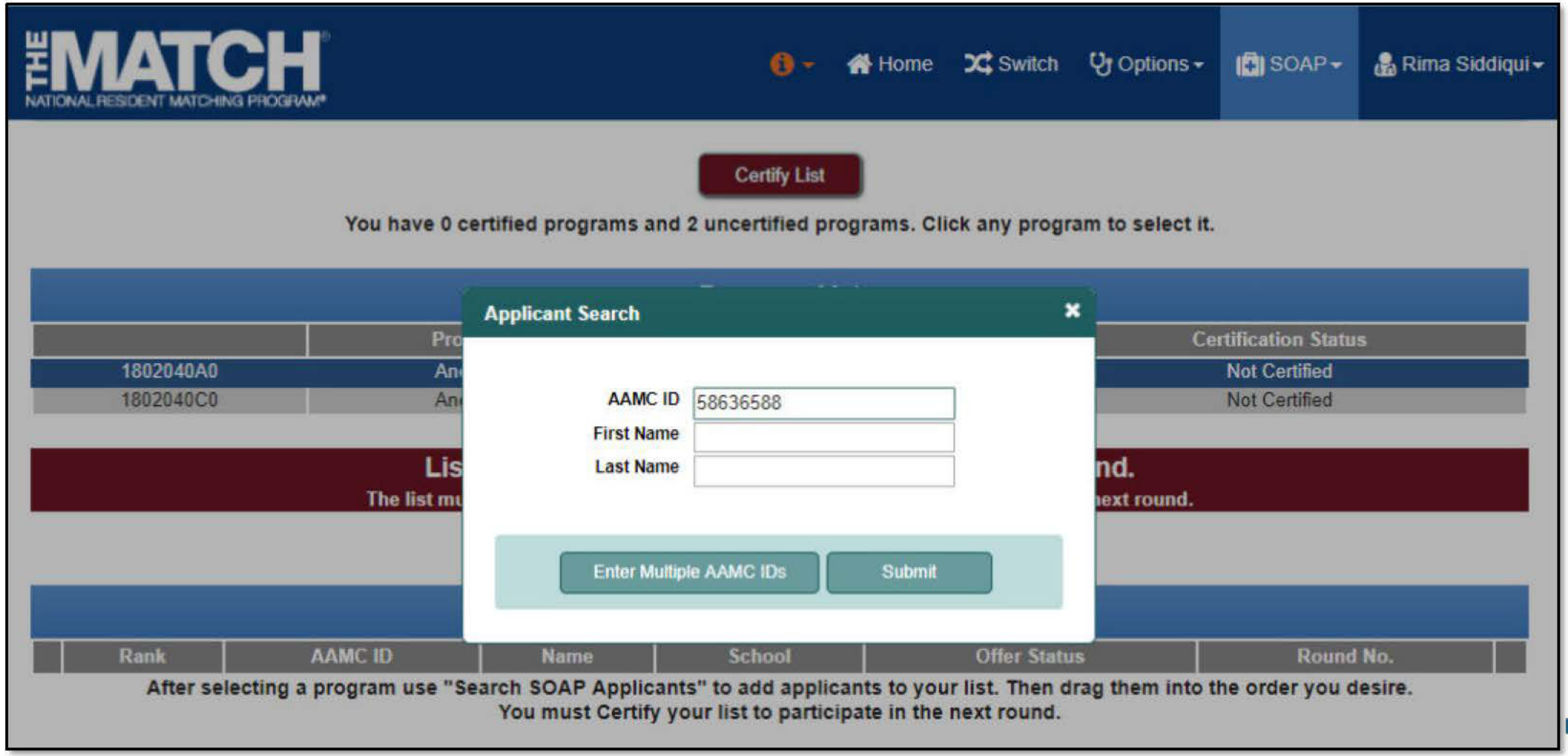
CREATING A PREFERENCE LIST



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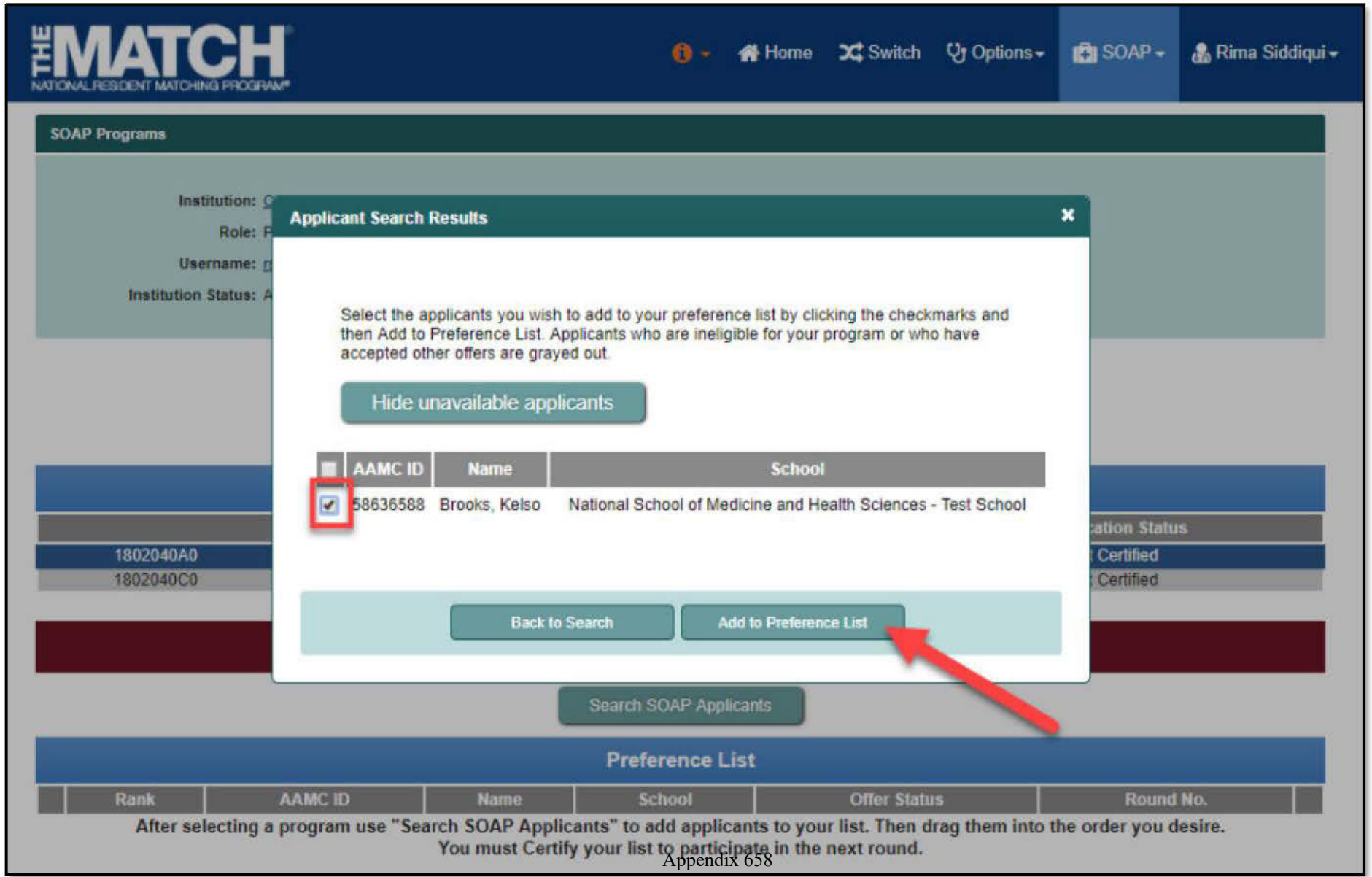
CREATING A PREFERENCE LIST



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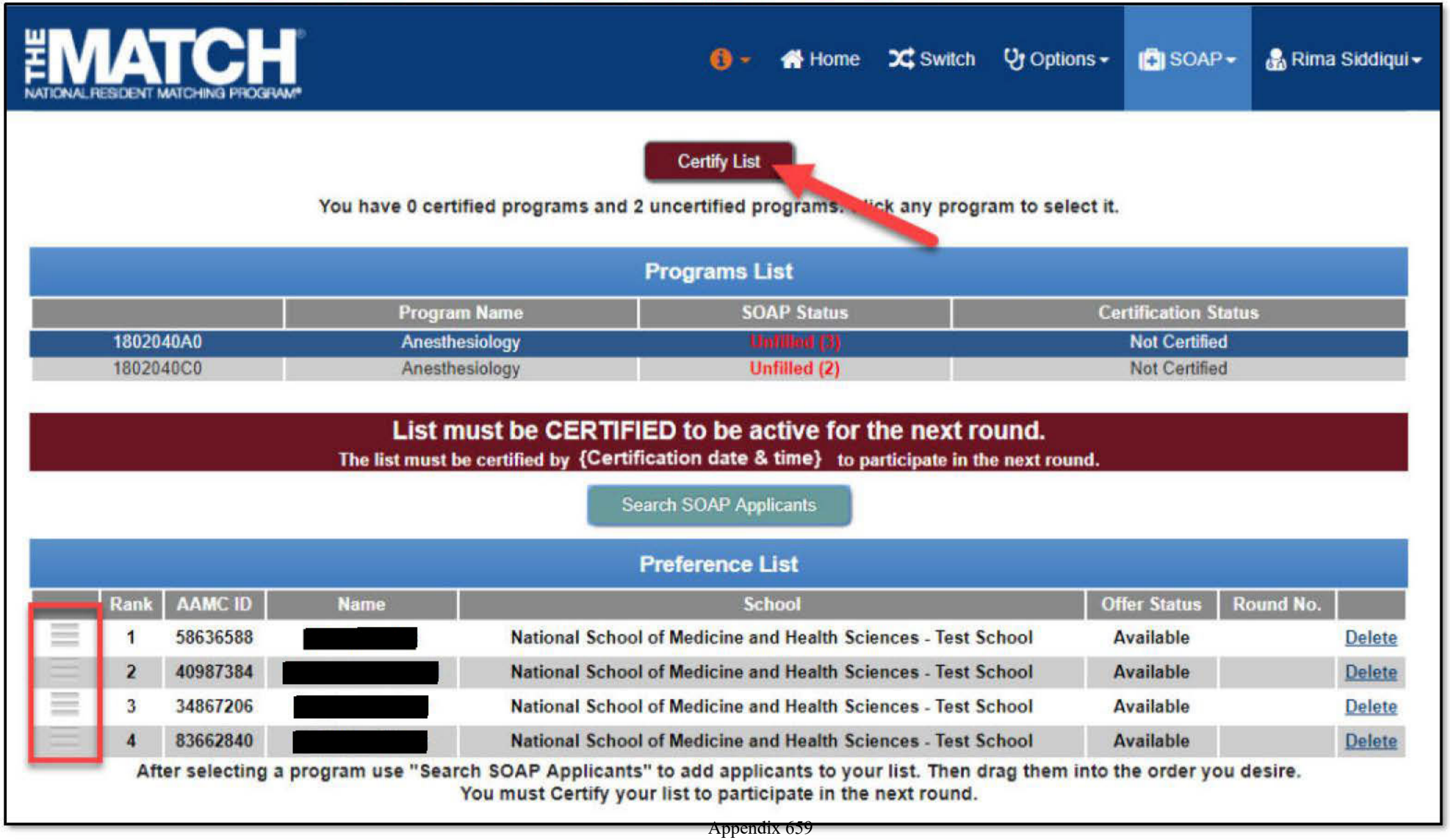
CREATING A PREFERENCE LIST



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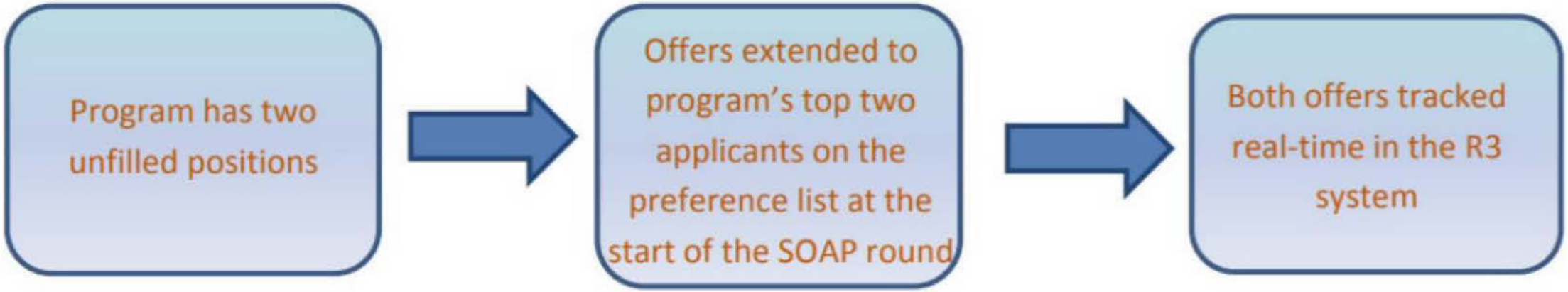
HOW SOAP ROUNDS WORK



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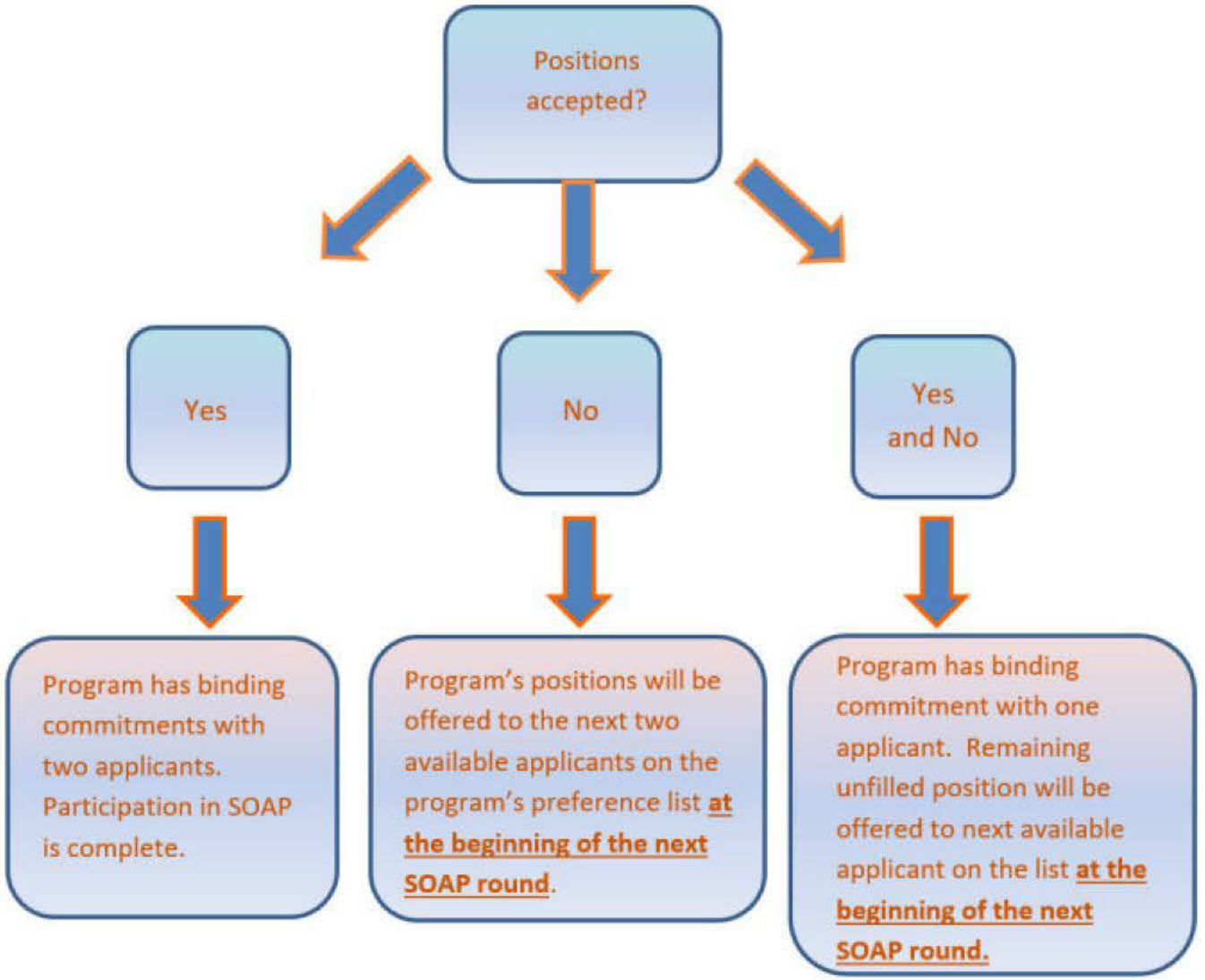
HOW SOAP ROUNDS WORK



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OFFER ROUNDS THURSDAY, MARCH 16

Round 1 9:00 – 11:00 a.m.

8:55 a.m.	Deadline to certify preference list for Round 1 offers
9:00 a.m.	Applicants receive offers
11:00 a.m.	Applicant deadline to accept or reject offers

Round 2 12:00 - 2:00 p.m.

11:55 a.m.	Deadline to modify and re-certify preference list for Round 2 offers
12:00 p.m.	Applicants receive offers
2:00 p.m.	Applicant deadline to accept or reject offers

Round 3 3:00 – 5:00 p.m.

2:55 p.m.	Deadline to modify and re-certify preference list for Round 3 offers
3:00 p.m.	Applicants receive offers
5:00 p.m.	Applicant deadline to accept or reject Round 3 offers

Round 4 6:00 – 8:00 p.m.

5:55 p.m.	Deadline to modify and re-certify preference list for Round 4 offers
6:00 p.m.	Applicants receive offers
8:00 p.m.	Applicant deadline to accept or reject Round 4 offers

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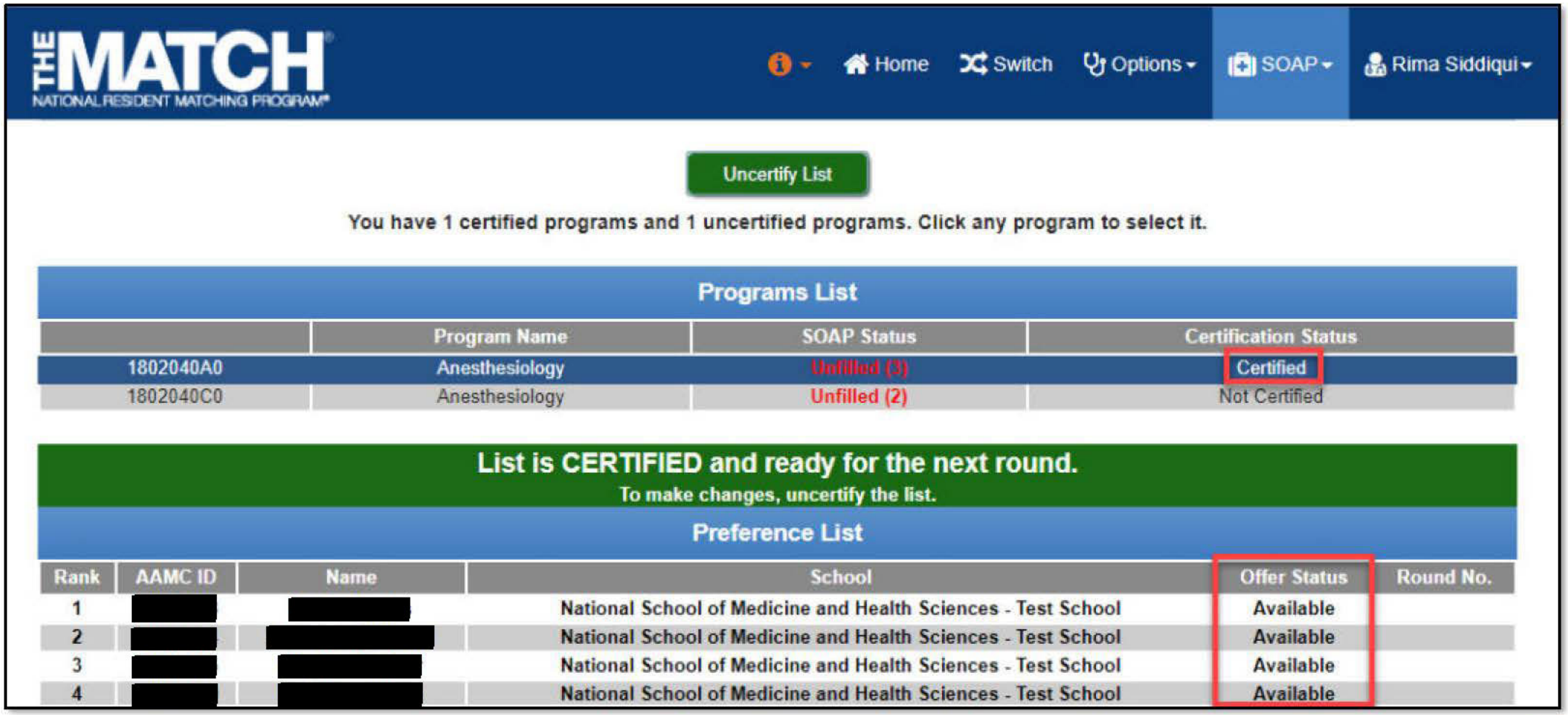
MONITORING & UPDATING PREFERENCE LISTS



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MONITORING & UPDATING PREFERENCE LISTS

SOAP Programs

Institution: Henrico Univ Hlth Sys-VA - Richmond, VA
Role: Program Director
NRMP Institution Code: 1743
Username: dcarr123
ACGME Inst Code: 140666
Institution Status: ACTIVE

Uncertify List

You have 1 certified programs and 0 uncertified programs. Click any program to select it.

Programs List

	Program Name	SOAP Status	Certification Status
1743320C0	Pediatrics	Unfilled (2)	Certified

List is CERTIFIED and ready for the next round.
To make changes, uncertify the list.

Preference List

Rank	AAMC ID	Name	School	Offer Status	Round No.
	[redacted]		National School of Medicine and Health Sciences - Test School	Accepted	1
			National School of Medicine and Health Sciences - Test School	Accepted	1
			National School of Medicine and Health Sciences - Test School	Offer Sent	1
1			National School of Medicine and Health Sciences - Test School	Available	
			National School of Medicine and Health Sciences - Test School	Rejected	1
			National School of Medicine and Health Sciences - Test School	Unavailable	

After selecting a program use "Search SOAP Applicants" to add applicants to your list. Then drag them into the order you desire.
You must Certify your list to participate in the next round.

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AFTER THE ROUNDS

Thursday, March 16

8:30 P.M. ET	Programs can update the number of unfilled positions to be displayed on the *List of Unfilled Programs*
9:00 P.M. ET	**SOAP Ends** Updated *List of Unfilled Programs* available to applicants to include remaining unfilled SOAP programs and unfilled programs not participating in SOAP

Note: Program *Confidential Roster of Matched Applicants* will be released (by email and R3 system) on at 2:00 p.m. ET.

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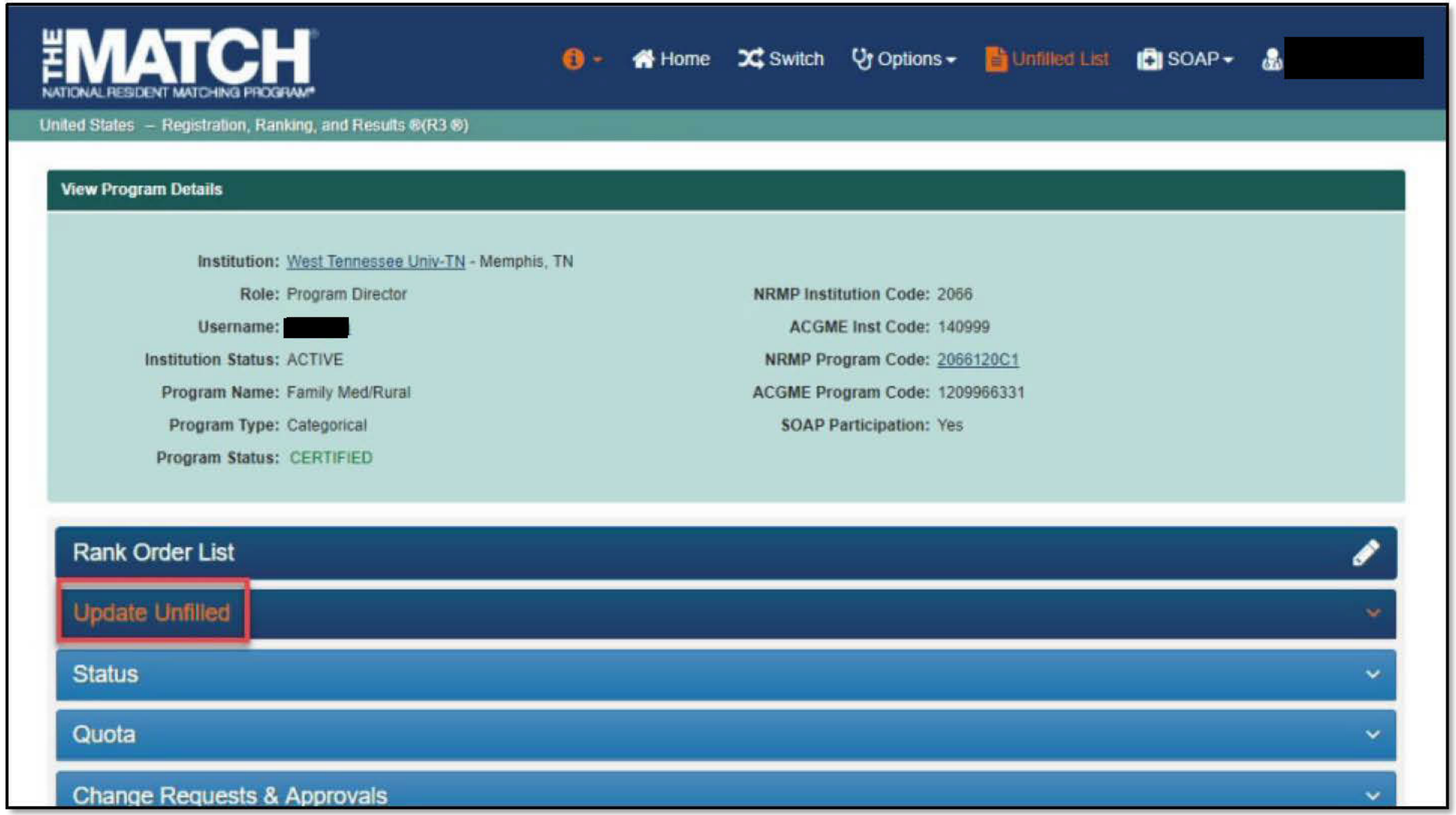
UPDATING THE LIST OF UNFILLED PROGRAMS



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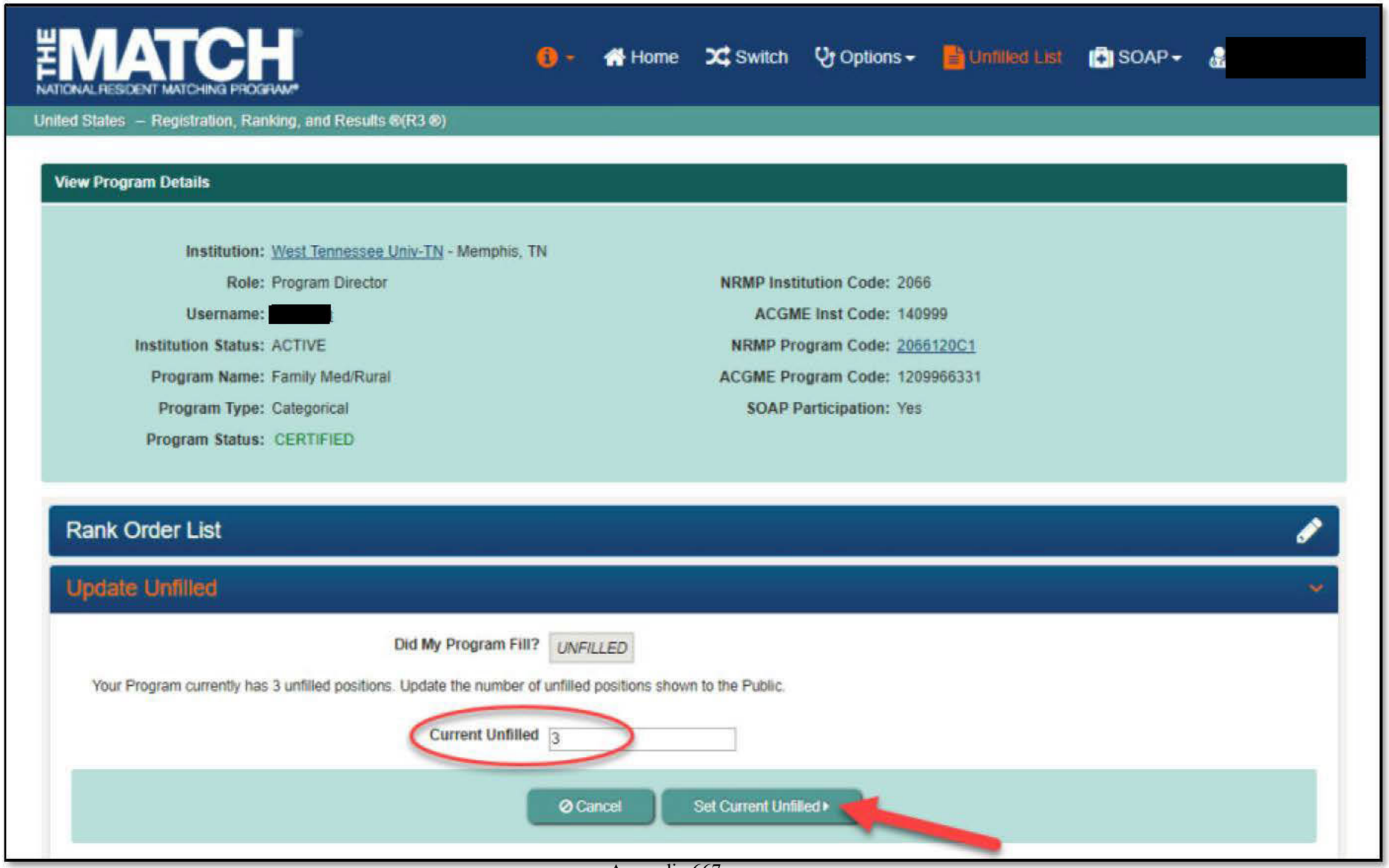
UPDATING THE LIST OF UNFILLED PROGRAMS



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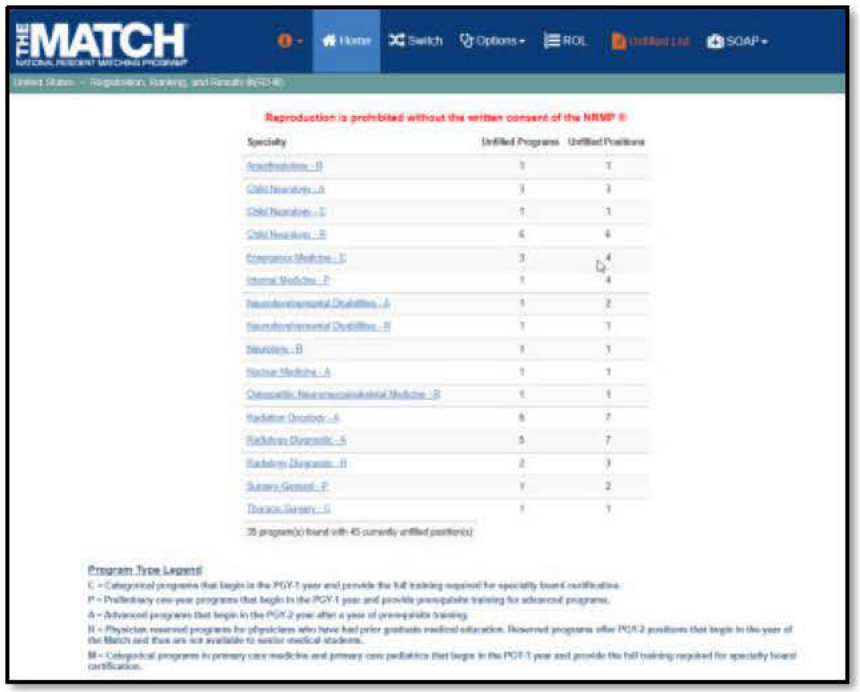
POST SOAP

All applicants who are unmatched or partially matched will have access to the *List of Unfilled Programs.*

Applicants apply to remaining unfilled programs through ERAS.

Programs can create positions ONLY for partially-matched applicants beginning at 9:00 p.m. Eastern Time on Thursday



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MATCH DAY!

Friday, March 17

12:00 P.M. ET	Medical school Match Day ceremonies
	Program *Match Results by Ranked Applicant* and *SOAP Programs Preferred Applicants* available in R3 under Options ⟹ Reports
	Applicant Match results available
	Advance Data Tables available

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PRINT & SAVE YOUR RESULTS

The Main Residency Match closes in the R3 system at 11:59 p.m. ET on June 30.

- Match reports will no longer be available after June 30.
- Print, save, and archive Match reports for future use.
- NRMP charges $200 per report after the Match has closed in the R3 system, and only *Match Results by Ranked Applicants* and *Characteristics of Matched Applicants* reports will be available.

THE MATCH

Confidential Roster of Program's Matched Applicants

Main Residency Match - 2021

Appointment Year 2021

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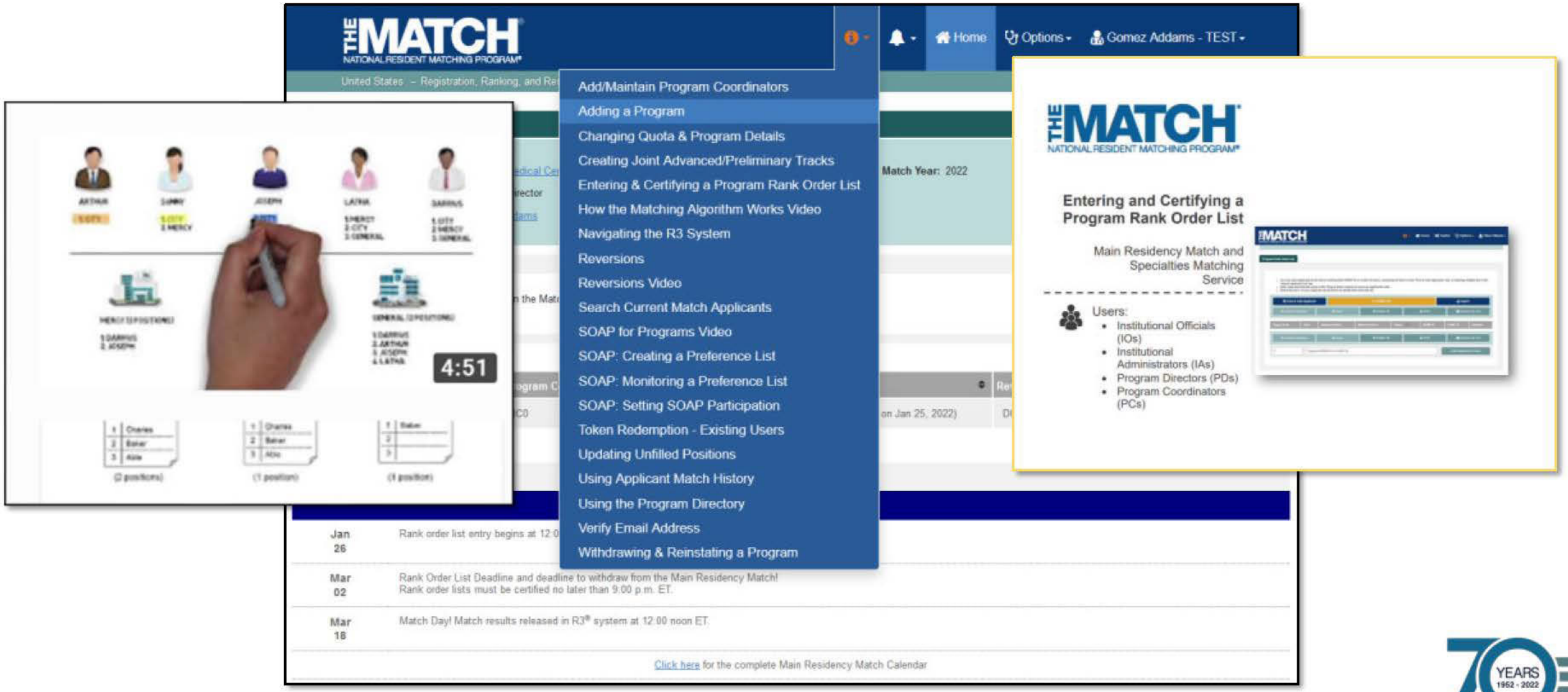
VIDEO RESOURCES & SUPPORT GUIDES



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Questions?

THANK YOU and Good Luck in the Match!

www.nrmp.org
support@nrmp.org
866-653-NRMP

www.aamc.org/contact-eras
202-828-0413

Exhibit 23:
AAMC Exhibit 62
ERAS Applicant SOAP FAQs

ERAS® Applicant SOAP® Frequently Asked Questions (FAQ)

PRE-SOAP

Where can I get information about the Match Week Supplemental Offer and Acceptance Program® (SOAP®)?

- Please review information on the National Resident Matching Program® (NRMP®) and ERAS® websites.

Is there anything I can do to prepare for applying to programs during SOAP?

- Please review the ERAS Applicant Checklist for SOAP.

ELIGIBILITY

How do I know if I am eligible to participate in SOAP?

- On Monday, March 17 at 10 a.m. ET, you will learn your match status (by email and the NRMP Registration, Ranking, and Results® (R3®) system). If you are SOAP-eligible unmatched or partially matched, you can access the *List of Unfilled Programs* in the R3 system.

If I have not registered for the ERAS program, can I participate in SOAP?

- Yes, if you are registered with the NRMP, and the NRMP has indicated that you meet the eligibility requirements to participate in SOAP. You will need to get a token from your designated dean's office and register in the ERAS system.
- Once you are registered in the ERAS system and log in on Monday, March 17 at 11 a.m. ET, you will be prompted to confirm your SOAP participation.
- If you **ARE** participating in SOAP, select "I am registered for the NRMP Main Residency Match and am participating in SOAP."
- If you **ARE NOT** participating in SOAP, select "I am not participating in SOAP."
- Applicants who are not participating in SOAP will not be able to take action in the MyERAS® system.
- While we recommend that you certify and submit your MyERAS application prior to the start of the NRMP Match Week and SOAP, you may take this action after the ERAS system opens on Monday, March 17 at 11 a.m. ET.

I'm SOAP-eligible. Can I apply to positions outside of SOAP?

- No. SOAP-eligible applicants can only apply to SOAP-participating programs (those with unfilled positions in the NRMP's Main Residency Match®) via the ERAS program.

How do I know which programs and tracks I am SOAP-eligible for?

- The ERAS system no longer receives applicants' SOAP eligibility information. All programs participating in the NRMP SOAP process will be displayed in the MyERAS system. Please refer to the NRMP R3 system for the list of programs you are eligible for in-between rounds and use the MyERAS Program Search filters for specific tracks and/or NRMP Program codes.

I'm SOAP-ineligible. Can I still apply to programs?

- Yes. During SOAP, you may apply to programs not participating in the Main Residency Match. You will be subjected to the regular application fee structure for ERAS residency applicants.

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FEES

Is there a fee for SOAP?

- If you applied to at least one residency program (for the 2025 ERAS season) by Monday, March 17 at 7:30 a.m. ET, you will **not** pay any application fees during SOAP.

What if I did not apply to a residency program before SOAP? Is there a fee to use the ERAS program?

- If you did not apply to at least one residency program by Monday, March 17, and you are SOAP-eligible, you will be charged a fee of $99. If you have not sent your USMLE or COMLEX-USA transcripts, a fee of $80 per transcript type will apply.

If I use my 45 applications during SOAP, can I pay for additional applications to use during SOAP?

- No, you cannot apply to additional SOAP programs once you have reached the 45-program maximum. Please only apply to tracks you are eligible for and check the NRMP R3 system in between rounds.

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TIMELINE

Where can I find the SOAP schedule?

- Please review the 2025 ERAS SOAP Schedule..

When can I submit applications during SOAP?

- SOAP-eligible applicants can apply Monday, March 17 at 11 a.m. ET through Thursday, March 20 at 9 p.m. ET.

NUMBER OF APPLICATIONS

How many applications do I have for SOAP?

- SOAP-eligible applicants can apply to 45 programs from Monday, March 17 at 11 a.m. ET through Thursday, March 20 at 9 p.m. ET. Applicants cannot withdraw applications to replace or exceed the allotted 45 programs.

Can I reapply to programs I applied to during the regular ERAS season?

- Yes, you may apply to programs previously applied to prior to SOAP by doing the following:
  - Log in to your MyERAS account.
  - From the Programs menu, select "Reapply to Programs."
  - Select the programs you would like to reapply to.
  - Select "Reapply to Programs" and follow the prompts.
- Please note, the program must participate in SOAP and have unfilled positions that you are eligible for.
- As a reminder, LoRs assigned to a program during the regular season cannot be unassigned.

Can I reapply to programs in SOAP that I already applied to during SOAP?

- No. You can only apply to a program once during SOAP. If a program has received your application during SOAP, the program will have your information on file for all future rounds.

APPLICATIONS

Can I make changes to my application during SOAP?

- You cannot make changes to your application once you have certified and submitted it in the MyERAS program. The personal information section will remain available for updates and edits as usual.

Can I create a new personal statement for SOAP/different specialties/programs?

- Yes. You may update or create new personal statements and assign them to different specialties/programs.

Can I upload new Letters of Recommendation (LoRs) for SOAP?

- Yes. You can upload new letters of recommendation. Once you have applied to a program, you cannot unassign LoRs.

Can I use program signals when applying to programs during SOAP?

- No. Program signals are not available during SOAP.

HELP

If you have any questions, please contact the AAMC Support Center (202-862-6264) Monday – Friday, 8 a.m. – 6 p.m. ET.

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Exhibit 24:
AAMC Exhibit 78
Vital Issues for the "New-Age" Resident Experience

AAMC
Tomorrow's Doctors, Tomorrow's Cures®

Learn
Serve
Lead

Vital Issues for the "New-age" Resident Experience

AAMC Board of Directors Meeting
February 28, 2023

Association of American Medical Colleges

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Introductions

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Disclosures

This presentation is brought to you by ORR members as a result of a focus group discussion based on our experiences as residents. Although we feel this is representative of a variety of viewpoints across program specialties across the country, this in no way is reflective of all perspectives.

We otherwise have no relevant disclosures.

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Objectives

- Review resident physician's unique role in the medical system
- Provide the resident trainee perspective of current challenges consistent throughout different specialties across the country
- Discuss opportunities for continued improvement in the resident experience and training model

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Discuss with those next to you!

Prompt# 1 (10-min):

How would your institution respond if every resident did not show up for work one day?

Prompt# 2 (10-min):

What would prompt residents not to show up for work?

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80-hour weeks, bad pay, exhaustion: Here's why UW medical residents are walking out

In hospitals across Seattle, doctors-in-training are taking a "unity" break to protest low wages and punishing schedules.

by Dr. Kisha Clune & Dr. Brandon Peplinski / September 25, 2019

University of Washington medical residents at a rally outside UW Medical Center. These doctors-in-training are locked in contract negotiations with the university, fighting for increased wages, childcare and vacation. (Courtesy UWHA)

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Medical residents, interns walk off the job at UCSF Medical Center over failed contract talks

By Victor Tence Mar 19, 2019

1 of 2

Josh Bukowski, a third year resident of the emergency medicine residency program, speaks during a 15 minute "Unity Break" against...

THE LATEST

Why do AI chatbots tell lies and act weird? Look in the mirror.
UPDATED 10 HRS AGO

The busy furniture hustlers of Silicon Valley
UPDATED 10 HRS AGO

Mushroom boom: how to plan a foraging adventure on the West Coast
UPDATED 12 HRS AGO

Ephemeral tattoos were 'made to fade.' Some still haven't.
UPDATED 12 HRS AGO

Oakland teen arrested in connection with shooting homicide
UPDATED 10 HRS AGO

Five under $20: what to do in San

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What were the concerns?

- Living wage
- Affordable housing
- Improved work conditions/environments
- Child-care
- Proper representation during disciplinary proceedings (i.e., grievance procedures)

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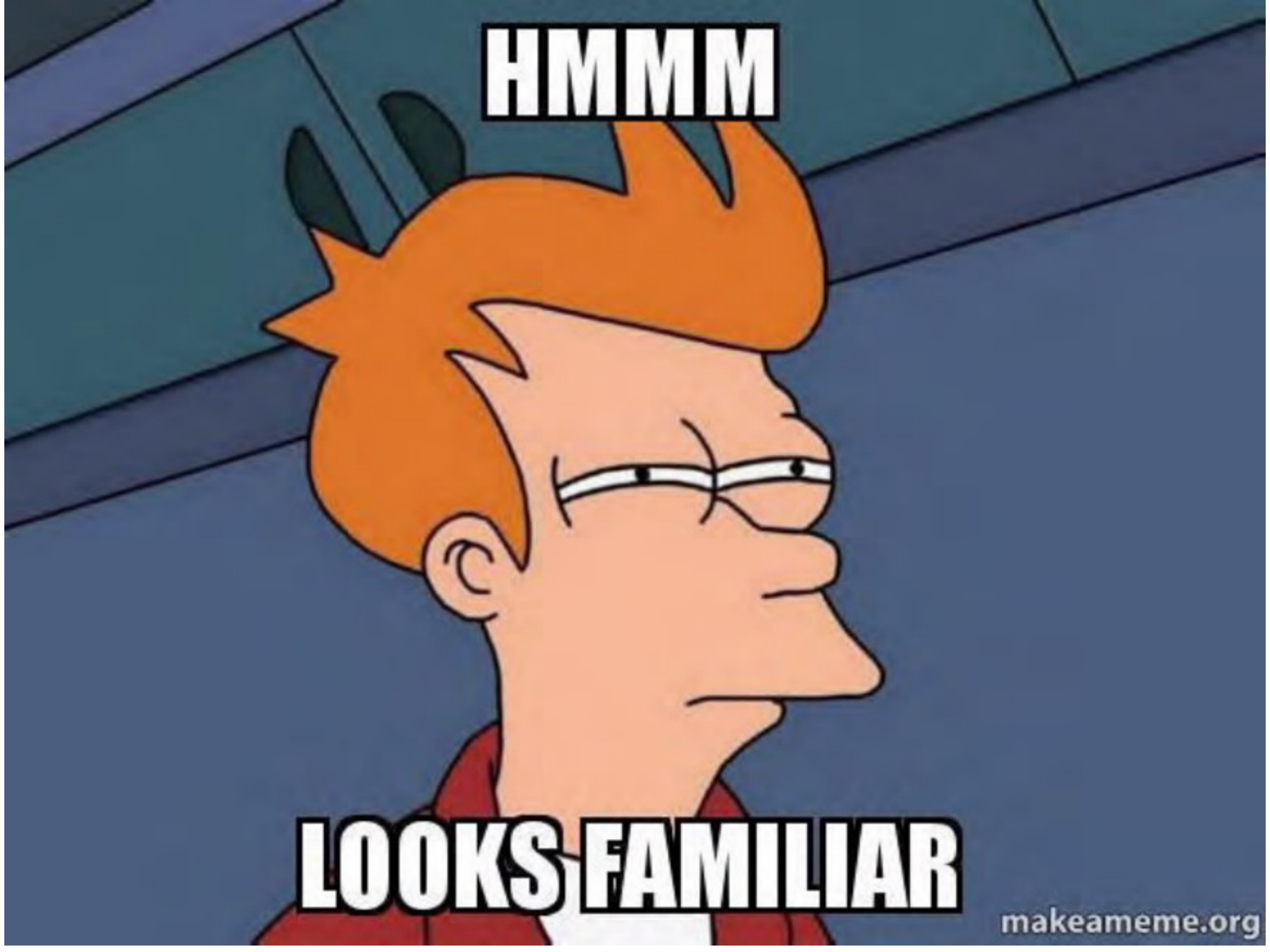

Appendix 687

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We've been here before…

April 1934—the Interne Council of Greater New York is formed by interns, dissatisfied with **no salaries**, lack of teaching rounds, and often dangerous working conditions such as *ambulance riding*

Success!

New York Board of Estimate awarded salaries of $15.00 per month to city hospital interns.

1944—Association of Internes and Medical Students (AIMS) provide testimony to Congress, urging medical schools to abandon their longstanding, restrictive, discriminatory admissions policies "against Negroes, Jews, Catholics, Italians, and women…"

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Harmon RG. Health and Society. 1978

Post-WWII House-staff concerns

- Adequate postgraduate training for military veteran doctors
- Growing interest in specialization given technological advances, especially in drugs and surgery
- More residency positions
- Limitation of routine laboratory and clerical chores
- Reasonable working and on-call hours
- More clinical conferences
- Better housing
- Better food
- Minimum intern salary of $1200
- Elimination of discriminatory practices in medicine and medical education
- International cooperation

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Harmon RG. Health and Society. 1978

Lest we forget McCarthyism

1948 AMA Convention authorizes an investigation of AIMS on the basis that it **"advocates the overthrow of the United States government by force and violence .. . favors strikes upsetting to proper medical education,"** exhibits **"Communistic tendencies,"** and has **"Communistic affiliations."**

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Appendix 690

Harmon RG. Health and Society. 1978

AAMC

When the strikes go marching in

- **February 1970**—60 interns at San Francisco General Hospital
  - Demand improvements in social services, laboratory and X-ray coverage, pharmacy hours, and outpatient services
- **December 1970**—House-staff association of D.C. General Hospital stage a 12-hour strike on December 4, 1970
  - Grievances were silenced by a pay raise of nearly $2000 per year
- **March 1975**—Committee of Interns and Residents (CIR) strikes at 15 voluntary hospitals and six affiliated public hospitals
  - Biggest job action by physicians in U.S. history
  - Concerns about excessive hours and “scut” work

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Harmon RG. Health and Society. 1978

You've got to fight, for your right…to unionize?

Up to this point, much of the labor organization seen only in public hospitals, where permitted by state or local law

1972—State Labor Relations Board in Pennsylvania rules house officers to be **"students,"** not employees, and ineligible for collective bargaining rights

1974—Public Law 93-360 enacted and amends the 1935 National Labor Relations Act (NLRA), extending collective bargaining rights to **employees of private, voluntary, nonprofit hospitals.**

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Harmon RG. Health and Society. 1978

Sides are chosen

In 1975, hospitals and the AAMC argue the following:

1. Interns and residents are **not employees or integral parts of the hospital work force**, but students preparing to join it.

2. Patient care is for the *benefit* of the student (house officer) rather than a service that the student renders for the benefit of the hospital.

3. House staff is **not experienced** enough for the independent practice of medicine.

4. Long hours are necessary for house staff to be exposed to a wide range of experience.

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Appendix 693

Harmon RG. Health and Society. 1978

Sides are chosen

5. House staff does not receive salary for work, but rather, stipends for training.

6. The **equality** of bargaining power is incompatible with the student-teacher relationship.

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Appendix 694

Harmon RG. Health and Society. 1978

AAMC

Sides are chosen

Local associations and the Physicians National House-staff Association (PNHA) argue the following*:

1. Student status is contrary to the legislative history of the 1974 hospital amendments to the NLRA.

2. House staffs have collectively bargained in a responsible manner in city and state hospitals *for years*, with a positive rather than a negative effect on patient care.

3. Patient care activities accounted for well **over 70% of house-staff time**

*AAMC's Organization of Student Representatives were also in support

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Harmon RG. Health and Society. 1978

Sides are chosen

4. If house-staff programs were cancelled, **the cost of providing care by full-time physicians would be more than before,** especially considering the long hours worked at low wages

5. Hospitals fund the bulk (often over 70%) of house-staff training programs *out of patient care revenues*

6. Their revenues are generated by house staff *acting* as employees.

7. House staff members are considered to be employees by the Internal Revenue Service and therefore ineligible for the Section 117 $3600 fellowship income exclusion.

8. House staff members are often fully licensed for independent practice by their state, able to prescribe a full range of medications including narcotics, without co-signature

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Boston Medical Center Corporation *and* House Officers' Association/Committee of Interns and Residents, Petitioner. Case 1–RC–20574

November 26, 1999

DECISION ON REVIEW AND DIRECTION OF ELECTION

BY CHAIRMAN TRUESDALE AND MEMBERS FOX, LIEBMAN, HURTGEN, AND BRAME

- The 1999 National Labor Relations Board (NCLB) "find (s) that the interns, residents, and fellows employed by BMC, while they may be students learning their chosen medical craft, are also "employees" within the meaning of Section 2(3) of the Act."
    - Medical residents are employees when it comes to federal labor rules but also students who must abide by educational standards

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Appendix 697
National Labor Relations Board Decisions. 330 N.L.R.B. 152. 1999

Role of the "New-age" Resident

- Healthcare delivery is team-based
  - Often falls on residents to be the coordinators of the team

- Residents accept this responsibility as *crucial* to not only the care of their patients but their career training

- Residents are invested in their own success
  - Healthcare systems are aware of their commitment to this and generally lack of options that arise from deviation of this course.

- The amount of work required of residents has increased tremendously
  - No longer only related to "patient care"
  - Seems that hospital systems have attempted to combat this trend with the continued increased hiring and elevating of advanced practice providers

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The tight rope of service vs education

- Residents represent a unique area of medical care without discernable RVU value
- Residents accept that payment is often intangible in terms of experience and opportunity for training
- With salaries and training costs increasing and hours decreasing, cost-effectiveness of house staff may be eroded to such an extent that *replacement by salaried physicians, nurse practitioners, or physician assistants becomes attractive*.

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Residents complained before loss of accreditation, UNM says

BY RYAN BOETEL / JOURNAL STAFF WRITER

SUNDAY, DECEMBER 15TH, 2019 AT 12:05AM

UNM Hospital. (Journal file)

Appendix 700

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True value of a resident?

- To replace **the eight neurosurgery residents** who left the UNM program, the university hired **twenty-three advanced practice providers to replace them**.
- The loss of accreditation cost the university **five times** as much as if they had kept their residents (as the average neurosurgery nurse practitioner earns nearly twice as much as a resident)

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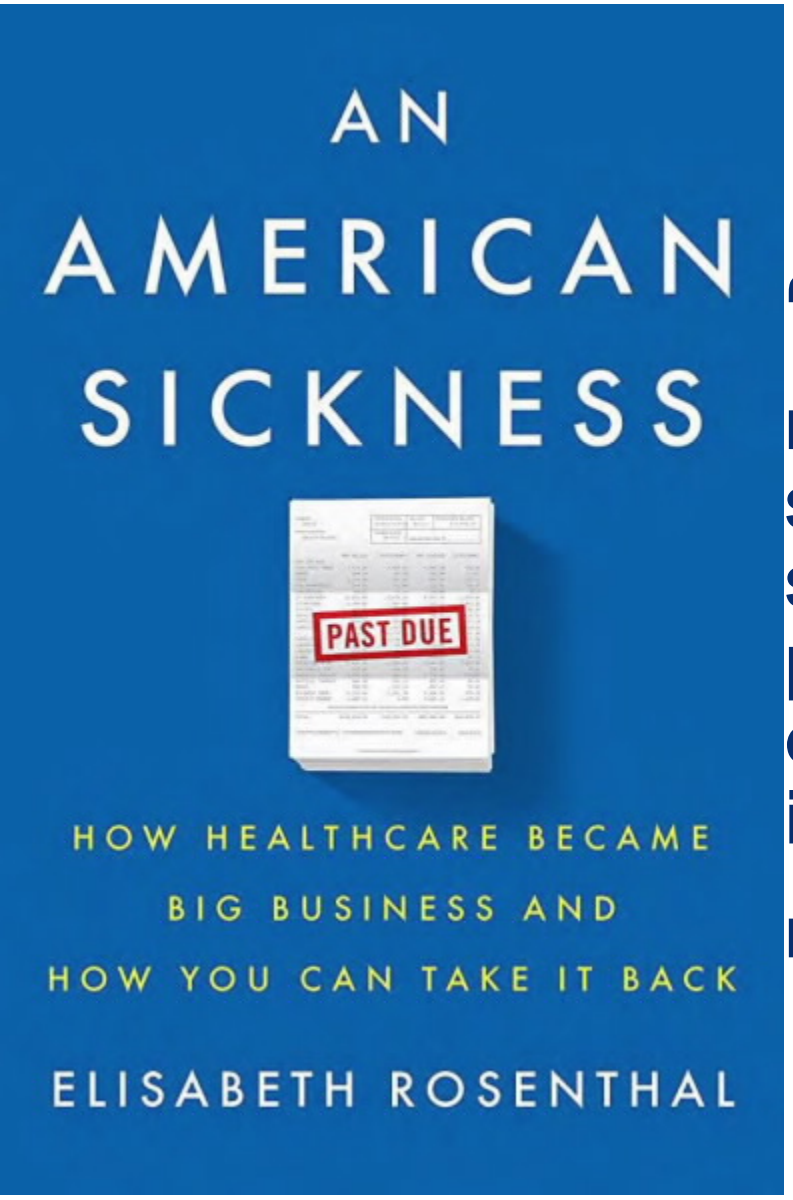
Appendix 701 Carmody B. “How much are resident physicians worth?” 2022

True value of a resident?



"The median cost to a hospital for each full-time resident in 2013 was $134,803. That includes a salary of between $50,000 and $80,000. Federal support translates into about $100,000 per resident per year. Researchers have calculated that the **value of the work each resident performs annually is $232,726**. Even without any subsidy, having residents is a better than break-even deal."

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Competing Interests

- APPs contribute to the financial health of healthcare institutions in a documented, meaningful way given their ability to directly bill for services.

- Resident financial value remains much more intangible due to inability to independently bill

- COVID pandemic fueled areas of employee retainment and attrition
  - Many centers still face with large nursing and support staff shortages
  - Well documented shift towards financial incentive of travel nursing
  - Healthcare systems going to great lengths to increase nursing and support retainment

- Increased tasks/work being transitioned to residents to improve other stakeholder workplace “satisfaction” with a goal of improved retainment

- Does not remove the amount of work already required of residents

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Effects

- Stark feelings of feeling undervalued

- Strong sense of feeling that hospital systems and healthcare systems are trying to continuously place *increased value on other stakeholders* (nursing, APPs) due to financial incentives at the EXPENSE of resident workforce
  - Facilitates interprofessional resentment **(whether real or imagined)**
  - Encourages mistrust between resident trainees and training institutions

- If not felt supported by the system, residents seek to protect themselves through other avenues

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Resident Unionization: A symptom rather than solution to the problem

JAMA Network | Open

Original Investigation | Medical Education

National Evaluation of the Association Between Resident Labor Union Participation and Surgical Resident Well-being

Brian C. Brajcich, MD, MS; Jeanette W. Chung, PhD; Douglas E. Wood, MD; Karen D. Horvath, MD; Philip D. Tolley, MD; Elizabeth F. Yates, MD; Chandrakanath Are, MD, MBA; Ryan J. Ellis, MD, MS; Yue-Yung Hu, MD, MPH; Karl Y. Bilimoria, MD, MS

- 5701 residents at 285 general surgery programs were surveyed across US to evaluate the association of resident unions with well-being, educational environment, salary, and benefits among surgical residents in the US.

- Unionized programs offered **improved vacation and housing stipend benefits**, but resident unions were *not associated with improved burnout, suicidality, job satisfaction, duty hour violations, mistreatment, educational environment, or salary*.

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Brajcich BC et al. JAMA Open. 2021.

AAMC

Work Life Balance Challenges in Residency

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1 in 10 physicians considered or attempted suicide in 2021*

* Medscape's Physician Suicide Report 2022

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Then and Now

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ACGME

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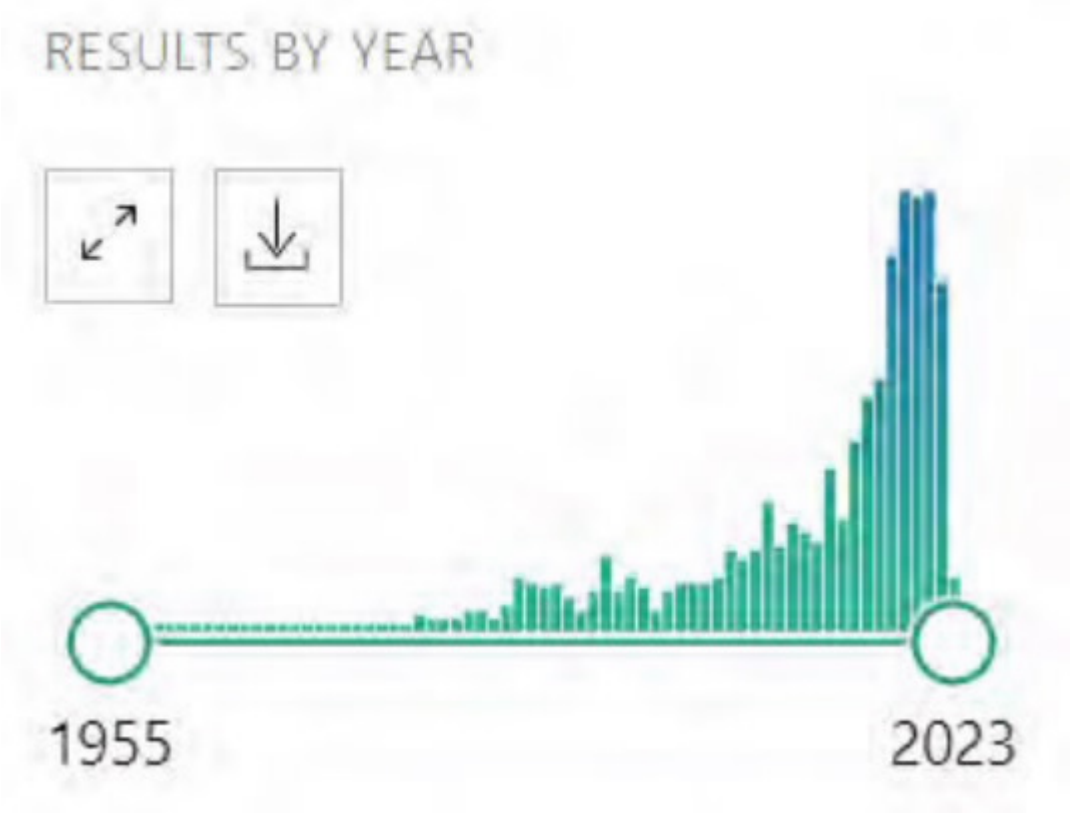
A Focus on Wellness



Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician and **require proactive attention to life inside and outside of medicine.**

Well-being requires that physicians retain the joy in medicine while managing their own real-life stresses. Self-care and responsibility to support other members of the health care team are important components of professionalism; they are also skills that must be modeled, learned, and nurtured in the context of other aspects of residency training.

Pubmed search "wellness programs resident physicians"

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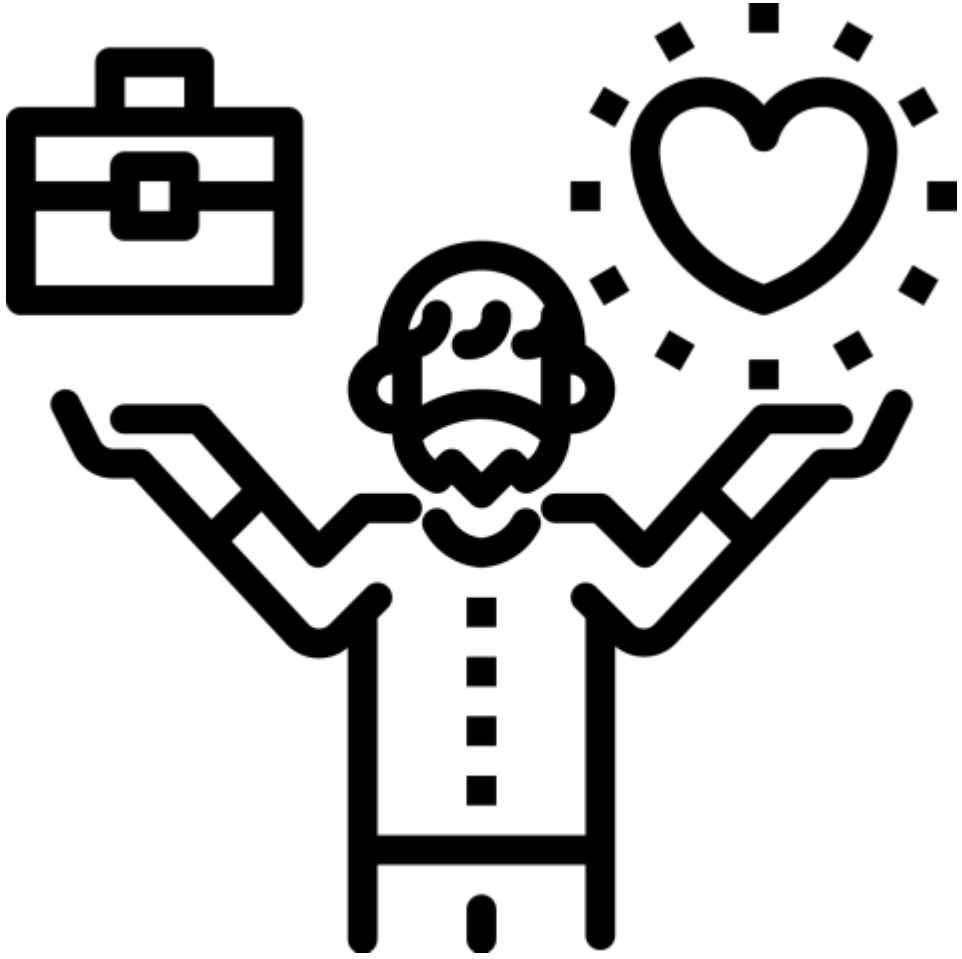
Definitions

Wellness: Holistic concept of good health

Burnout: Physical or mental collapse caused by overwork or stress

Work Life Balance: The division of one's time and focus between working and family or leisure activities



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Wellness Programs

- Yoga
- Meditation
- Retreats
- Therapy dogs
- Social Events
- Access to mental health services
- Didactics on resilience/ sleep etc

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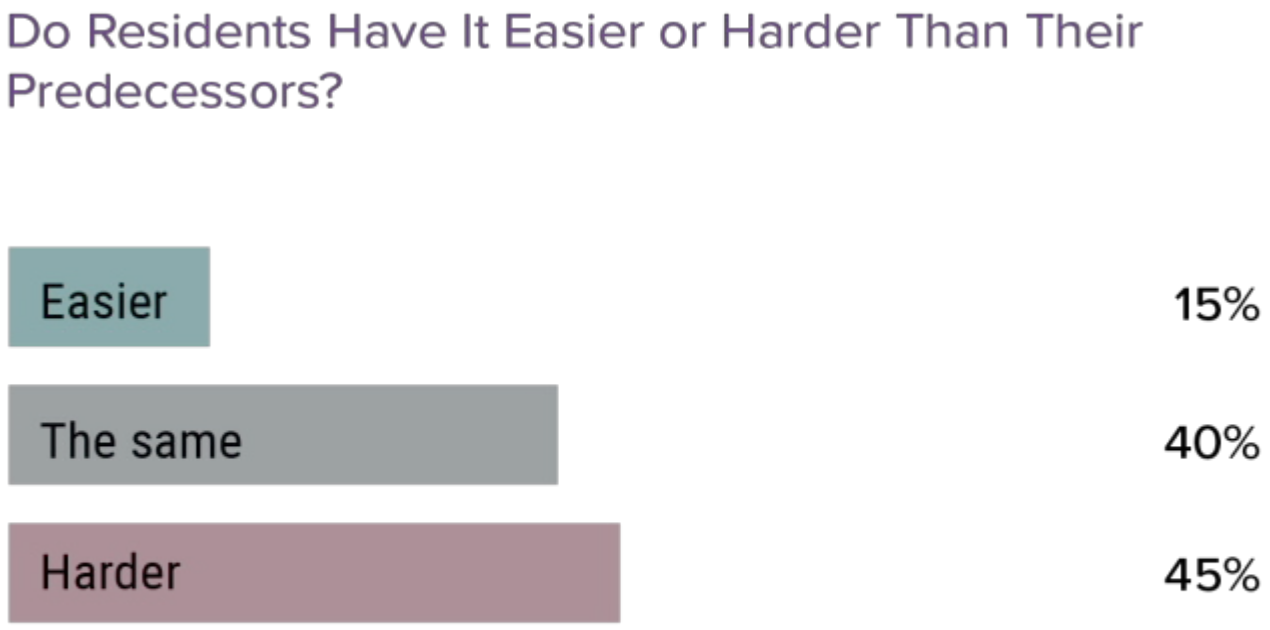
Resident Perception



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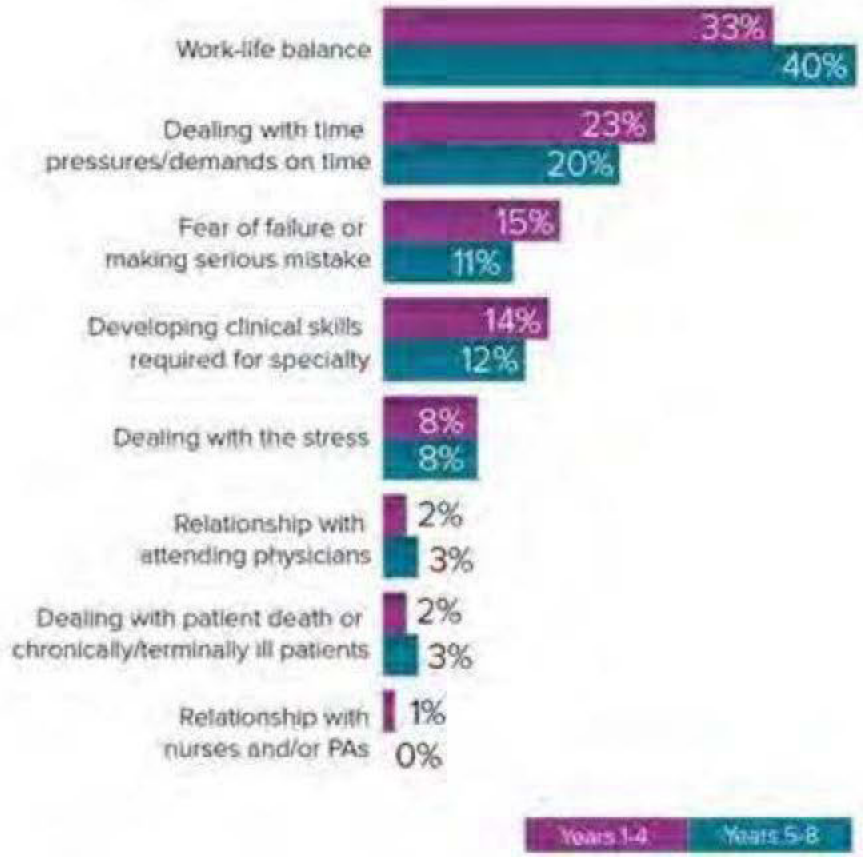
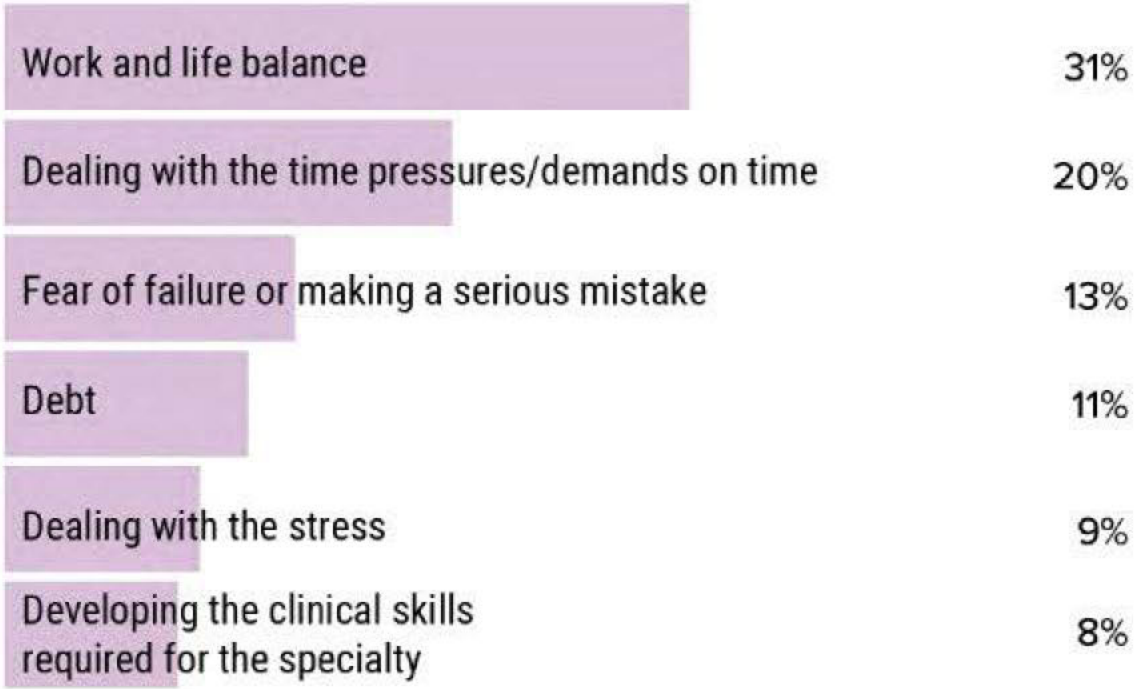
Biggest Challenges Faced in Residency



Medscape 2016



Medscape 2022

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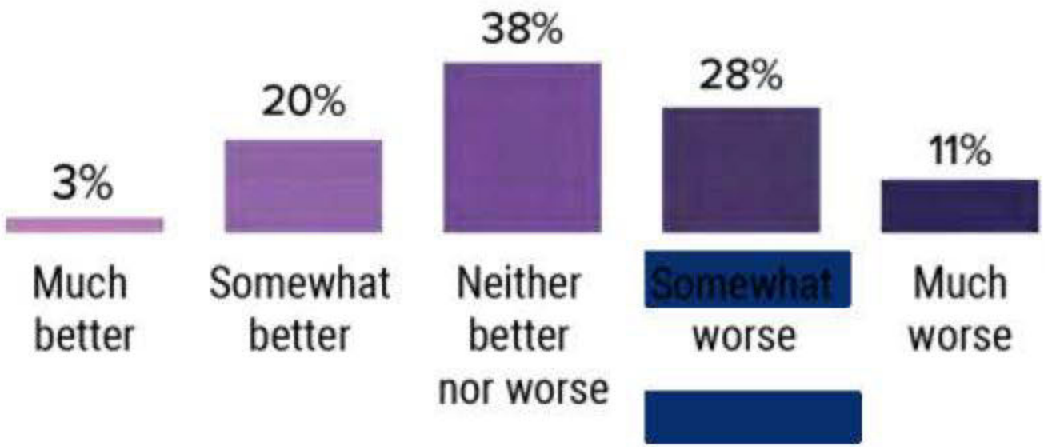
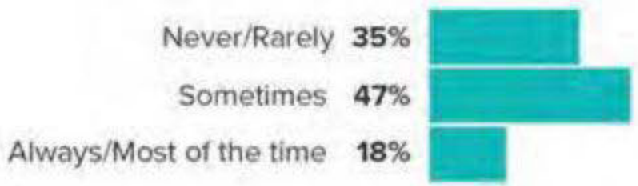
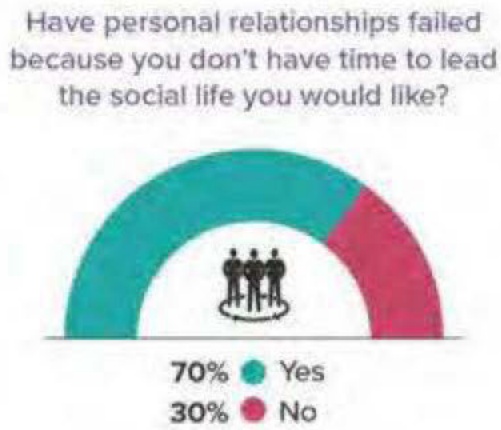
Defining the problem

Is Personal and Professional Life Balance What Residents Expected?



How Often Do Residents Have Time to Lead a Satisfying Social Life?





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Focus on Wellness/ Burnout

Kans J Med. 2022; 15: 403–411.
Published online 2022 Nov 28. doi: 10.17161/kjm.vol15.18420
PMCID: PMC9710504
PMID: 36467446

Burnout, Depression, Anxiety, and Stress Among Resident Physicians 18 Months Into the COVID-19 Pandemic: A Cross-Sectional Study

Samuel Ofei-Dodoo, Ph.D., MPA, M.A.,[1,2] Gretchen Irwin, M.D., MBA,[1] Brynn Wright, M.D.,[2] Kimbe
MPH,[3] Kimberly Williams, M.D.,[4] Philip Dooley, M.D.,[2] and Maurice Duggins, M.D.[2]

• Author information • Article notes • Copyright and License information Disclaimer

Annals of Emergency Medicine
Available online 7 February 2023
In Press, Corrected Proof ⓘ What's this?

Physician wellness/Original research

Workplace Mistreatment, Career Choice Regret, and Burnout in Emergency Medicine Residency Training in the United States

Dave W. Lu MD, MS [a], Tiannan Zhan MS [b], Karl Y. Bilimoria MD, MS [b], Earl J. Reisdorff MD [c], Melissa A. Barton MD [c], Lewis S. Nelson MD [d], Michael S. Beeson MD, MBA [e], Michelle D. Lall MD, MHS [f]

Appendix 717

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Resident Experience

EMR, work/prep from home

Complexity of patients

Increased medical knowledge

Decreased LOS, greater turnover

Financial burden

Family/ personal safety with COVID

Staffing shortages/ turnover

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What works

Duty hour enforcement

Lactation support

Family leave guidelines

Focus on wellness

More discussion about abuse, mistreatment, microaggressions

Focus on disparities in our application and employment systems

Modifiable barriers	Proposed modifications
Unfriendly work environment	• Enable culture change by incorporating wellness themes at annual events (intern orientation, resident retreats) and monthly noon conferences. • Empower second- and third-year residents to be team leaders who support/nurture younger trainees every day. • Incentivize positive teamwork and communication among staff members (competitions, prizes, activity-tracking challenges, etc.). • Normalize the experience of "the inner critic" to combat personal insecurity and self-doubt. • Train residents in peer support.
Unhealthy work environment	• Provide fresh and healthy food options. • Provide vegetarian and gluten-free food options. • Provide access to water, coffee, and tea in resident workrooms. • Encourage grouping of nonurgent phone calls and pages to minimize on-call sleep interruptions during extended shifts. • Uphold duty hours restrictions. • Normalize safely handing off admissions that come in close to change-of-shift.
Lack of wellness initiatives	• Encourage formation of resident wellness groups, supported by program funding. • Improve awareness of and collaboration with hospital and residency leadership. • Provide education about avoiding burnout and teach concrete healthy coping strategies. • Collaborate among specialties to create a hospital-wide wellness initiative.
Lack of space to recharge or reflect	• Create dedicated space for residents to practice self-care at the hospital. • Provide quiet, clean space in the hospital for residents only. • Encourage debriefing of tragic and traumatic events in resident-only spaces.
Personal health-related behaviors	• Exercise: Provide free or discounted gym membership, on-site gym, and/or yoga classes. • Healthy food: Provide discounted or incentivized community-supported agriculture shares, share recipes for healthy food at home, improve hospital food offerings. • Mental health: Improve access to formal mental health services/counseling; identify dedicated providers for hospital staff. • Health care maintenance: Designate time in the schedule for doctor and dentist appointments.

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Navigating Unique Challenges in Residency

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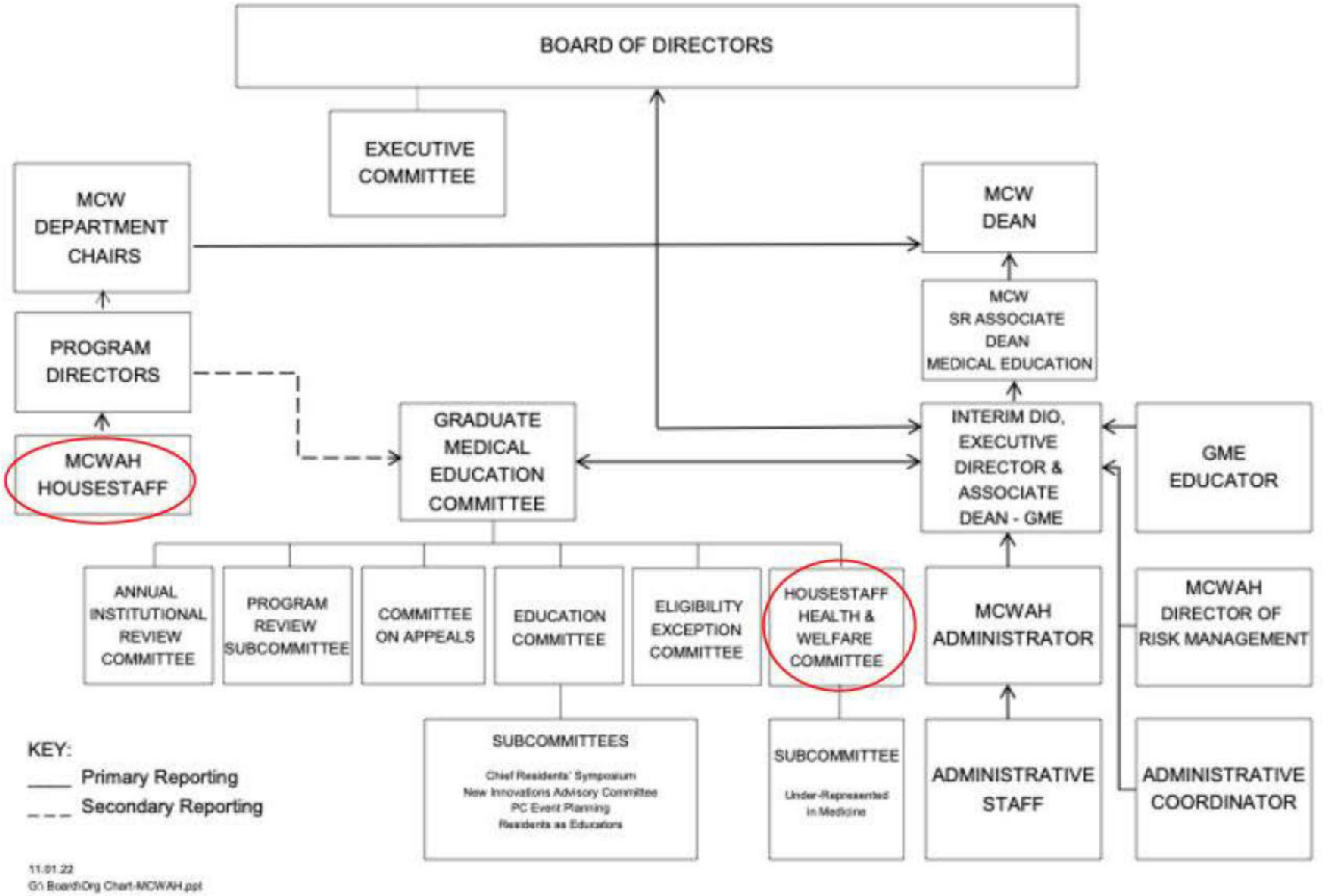
MEDICAL COLLEGE OF WISCONSIN AFFILIATED HOSPITALS
ORGANIZATIONAL CHART



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*All data utilized were collected from the ACGME data

Appendix 723

Wang et al. *Brain and Neurological Disorders*. 2022

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- Retrospective, observational study using data from AMA National GME Census for a 10 year period

Why Residents Quit: National Rates of and Reasons for Attrition Among Emergency Medicine Physicians in Training

Dave W. Lu, MD, MSCI, MBE*†
Nicholas D. Hartman, MD, MPH‡
Jeffrey Druck, MD§
Jennifer Mitzman, MD¶
Tania D. Strout, PhD, RN, MS*†

*Tufts University School of Medicine, Department of Emergency Medicine, Medford, Massachusetts
†Maine Medical Center, Department of Emergency Medicine, Portland, Maine
‡Wake Forest School of Medicine, Department of Emergency Medicine, Winston-Salem, North Carolina
§The University of Colorado School of Medicine, Department of Emergency Medicine, Aurora, Colorado
¶The Ohio State University College of Medicine, Department of Emergency Medicine, Columbus, Ohio

- Calculated annual national attrition rates for 51,882 unique EM residents and obtained the reason/resident characteristics association with the attrition

- A **greater proportion of Hispanic/Latino (1.8%)** residents left their programs when compared to their White (0.9%) counterparts ($p<0.001$).

- In the attrition population, **44.2% of the residents were women**, a significantly higher proportion when compared to the proportion of female EM residents overall (38.8%, $p=0.011$) and were significantly **more likely** than male residents to leave **due to "health/family reasons"** (21.5% vs 9.6%, $p=0.019$)

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Lu et al. *Western Journal of Emergency Medicine*. 2018

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JAMA Surgery | Original Investigation

Prevalence and Causes of Attrition Among Surgical Residents
A Systematic Review and Meta-analysis

Zeyad Khoushhal, MBBS, MPH; Mohamad A. Hussain, MD; Elisa Greco, MEd, FRCSC; Muhammad Mamdani, MA, MPH, PhD; Subodh Verma, MD, PhD, FRCSC; Ori Rotstein, MD, MSc, FRCSC; Andrea C. Tricco, MSc, PhD; Mohammed Al-Omran, MD, MSc, FRCSC

- Of 19,821 general surgery programs included in study, attrition prevalence among general surgery residents was **18%**
- Female residents were **more likely** to leave than male residents (25% vs 15%)
- Residents were most likely to leave after the first postgraduate year owing to an **uncontrollable lifestyle** (range, 12%-87.5%)
- The most common destination of residents who left was **relocating to another general surgery program or switch to another specialty (anesthesia was most common)**.

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Khoushhal et al. *JAMA Surg*. 2017.

A STAT INVESTIGATION

‘It was stolen from me’: Black doctors are forced out of training programs at far higher rates than white residents

By Usha Lee McFarling June 20, 2022

“While much attention has been placed on increasing the number of Black students who enter medical school, little focus has been placed on how many people are lost during residency, the critical tail end of training, when young physicians are vulnerable to subjective evaluations that can be tinged by bias.”

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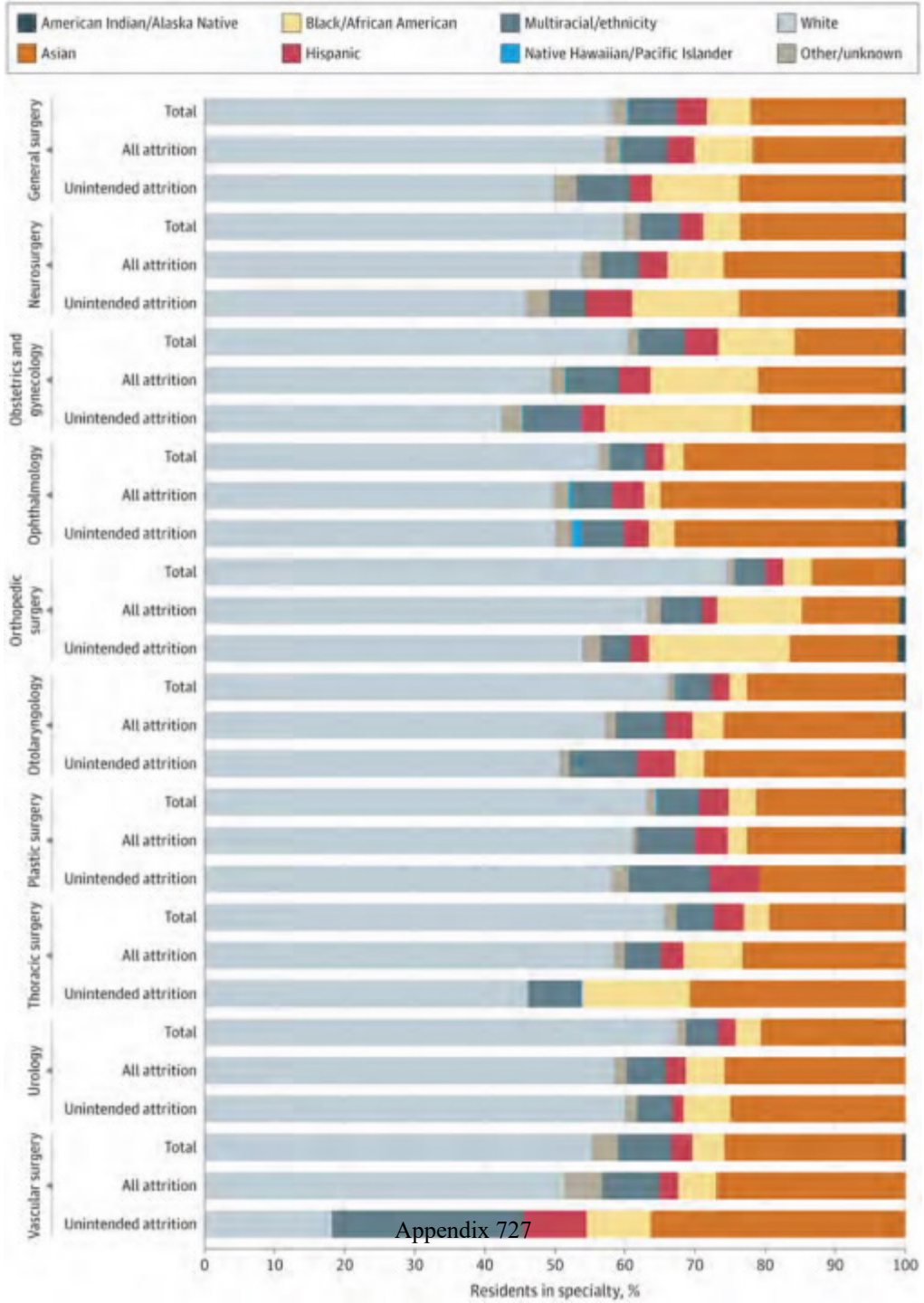
The RR for Black/African American residents to experience attrition and unintended attrition compared with all other races was 1.66 (95% CI, 1.53-1.80; P < .001) and 2.59 (95% CI, 2.31-2.90; P < .001), respectively



Appendix 727

Haruno et al. *JAMA Surg*. 2023

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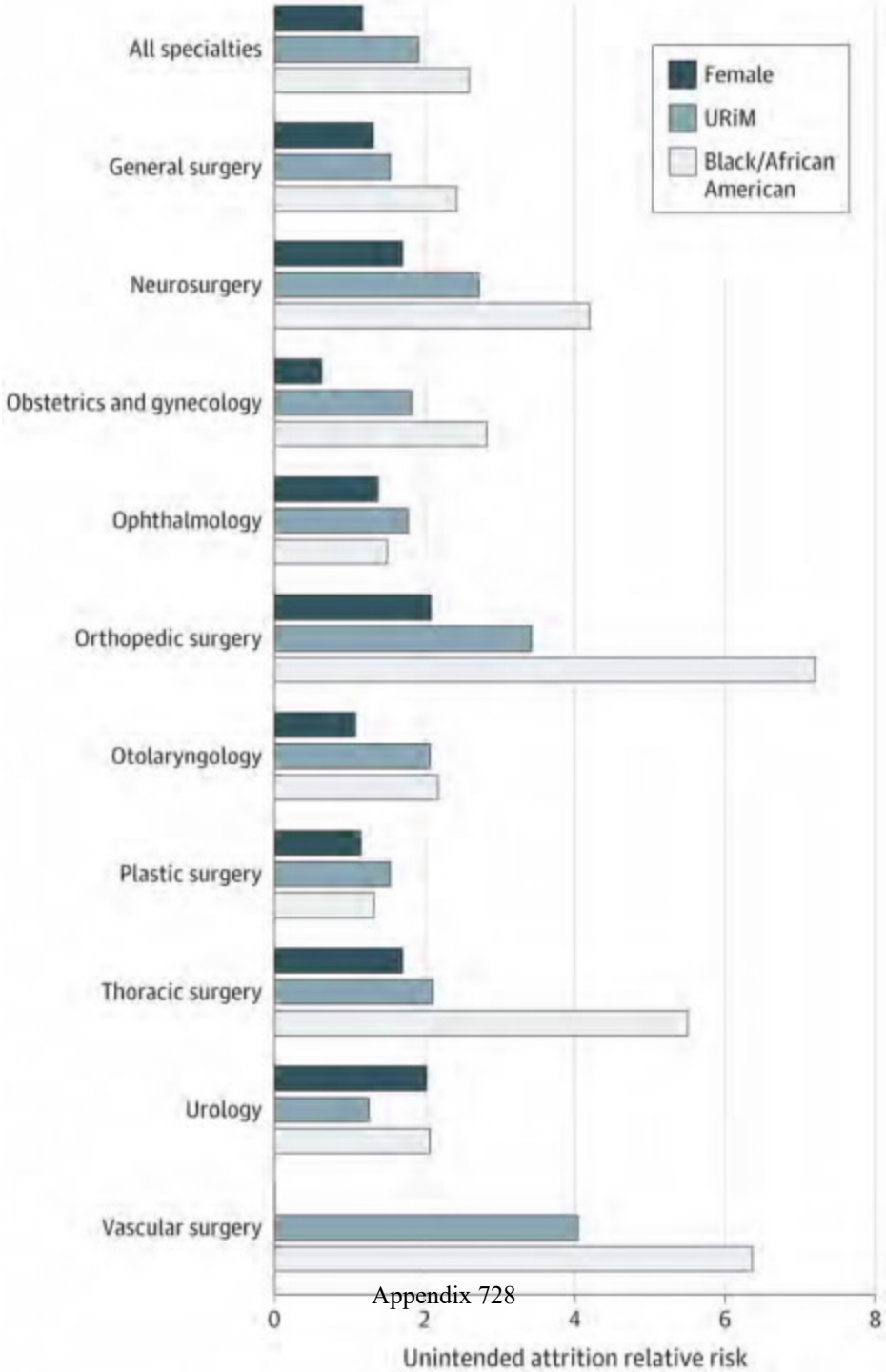
- Black/African American residents accounted for **6.3% of all surgical residents** but were ***9.6%*** of all residents ***experiencing attrition*** and ***14.4% of those dismissed.***



Appendix 728

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- Minoritized groups less likely to feel a sense of community and fit within their programs compared with their White counterparts[cite]
  - More likely to report feeling unable to count on peers for help
- Factors that contribute to **URiM trainees *choosing to leave*** surgery for another specialty:[cite]
  - **Cultural stereotypes**
  - **Lack of mentorship**
  - **Conscious and unconscious biases**
  - **Differential evaluations/expectations**

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JAMA Surgery | Original Investigation | PACIFIC COAST SURGICAL ASSOCIATION

Association of General Surgery Resident Remediation and Program Director Attitudes With Resident Attrition

Alexander C. Schwed, MD; Steven L. Lee, MD; Edgardo S. Salcedo, MD; Mark E. Reeves, MD; Kenji Inaba, MD; Richard A. Sidwell, MD; Farin Amersi, MD; Chandrakanth Are, MD; Tracey D. Arnell, MD; Richard B. Damewood, MD; Daniel L. Dent, MD; Timothy Donahue, MD; Jeffrey Gauvin, MD; Thomas Hartranft, MD; Garth R. Jacobsen, MD; Benjamin T. Jarman, MD; Marc L. Melcher, MD; John D. Mellinger, MD; Jon B. Morris, MD; Mark Nehler, MD; Brian R. Smith, MD; Mary Wolfe, MD; Amy H. Kaji, MD; Christian de Virgilio, MD

- 21 general surgery residencies surveyed to compare high attrition and low attrition rate programs and first-time pass rates on the General Surgery Qualifying Examination and General Surgery Certifying Examination of the American Board of Surgery (ABS)

- No difference in the pass rates on the qualifying/certifying examinations

- However, differences found in use and perception of **remedial vs re-directional** (to another field) interventions between of program directors at low vs high attrition programs, respectively.

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ACGME Common Program Requirements (Residency)

Common Program Requirements (Residency) Contents

Introduction
Int.A. Preamble
Int.B. Definition of Specialty
Int.C. Length of Educational Program
I. Oversight
I.A. Sponsoring Institution
I.B. Participating Sites
I.C. Recruitment
I.D. Resources
I.E. Other Learners and Other Care Providers
II. Personnel
II.A. Program Director
II.B. Faculty
II.C. Program Coordinator
II.D. Other Program Personnel
III. Resident Appointments
III.A. Eligibility Requirements
III.B. Number of Residents
III.C. Resident Transfers
IV. Educational Program
IV.A. Curriculum Components
IV.B. ACGME Competencies
IV.C. Curriculum Organization and Resident Experiences
IV.D. Scholarship
V. Evaluation
V.A. Resident Evaluation
V.B. Faculty Evaluation
V.C. Program Evaluation and Improvement
VI. The Learning and Working Environment
VI.A. Patient Safety, Quality Improvement, Supervision, and Accountability
VI.B. Professionalism
VI.C. Well-Being
VI.D. Fatigue Mitigation
VI.E. Clinical Responsibilities, Teamwork, and Transitions of Care
VI.F. Clinical Experience and Education

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Who gets to move on?

- Summative evaluation is utilized to make decisions about promotion to the next level of training, or program completion (ultimately determined by the program director)
  - Residents are compared against the goals and objectives of the rotation and program, respectively.
  - More frequent feedback is strongly encouraged for residents who have deficiencies that may result in a poor final rotation evaluation.
- To ensure due process, it is essential that the program director follow **institutional policies and procedures.**

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Work from Home

- Expectation remains that scheduling be structured so that residents are able to complete most work on site during scheduled clinical work **hours without requiring them to take work home.**
- New requirements *acknowledge* the changing landscape of medicine, including electronic health records, and the resulting increase in the amount of work residents choose to do from home.
- Reading done in preparation for the following day's cases, studying, and research done from home **do not** count toward the 80 hours.

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- Programs are responsible for ensuring that residents are provided with manageable workloads that can be accomplished during scheduled work hours
  - Assigned direct patient load must be manageable
  - Have appropriate support from their clinical teams residents
  - Not overburdened with clinical work and/or other non-physician duties

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Have our learning environments adapted?

- Transition from medical school to residency
  - Discordance between UME and GME learning environment/competencies?

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- Efforts to *reduce student burnout*, *enhance wellness*, and *improve the learning environment* have been widely incorporated at the national level
- Some approaches used to enhance the learning experience and climate for trainees:
  - Longitudinal clinical rotations
  - Resident-as-teacher programs
  - Enhanced opportunities for students to build relationships with faculty
  - Pass-fail curricula
  - Ambulatory rotations
  - Faculty recognition and promotion as educators

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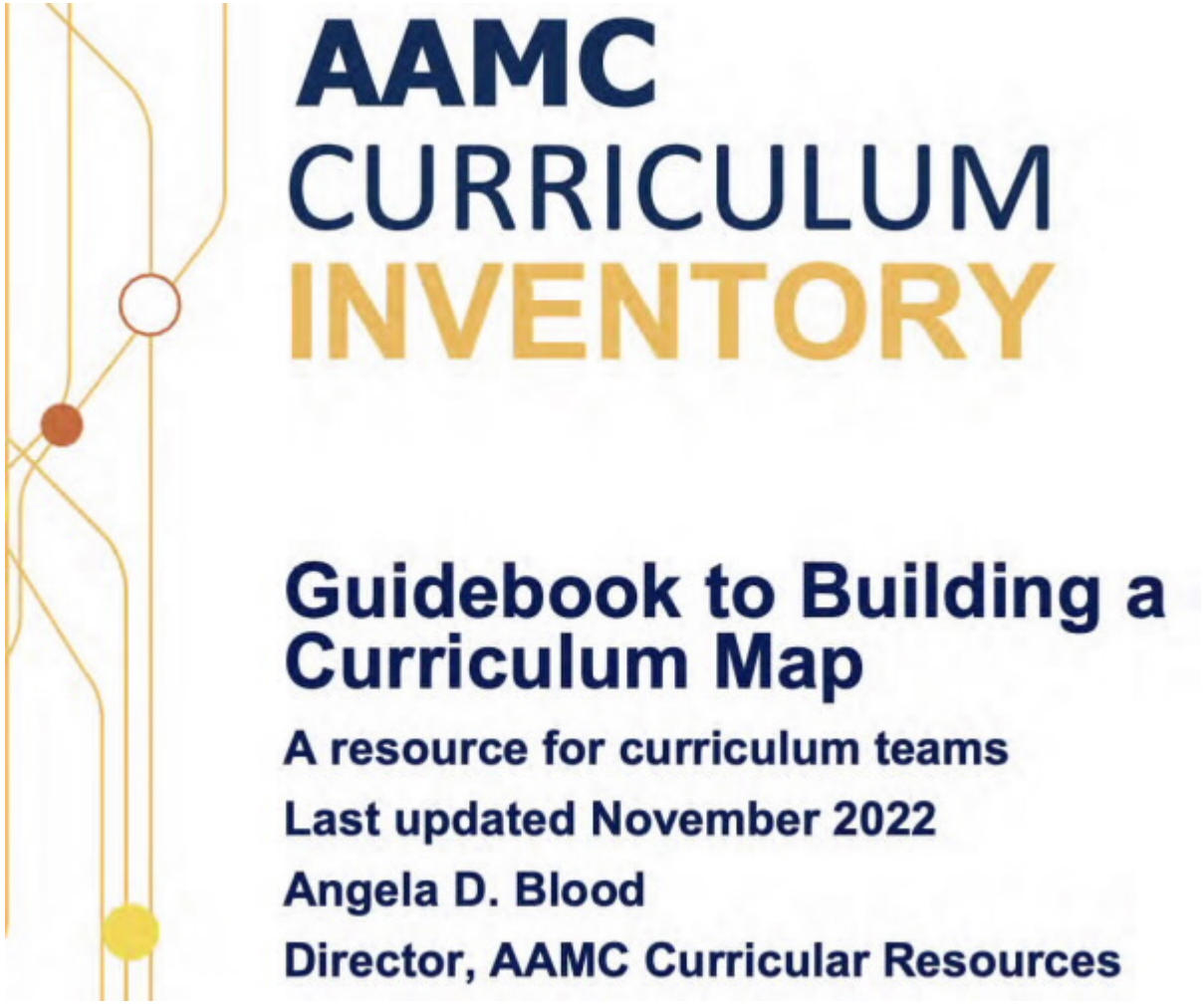

- Workbook provides a suggested step-by-step process, designed to serve as a benchmarking and reporting tool on content, structure, delivery, and assessment of U.S. and Canadian MD and DO medical school curriculum
- Schools can also design their own approach
- Workbook can be useful for
  - New schools
  - Schools new to curriculum mapping
  - Schools with an existing curriculum map that wish to take a fresh look at their data
  - Data quality

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GME Milestones as a roadmap

Core Competencies (ACGME + ABMS) provide a systematic framework to think about both curriculum and assessment in medical education. **Each specialty** was tasked with crafting specific milestones within each Competency

A comparison of Traditional versus Competency-Based Medical Education

Variable	Traditional Educational Model	CBME
Driving force for curriculum	Knowledge acquisition	Knowledge application
Driving force for process	Teacher	Learner
Path of learning	Hierarchal	Non-hierarchical
Responsibility of content	Teacher	Teacher and student
Goal of educational encounter	Knowledge and skill acquisition	Knowledge and skill application
Type of assessment tool	Single assessment measure (e.g., test)	Multiple assessment measures (e.g., direct observation)
Assessment tool	Proxy	Authentic (mimics real profession)
Setting for evaluation	Removed	In clinical and professional settings
Timing of assessment	Emphasis on summative	Emphasis on formative
Program completion	Fixed time	Variable time

Adapted from Carraccio, 2002

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EDUCATIONAL ADVANCES IN EMERGENCY MEDICINE

Challenges in measuring ACGME competencies: considerations for milestones

Prathiba Natesan[1], Nicholas J. Batley[2*], Rinad Bakhti[2] and Philippe Z. El-Doueihi[2]

- Natesan and colleagues examined the validity of ACGME-International competency measurements for evaluators in Emergency Medicine and Neurology

- Found that milestones may be useful only for rating the overall competence of residents but presents little information on their *specific strengths and weaknesses* in the six competencies.

- A global impression by evaluators guides likely guides responses on individual competencies, in agreement with prior literature

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Appendix 739

Natesan et al. International Journal of Emergency Medicine. 2018

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- 104 unique studies reviewed to see literature on otolaryngology residency training curriculum aligns with the 6 core ACGME competencies

- Faucett and colleges found a lack of emphasis on **nonclinical core competencies**, including professionalism, interpersonal and communication skills, and systems-based practices

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Appendix 740

Faucett et al. JAMA Otolaryngology–Head & Neck Surgery. 2018

Have our learning environments adapted?

- Transition from medical school to residency
  - Is there *discordance* between UME and GME learning environment/competencies?
  - Are direct efforts of the leadership in academic medicine **transparent** and **meaningful**?

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We Have No Choice but to Transform: The Future of Medical Education After the COVID-19 Pandemic

Catherine R. Lucey, MD, John A. Davis, MD, PhD, and Marianne M. Green, MD

A 10-Point, 10-Year Platform for Medical Education Transformation

1. Adopt a national vision of the successful workforce focused on committing to improving health and health care in all communities across the country.
2. Achieve social justice in medical education and health care across the country by actively seeking out and eliminating the consequences and manifestations of structural racism in medicine and medical education.
3. Design curricula to prepare all in the physician workforce, present and future, to embrace the breadth of roles and responsibilities needed to address syndemic causes of suffering from illness and disease.
4. Identify and address the most pressing causes of morbidity and mortality in communities across the nation by challenging medical education programs to partner with local communities and governments to focus educational programs on these issues.
5. Facilitate growth mindsets and support lifelong learning in future physicians—and promote equity in learning environments—by adopting a standard of programmatic assessment strategies across the continuum of medical education.
6. Protect patient safety while improving efficiency of training by implementing competency-based training.
7. Increase equity, affordability, effectiveness, and efficiency of selection processes by redesigning national systems and investing in national technology platforms.
8. Protect the workforce by prioritizing learner and physician well-being.
9. Address health care access issues for underserved communities across the nation through innovative partnerships.
10. Strengthen and promulgate the social contract between the medical profession, the public, and state and federal governments in support of health and well-being.

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Action	Example 1: Clinical workplace learning	Example 2: Licensing, certification, and accreditation strategies
Continue	• Clinical rotations and experiences for learners within months of graduation	• Program director assessment of competency (ABMS) • LCME self-study activities (LCME)
Postponed	• Clinical aspects of core clerkships	• MSPE release and NRMP match date • USMLE exams • MOC activities (ABMS)
Adapt	• Convert visiting student rotations to virtual activities • Reassign GME trainees to alternate clinical environments based on emergency operations	• MCAT administration (shortened exam) • Conduct of LCME site visits: virtual and targeted (LCME) • Alternative administration strategies for USMLE Step 1, 2 CK, and 3 exams
Drop	• Observational experiences for first-year students • Student service-learning experiences (free clinics) • In-person visiting student rotations (COPA)	• Step 2 CS examinations (USMLE) • 2020 Milestone reporting requirements (ACGME) • 2020 Volume tracking for procedural specialties (ACGME, ABMS) • 2020 Accreditation and CLER activities (ACGME)
Add	• Epidemiologic principles for outbreak predication and management • Expanded infection control • Telehealth competencies and experiences for all learners	• Early licensing strategies for near-graduates

Abbreviations: ABMS, American Board of Medical Specialties; LCME, Liaison Committee on Medical Education; MSPE, Medical Student Performance Evaluation; NRMP, National Resident Matching Program; USMLE, United States Medical Licensing Examination; MOC, maintenance of certification; GME, graduate medical education; MCAT, Medical College Admission Test; CK, clinical knowledge; CS, clinical skills; COPA, Coalition for Physician Accountability; ACGME, Accreditation Council for Graduate Medical Education; CLER, Clinical Learning Environment Review.

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Habits of mind Commitments to	Core beliefs
Social justice	• Systems of government and of scientific thought have not been structured to provide equal access to benefits to all people. • Structural oppression has led to individual bias and disparities in social systems, including health care delivery. • Respectful engagement with others from different backgrounds requires cultural humility.
Scientific curiosity	• Complex problems of today require exploration through a variety of disciplinary lenses. • Current concepts must be challenged to generate new knowledge. • Investment in research in all fields is imperative.
Growth mindset and continuous improvement	• The purpose of assessment is to ensure that all physicians reach the expected level of competency. • Feedback and coaching from all colleagues in all professions can guide growth when combined with personal reflection. • High-quality systems are needed to protect vulnerable patients from fallible human beings. • Data on outcomes of care and education can guide improvement.
Adaptive leadership and collaborative teamwork	• Solving complex problems in health and health care delivery requires experts from different disciplines and professions. • Teams with demographic, lived experience, and disciplinary diversity are positioned to provide the most effective solutions. • Physicians must be prepared to know when they should step up to lead and when they are better suited to a supporting role.
Cultivating trustworthiness	• Trust implies a relationship in which one person or community is vulnerable and another has greater privilege. • Trustworthiness is earned through demonstration of character, caring, and competence; the least important of these is competence. • Trust propensity relates to past experiences of trust and betrayal; trustworthy individuals work to overcome trust reticence related to adverse past experiences.

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Lucey et al . Academic Medicine. 2021

Milestones 2.0: A Step Forward

Laura Edgar, EdD
Sydney Roberts, MHA
Eric Holmboe, MD, MACP, FRCP

BOX Subcompetencies for the Harmonized Milestones

Interpersonal and Communication Skills (ICS)
- Patient- and Family-Centered Communication (ICS-1)
- Interprofessional and Team Communication (ICS-2)
- Communication Within Healthcare Systems (ICS-3)

Practice-Based Learning and Improvement (PBLI)
- Evidence-Based and Informed Practice (PBLI-1)
- Reflective Practice and Commitment to Personal Growth (PBLI-2)

Professionalism (PROF)
- Professional Behavior and Ethical Principles (PROF-1)
- Accountability/Conscientiousness (PROF-2)
- Self-Awareness and Help-Seeking (PROF-3)

Systems-Based Practice (SBP)
- Patient Safety and Quality Improvement (SPB-1)
- System Navigation for Patient-Centered Care (SBP-2)
- The Physician's Role in Healthcare Systems (SBP-3)

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Diversity, Equity, and Inclusion Competencies Across the Learning Continuum

- **Domain I: Diversity**
  - Advancing Diversity and Integration in Practice
  - Advocating for a Diverse Health Care Team and System
- **Domain II: Equity**
  - Mitigating Stigma and Implicit and Explicit Biases
  - Eliminating Inequities in Health Care
  - Practicing Anti-racism and Critical Consciousness in Health Care
  - Advocating for Equity in Health and Health Care
- **Domain III: Inclusion**
  - Fostering Belongingness
  - Providing Culturally Responsive Patient Care
  - Advocating for Inclusive Practices and a Healthy and Inclusive Physical (Built) Environment

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Have our learning environments adapted?

- Transition from medical school to residency
  - Discordance between UME and GME learning environment/competencies?
  - Are direct efforts of the leadership in academic medicine transparent and **meaningful**?
  - Do our expectations for trainees reflecting the appropriate response to the current political climate?

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Discipline	Response to pandemic	Utility in syndemic responsiveness
Biological sciences	• Virologic etiology and mechanism of spread of pandemic • Management of physiologic derangements • Vaccine development	• Investigate molecular basis of chronic metabolic disease in relationship to elements of toxic stress, specifically racism, environmental toxins, and poverty
Clinical and translational sciences	• Therapeutic trials of novel agents and respiratory support strategies • Clinical infection control strategies	• Develop and test new therapies for chronic, severe mental illness
Social and behavioral sciences	• Counseling for behavioral change • Understanding the cause of differential impact of the pandemic on racial and ethnic minorities • Understanding and addressing vaccine hesitancy	• Recognizing the consequences of structural racism within the profession of medicine and scientific discovery • Engaging with patients and their communities around social and behavioral change
Epidemiology and data science	• Pandemic tracking	• Identification of health disparities by socioeconomic and other demographic strategies • Operationalizing population health
Ethics	• Ethical conduct of clinical trials • Ethical management of scarce resources and rationing	• Ethics of limitations on reproductive health care by faith-based educational institutions • Ethics of for-profit health care strategies
Systems engineering	• Redesign of clinical care delivery • Continuous improvement of processes based on measured outcomes • Evaluation and investigation of differential outcomes by population	• Investigate differential health care outcomes in care provided to populations that have been historically marginalized
Public health	• Population-level interventions (masking, quarantine) • Crisis communication	• Advocacy for greater public health resources to address climate change, environmental toxins, and adverse social conditions
Education	• Effective continuing medical education • Mass education for laypeople	• Novel methods in health professions education to address contemporary issues

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Retraction to: Diversity, Inclusion, and Equity: Evolution of Race and Ethnicity Considerations for the Cardiology Workforce in the United States of America From 1969 to 2019

Originally published 6 Aug 2020 | https://doi.org/10.1161/JAHA.119.014602 | Journal of the American Heart Association. 2020;9:e014602

This article is retracted by

Other version(s) of this article

[redacted]

DAILY COMMENT

THE SUPREME COURT APPEARS READY, FINALLY, TO DEFEAT AFFIRMATIVE ACTION

Moderate conservative Justices voted with liberals to protect the program in the past, but there are no such Justices now.

By Nicholas Lemann

January 27, 2022

FIRST OPINION

Exclude race from medical school admissions and students, patients, and the entire health care system lose out

By Lee [illegible]22

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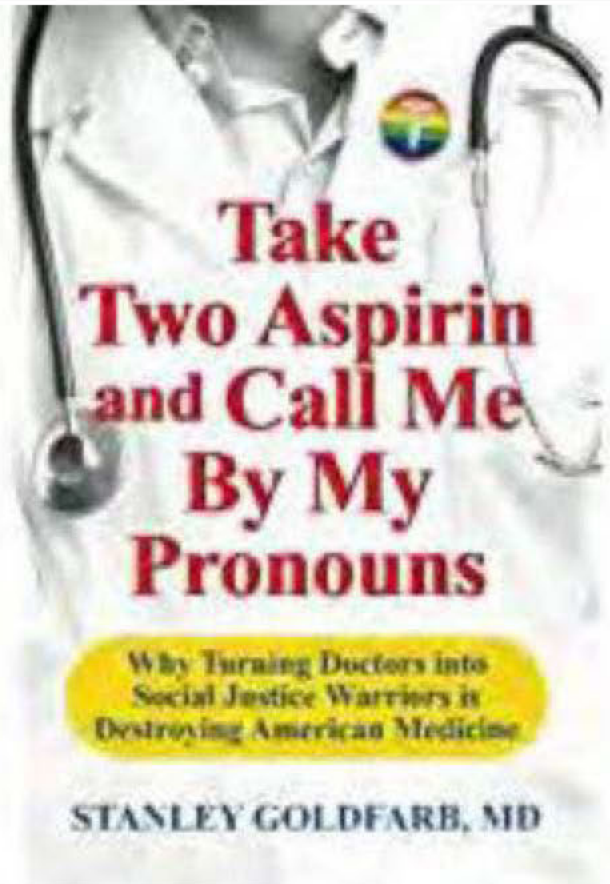
OPINION | REVIEW & OUTLOOK Follow

Medical Education Goes Woke

Future doctors will be obliged to learn how health relates to 'systems of oppression.'

By The Editorial Board Follow
July 26, 2022 7:05 pm ET



MEDIA · Published November 1, 2022 3:59pm EDT

Doctor blames 'cancel culture' on losing key gig after speaking out against liberal ideology in healthcare

Do No Harm chairman Dr. Stanley Goldfarb was terminated by UpToDate

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Summary

- The “new-age” resident experience reflects the response of academic medicine to ***longstanding labor rules***, ***expectations for learning environments/curriculum***, and ***political interplay*** between local, state, and national organizations (“Alphabet soup”)
- Lack of transparent or adaptable institutional policies may hinder resident wellness and allow insensitive attitudes to be assumed of leadership
- Residents may **resort to their own advocacy** when they feel **abandoned** by the institutions to which they commit much of their lives

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Special thanks

AAMC Board of Directors

AAMC Leadership and Staff

Organization of Resident Representatives

Our respective institutions [redacted]

Dr. [redacted] (PGY-1 ENT, [redacted])

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Questions?

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Exhibit 25:
SJC-AMA-000000073
Report 5 of the Council on Medical Education

HOD ACTION: Recommendations in Council on Medical Education Report 5 be adopted and the remainder of the report be filed.

REPORT 5 OF THE COUNCIL ON MEDICAL EDUCATION (I-23)
Organizations to Represent the Interests of Resident and Fellow Physicians (Resolution 304-A-22)
(Reference Committee C)

EXECUTIVE SUMMARY

The American Medical Association (AMA) adopted policy H-310.912, "Residents and Fellows' Bill of Rights" to protect the rights and well-being of medical residents and fellows in the United States. This set of guidelines and principles aims to ensure the professional development, well-being, and rights of medical residents and fellows are safeguarded, allowing them to provide quality care and grow in their medical careers. This bill of rights stems from a history of reforms to improve the training experience for residents and fellows.

As the needs of residents and fellows continue to evolve with the changing medical education ecosystem, it is necessary to understand the entities best suited to protect the rights and well-being of these trainees as detailed in the Residents and Fellows' Bill of Rights. These entities include governmental agencies, resident/fellow forums, resident medical staff organizations, accreditors, associations, and unions. Ultimately, there is no single entity suited to being permanently responsible for the interests of residents and fellows that can hold institutions accountable for fulfilling the Residents and Fellows' Bill of Rights, as described in AMA policy. Residents and fellows need to be empowered as the leading advocates for the Resident and Fellows' Bill of Rights to make this policy a reality.

What is fundamental is representation and organization of residents and fellows to advocate within their institutions and nationally to influence medical education and workplace policies. The AMA and Federation of Medicine can advocate for resident and fellow empowerment both within our profession and at the residents and fellows' sponsoring institutions to facilitate implementation of the rights detailed in this bill of rights. In addition, self-advocacy requires protection from retaliation and threats to livelihood for trainees participating in good faith advocacy.

The Council on Medical Education recommends adopting new policy encouraging the formation of peer-led resident/fellow organizations that can advocate for implementation of the AMA's Resident and Fellows' Bill of Rights at institutions that sponsor graduate medical education (GME), as well as the development of a formal process for resident/fellow physicians to transfer to another GME program without penalty when an employment situation is not sustainable for a trainee and/or program. The Council on Medical Education also recommends amplifying awareness of FREIDA™ as a resource for medical students, residents, and fellows; investigating its current capacity to post open, vacant positions by program directors; and adding the ability for residents and fellows to post positions with program transfers. Lastly, the Council recommends amending Policy H-310.912, "Residents and Fellows' Bill of Rights."

HOD ACTION: Recommendations in Council on Medical Education Report 5 be adopted and the remainder of the report be filed.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION
DRAFT OUTLINE

CME Report 5-I-23

Subject: Organizations to Represent the Interests of Resident and Fellow Physicians (Resolution 304-A-22)

Presented by: Cynthia Jumper, MD, Chair

Referred to: Reference Committee C

Resolution 304-A-22, "Accountable Organizations to Resident and Fellow Trainees," was authored by the American Medical Association (AMA) Resident and Fellow Section and submitted to the 2022 Annual Meeting of the House of Delegates (HOD). The resolution reads as follows:

> RESOLVED, That our American Medical Association work with relevant stakeholders to: (1) determine which organizations or governmental entities are best suited for being permanently responsible for resident and fellow interests without conflicts of interests; (2) determine how organizations can be held accountable for fulfilling their duties to protect the rights and well-being of resident and fellow trainees as detailed in the Residents and Fellows' Bill of Rights; (3) determine methods of advocating for residents and fellows that are timely and effective without jeopardizing trainees' current and future employability; (4) study and report back by the 2023 Annual Meeting on how such an organization may be created, in the event that no organizations or entities are identified that meet the above criteria; and (5) determine transparent methods to communicate available residency positions to displaced residents.

The resolution was subsequently referred by the HOD for a report back the House; this report is in response to the referral. The title of this report has been revised slightly to avoid potential confusion of the term "accountable organization" with "accountable care organization" or ACO.

Background

AMA Residents and Fellows' Bill of Rights

In 2011, the AMA adopted policy H-310.912, "Residents and Fellows' Bill of Rights" with the intent to protect the rights and well-being of medical residents and fellows in the United States. This set of guidelines and principles aims to ensure the professional development, well-being, and rights of medical residents and fellows are safeguarded, allowing them to provide quality care and grow in their medical careers. The key provisions of the bill can be summarized as follows:

1. An education that fosters professional development, takes priority over service, and leads to independent practice.
2. Appropriate supervision by qualified physician faculty with progressive resident responsibility toward independent practice.

3. Regular and timely feedback and evaluation based on valid assessments of resident performance.
4. A safe and supportive workplace with appropriate facilities.
5. Adequate compensation and benefits that provide for resident well-being and health.
6. Clinical and educational work hours that protect patient safety and facilitate resident well-being and education.
7. Due process in cases of allegations of misconduct or poor performance.
8. Access to and protection by institutional and accreditation authorities when reporting violations.

The need to establish this bill of rights stems from a history of reforms to improve the training experience for residents and fellows. Prior to 1989, there had been no national standardized duty hour regulations for residents in the United States. Residency programs typically had arbitrary work hour policies, and it was common for residents to work extremely long hours, including shifts that lasted over 24 consecutive hours or more. On-duty hours of first-year residents exceeded a mean of 80 hours per week (e.g., neurosurgery residents reported averaging 110 hours per week).[1] The lack of uniform regulations produced significant variations in work hour practices across different institutions and specialties. Excessive work hours also raised growing concern about the working conditions and treatment of medical residents due to high-profile cases of medical errors or adverse outcomes for patients. Several research studies conducted in the late 1980s and early 2000s shed light on the adverse effects of long work hours and sleep deprivation on resident physicians.[2,3,4,5] These studies highlighted the increased risk of medical errors, decreased quality of patient care, and the negative impact on resident well-being, and they provided empirical evidence that supported the need for reform in residency training.

One high-profile case that was instrumental to policy changes for residents was Libby Zion. Ms. Zion died while under the care of fatigued and overworked residents at New York Hospital (now New York Presbyterian Hospital).[6] Following a civil trial for this case, David Axelrod, the New York State commissioner of public health, appointed a commission led by Bertrand M. Bell, MD, to investigate her death and evaluate the circumstances that led to it. The New York State Ad Hoc Advisory Committee on Emergency Services report, which became known as the Bell Commission Report, examined the broader issues of patient safety, quality of care, and supervision within the medical context and brought attention to the need for appropriate supervision and patient safety measures within medical settings. Following the recommendations of the Bell Commission, New York State enacted the Libby Zion law in 1989, which implemented regulations on resident work hours, supervision, and the qualifications of supervising physicians. The law mandated a limit of 80 hours of work per week for residents, with additional restrictions on the duration of continuous work shifts.

The Libby Zion Law led to increased awareness and discussions about the need for national standards and guidelines regarding resident work hours, which eventually influenced the development of duty hour regulations at the national level by the Accreditation Council for Graduate Medical Education (ACGME).

ACGME Duty Hour Standards

Prior to 2003, the ACGME did not have national standardized duty hour regulations for residents in the United States. Residency programs had flexibility in setting their own work hour policies, resulting in significant variations in duty hour practices across institutions and specialties. The absence of specific ACGME duty hour standards meant that work hour practices were determined by individual residency programs and could vary widely. Some programs implemented more restrictive policies voluntarily, while others adhered to more traditional models with longer work hours and limited time off. In response to mounting concerns about resident well-being, patient safety, and the need for standardized guidelines, the ACGME developed formal duty hour regulations, which were implemented in 2003.[7] These regulations marked a significant shift in the approach to resident work hours and aimed to balance resident well-being, patient safety, educational opportunities, and work hours and mitigate fatigue while maintaining high-quality training experiences. Key reforms that were introduced in 2003 include:

1. **Work Hours Limits:** Residents were not to work more than 80 hours per week, averaged over a four-week period.
2. **Mandatory Time Off:** Residents were required to have at least one day off per week, averaged over four weeks, or at least one day off every seven days.
3. **Maximum Shift Length:** Residents would have a maximum shift length of 24 consecutive hours, with an additional six hours permitted for specific patient care activities and transitions. Following each shift, residents were required to have a minimum of 10 hours off duty for rest.
4. **Supervision and Handovers:** Residents were required to be supervised appropriately and strategies needed to be in place to ensure smooth handovers of patient care during shift changes. These changes aimed to enhance patient safety and ensure effective communication and continuity of care during transitions between resident physicians.
5. **Moonlighting Restrictions:** Moonlighting, referring to engaging in additional paid work outside of the residency program, was regulated to prevent excessive work hours and potential fatigue.
6. **Educational Requirements:** To emphasize the importance of education and learning opportunities, residents should have dedicated time for educational activities, including conferences, didactic sessions, and self-directed learning.
7. **Oversight and Compliance:** This reform established mechanisms to monitor and enforce compliance with the new duty hour standards. This included conducting regular site visits, surveys, and evaluations of residency programs to ensure adherence to the regulations.

In 2011, ACGME implemented additional reforms in duty hour standards to further address concerns about resident well-being, patient safety, and the need for enhanced educational experiences.[8] These reforms aimed to build upon the previous regulations, further enhancing resident well-being, patient safety, and educational experiences. Key reforms that were introduced in 2011 include:

1. **Limiting Shift Length for First-Year Residents:** Established stricter limits on shift duration for first-year residents (interns). Interns' shifts were capped at a maximum of 16 consecutive hours, recognizing the increased vulnerability of inexperienced residents to fatigue-related errors.
2. **Enhanced Supervision:** Emphasized the importance of appropriate supervision and oversight of resident physicians. Faculty and senior physicians were required to provide direct supervision and be physically present during critical patient care activities and procedures.

3. **Handover Principles:** Introduced principles for safe and effective handovers of patient care during shift changes. These principles aimed to ensure seamless transitions between resident physicians, minimizing the potential for errors and miscommunication.
4. **Individualized Learning Plans:** Emphasized the development of individualized learning plans for residents. These plans were intended to align with each resident's educational goals and ensure adequate opportunities for professional development and learning.
5. **Enhanced Monitoring and Compliance:** Implemented more robust mechanisms for monitoring and enforcing compliance with the duty hour standards. This included increased oversight, regular program evaluations, and the use of data-driven metrics to assess and address issues related to resident work hours.
6. **Resident Input and Feedback:** Emphasized the importance of resident input and feedback in shaping duty hour policies and ensuring resident well-being. Encouraged open communication channels for residents to voice concerns and provide input on work hour practices and the learning environment.

ACGME continues to conduct ongoing evaluations of the duty hour standards to optimize both resident training and patient care outcomes.

Additionally, the National Academy of Medicine (formerly known as the Institute of Medicine), published "Resident Duty Hours: Enhancing Sleep, Supervision, and Safety" in 2009. This report specifically examined the impact of resident duty hours on patient safety, resident well-being, and education. It highlighted concerns about the potential negative effects of long work hours and sleep deprivation on patient outcomes and resident performance. The report recommended several changes, including reducing the maximum number of continuous work hours, providing protected sleep periods, enhancing supervision, and promoting a culture of professionalism and shared responsibility.

Negative impacts of private equity in medical education: Hahnemann and Summa Health

The impact of private equity ownership of teaching hospitals and medical groups has raised concerns of new weaknesses and gaps in protecting residents and fellows' education and rights. As detailed in Council on Medical Education Report 1-I-22, "The Impact of Private Equity on Medical Training," the closure of Philadelphia's Hahnemann University Hospital (HUH) in fall 2019 highlighted the growing and damaging influence of private equity on medical education and training. It may be analogous to compare the excesses of managed care organizations in the 1990s, which provided impetus for the AMA to develop the Physicians for Responsible Negotiation, to the corporate overreaching exhibited by the owners of HUH, which has similarly served to catalyze opposition to the interference of private equity in medical education.

HUH's closing left 572 resident and fellow physicians without an ACGME-accredited program in which to continue their medical education.[9] They were also affected by the loss of long-tail medical liability insurance needed to continue practice. While the AMA and other local and national organizations in medical education came together to aid the affected physicians, residents and fellow trainees remain vulnerable to the negative effects of hospital closures that threaten the quality and completion of their graduate medical education (GME), financial well-being, and legal status within the United States.

A similar event occurred in 2016 at Summa Health™, an integrated nonprofit health care delivery system in the Akron, Ohio area that sponsors 15 ACGME-accredited residency and fellowship programs. A contract dispute between Summa Health™ and Summa Emergency Associates (SEA), an independent physician group that is separate from the health system led to the replacement of

about 60 faculty physicians and 30 residents in Summa's emergency medicine program. The 60 physicians were replaced by a group of emergency physicians paid by Canton-based US Acute Care Solutions.[10] This event led to the loss of accreditation for the institution's emergency medicine residency in 2017, causing displacement to the education of the affected residents and disruption to patient care services. The program acquired new leadership and faculty but remained nonaccredited until 2019.[11] As with HUH, the AMA and other organizations offered financial support to the affected trainees seeking relocation.

Organizations with purview over resident/fellow training and work conditions

As the needs of residents and fellows continue to evolve with the changing medical education ecosystem, understanding what entities are best suited to protect the rights and well-being of resident and fellow trainees, as detailed in the Residents and Fellows' Bill of Rights, becomes necessary. These organizations include governmental agencies, accreditors, resident/fellow forums, resident medical staff organizations, associations, and unions.

Governmental agencies

State and federal governments have broad authority to regulate workplace safety and standards through law and regulation. Federal authority to regulate residencies is linked to the federal government's major role as a funder of GME and health care.

In the United States, the abolition of slavery and the rise of the industrial economy after the Civil War led to the legal principle where workers bargained with owners for wages in exchange for their labor, leading to the formation of labor unions. With industrialization, workplace hazards expanded, and the study of workplace hazards became included in the scope of public health referred to as occupational safety and health.

With the New Deal, the National Labor Relations Act of 1935 established the right of employees to form and join unions, obligated employers to bargain collectively, and created the National Labor Relations Board (NLRB) to enforce employee rights. In addition, the first federal legislation to control workplace conditions was enacted. State and the federal departments of labor began to establish and enforce workplace health and safety standards, and unions bargained with employers for improved working conditions. In 1970, the Occupational Safety and Health Act established the National Institute of Occupational Safety and Health (NIOSH) in the National Institutes of Health to research workplace safety and the Occupational Safety and Health Administration (OSHA) to regulate working conditions.

OSHA health care standards focus on workplace exposures to infection, drugs, chemicals, and radiation; musculoskeletal injuries from patient handling; and workplace violence. OSHA standards are not specific to residents. OSHA does not regulate work hours, and there are no laws generally limiting work hours for adult employees. OSHA twice rejected petitions to regulate resident duty hours in 2002 and 2011. Agencies regulating specific industries (e.g., Federal Aviation Administration) may limit duty hours for workers in that specific industry. There are no federal agencies regulating resident work hours; however, the Centers for Medicare and Medicaid Services (CMS) grants deeming authority to ACGME to set standards for residency education as a requirement for receiving Medicare GME funding.

CMS primarily oversees the Medicare and Medicaid programs including Medicare GME funding. CMS does not usually set standards on working conditions, although in November 2022, CMS issued a memo on workplace violence and safety requirements in hospitals. Hospitals' failure to

meet CMS regulatory expectations may lead to citations. The full CMS memo is featured as Appendix B of this report.

States also have labor agencies that regulate workplace health and safety, but state laws specific to residency duty hours and working conditions, such as New York's Libby Zion law, are the exception rather than the rule. States also regulate hospitals and other clinical facilities, licenses physicians including residents, and may set standards for health and safety requirements for employees and patients.

Workplace laws and regulations are enforceable, but enforcement is divided between different agencies and levels of government (federal, state, local). It should also be noted that workplace regulations are rarely specific to residency and usually do not consider educational issues. Additionally, the process of changing laws and regulations is a long, complex legal process involving a broad array of interested parties whose political influence may shape outcomes with unintended consequences. Professional self-governance in establishing and enforcing professional standards has long been advocated by the AMA and the Federation of Medicine.

Accreditors

An accreditor is a non-governmental or private professional organization that develops professional standards and criteria and conducts peer evaluations and expert visits to assess if the criteria are met. An accreditor is entitled to accord formal status to operate an educational institution, program, or facility following successful examination of the application and evaluation of such entities. Accreditors are often deemed authority by governmental agencies because of their expertise and capacity to encourage compliance with standards.

The primary accreditors setting standards affecting residents are the ACGME and the Joint Commission, previously known as the Joint Commission on Accreditation of Healthcare Organizations. The ACGME accredits residency programs and their sponsoring institutions and the Joint Commission accredits health care organizations, including those sponsoring residency education.

The ACGME sets accreditation standards and requirements for all allopathic (MD) and osteopathic (DO) residency programs across various specialties and their sponsoring institutions. As of July 1, 2020, the ACGME became the accrediting body for all residency programs, including those previously accredited by the American Osteopathic Association.[12] The ACGME Board of Directors is comprised of members nominated by the AMA, American Board of Medical Specialties (ABMS), American Hospital Association, Association of American Medical Colleges, Council of Medical Specialty Societies, American Osteopathic Association, and American Association of Colleges of Osteopathic Medicine; public and at-large members; the chair of the Council of Review Committee Chairs, and two resident members. The ACGME also oversees each specialty's review committee, which all include a resident/fellow member, that accredits individual residency programs and proposes specialty-specific accreditation requirements. The ACGME also oversees the Institutional Review Committee, which accredits sponsoring institutions. ACGME accreditation requirements address the resident learning and working environment including work hours, leave, well-being, facilities, and services to support resident rest, safety, and well-being. The ACGME also requires at least two peer-selected residents to serve on each ACGME-accredited Sponsoring Institution's Graduate Medical Education Committee, which is required to oversee the learning and work environment at all residency programs sponsored by the institution.

ACGME's Council of Review Committee Residents (CRCR) also serves as a forum for resident physicians serving on the ACGME's board and review committees to provide input, feedback, and perspective on matters related to GME and accreditation. The CRCR consists of residents from various specialties across the United States appointed by their respective residency programs or specialty organizations to provide a resident physician perspective on accreditation policy.

In recognition of professional self-governance, government agencies usually defer to ACGME to set standards for resident education.

The ACGME promulgates educational standards for residency programs and sponsoring institutions that are enforceable through corrective actions such as probation or loss of accreditation. However, accreditors have few intermediate sanctions short of loss of accreditation, which would also negatively impact the affected residents at that institution/program. Accreditation standards must be related to education and the learning environment, which may limit accreditation standards from addressing workplace and patient care issues that cannot be tied to resident education. Furthermore, accreditation standards apply broadly and may not address specific problems at individual institutions or programs.

The Joint Commission accredits and certifies health care organizations and programs in the United States. The Joint Commission board includes representatives from the AMA, American College of Physicians, American College of Surgeons, American Dental Association, American Hospital Association, and public/at-large members. While the Joint Commission does not have specific accreditation standards or requirements pertaining directly to resident learning environment or work conditions, the Joint Commission indirectly impacts resident physician training and work conditions through its broader standards related to patient safety and quality of care. By emphasizing patient safety, organizations accredited by the Joint Commission are encouraged to create environments that prioritize patient well-being, which can impact working conditions for resident physicians.

Resident/fellow forum or resident medical staff organization

A resident/fellow forum or resident medical staff organization provides an opportunity for residents to give feedback directly to their sponsoring institution leaders including the designated institutional official (DIO). Additionally, the resident medical staff model gives residents a formal role in the medical staff, where they can influence institutional policy through the medical staff.

The ACGME requires sponsoring institutions with multiple ACGME-accredited programs to have a Graduate Medical Education Committee (GMEC) that includes a minimum of two peer-selected residents/fellows from among its ACGME-accredited programs. When a program only has one resident/fellow, the sponsoring institution must include that individual on its program's GMEC among its voting members. The ACGME requirements also mandate that sponsoring institutions with more than one program must ensure availability of an organization, council, town hall, or other platform (resident/fellow forum) that allows all residents/fellows across the sponsoring institution's ACGME-accredited programs to communicate and exchange information relevant to their ACGME-accredited programs and their learning and working environment. This requirement also mandates that any resident/fellow from that sponsoring institution can directly raise a concern to the forum; conduct their forum without the DIO, faculty members, or other administrators present; and have the option to present concerns that arise from discussions at the forum to the DIO and GMEC.[13] However, these requirements do not mandate that a sponsoring institution establish or support an ongoing resident organization at the institution. The resident/fellow forum can facilitate organizing and collective action by residents at the institution and discussion of institution

or program specific issues, but without ongoing institutional support and with frequent resident turnover, the resident/fellow forum's ability to address long-term resident concerns can be limited.

A resident medical staff organization formally incorporates residents into the organized medical staff with their own governance structure. The organized medical staff has responsibility for credentialing, privileging, peer review, and oversight of clinical quality and patient safety, and the organized medical staff is a self-regulating organization of professionals governed by bylaws that are a binding, mutually enforceable agreement between the organized medical staff and the hospital governing body. The resident medical staff organization can advocate for workplace health and safety through the medical staff and engage in peer review of residents. In addition, since most residency physician faculty are also members of the medical staff, the organized medical staff can enable formal discussions between residents and faculty about the learning and work environments at the institution. A limitation of the resident medical staff is that the organized medical staff is associated with a specific health care organization. Residents may have clinical rotations in other health care facilities independent of the sponsoring institution where the organized medical staff, and thus the resident medical staff, does not have authority.

Associations

Professional associations, such as the AMA and other medical societies, organize members of the profession to establish practice, educational, and ethical standards, advance professional knowledge and skills, and advocate for the profession and the people the profession serves. Government bodies usually give considerable deference to professional association standards, providing professional associations authority beyond that gained through advocacy by the association. Professional associations facilitate organizing and collective action by members and enable unified effort in dealings with government bodies, businesses, organizations, and other professions and trades. Professional associations can also enable mobilization of the resources of the profession including collective expertise and professional networks.

Since its founding, the AMA, through the Council on Medical Education, made advancing medical educational standards a high priority, having established accreditation and credentialing bodies including the ACGME and the ABMS. Federation members including state and specialty medical associations collaborate with the AMA on accreditation, certification, and licensure issues. The American Osteopathic Association has a similar role for osteopathic physician education. The Association of American Medical Colleges (AAMC) is the professional association of medical schools and teaching hospitals and takes a leadership role in allopathic medical education accreditation, and the American Association of Colleges of Osteopathic Medicine (AACOM) takes a similar role in osteopathic medicine education.

As association members, residents and fellows can leverage the influence of their professional associations to advocate for the rights and well-being of resident and fellow trainees. The Residents and Fellows' Bill of Rights is a leading example of AMA policy to protect resident and fellow rights and well-being. The AMA provides many opportunities for residents and fellows to influence and formulate AMA policy. The Resident and Fellow Section is composed of peer-selected resident and fellow leaders from state and specialty medical societies who develop section policy that is then proposed for adoption as AMA policy. Residents and fellows also have designated voting seats on AMA governing bodies including the House of Delegates, AMA Councils, and the Board of Trustees. Through the AMA, residents and fellows have influenced ACGME accreditation standards on the learning and working environment, including work hour standards, and have mobilized the medical profession to assist residents harmed by the closure of Hahnemann University Hospital.

In the AOA, the Bureau of Emerging Leaders is the representative body and advocate for all osteopathic medical students, osteopathic physicians in postdoctoral training, and early-career osteopathic physicians.

The AAMC established the Organization of Resident Representatives (ORR) to provide resident input into AAMC policy and to provide leadership opportunities for residents interested in academic medicine. ORR resident members are appointed by Council of Faculty and Academic Societies members representing either department chairs or program directors.

AACOM established the Assembly of Osteopathic Graduate Medical Education Residents and Fellows Council to develop future leaders in the osteopathic profession by creating a community and forum for residents and fellows to connect, collaborate, and learn.

Associations can facilitate organizing and collective action, providing residents with opportunities to network with residents from other institutions/regions/states. Residents may influence association policy that the association can utilize to support resident advocacy and lobby on their behalf. Associations can leverage their influence to help shape professional standards and norms. Associations also appoint members of accreditation organizations that develop standards and requirements. However, association policies are not directly enforceable; enforcement only occurs if adopted by governmental and regulatory bodies. Furthermore, association policies are usually not specific to problems at particular institutions or programs. Resident and fellow influence may also be limited by organization governance rules (e.g., resident leaders are not peer-selected, residents have no or limited participation in policymaking and/or leadership, and/or resources for resident activities are limited).

Unions

Through the National Labor Relations Act, a certified union has the sole legal authority to collectively bargain for employment terms and conditions for the class of employees the union represents. The employer is obligated to engage in collective bargaining with the union.

A union can serve as a collective voice for resident physicians representing their interests and concerns to their employer. Unions are recognized in law with the authority to negotiate binding labor contracts with employers, such as hospitals or healthcare systems. These enforceable contracts outline the terms and conditions of employment, including work hours, schedules, compensation, benefits, and grievance procedures. Through collective bargaining, unions can negotiate for improvements in work conditions, duty hours, supervision, workload, and other aspects that affect resident physicians' work and safety environment and well-being, but education standards are not part of collective bargaining. Unions often establish grievance procedures to address complaints and disputes regarding work conditions, training, or other employment-related matters. They provide support and guidance to resident physicians when filing grievances and assist in resolving conflicts. Unions can act as an intermediary between resident physicians and employers to ensure that concerns are addressed, and rights are protected. Unions can also advocate for changes in laws or regulations to enhance work hours, supervision, and other aspects of resident training. They can also offer educational support by providing educational resources, training programs, workshops, conferences, or seminars on topics such as contract negotiations, labor rights, and professional development. Unions that represent resident physicians include the Committee on Interns and Residents (CIR) of the Service Employees International Union (SEIU), the Union of American Physicians and Dentists and the Alliance of Resident Physicians.

Unions provide three basic functions: collective bargaining, political advocacy, and mutual aid (health insurance and pensions for membership). For physicians, the right to collectively bargain (i.e., negotiating contract terms with an employer on behalf of its employees) is a key driver of physician union development and participation. A study published in the Journal of the American Medical Association in 2022 focused specifically on resident/fellow unions as a tool to address burnout during training and serve as a needed counterweight to deleterious corporate influence in health care.[14] However, unions are not a panacea to the growing trend of corporate influence in medical education and practice. For example, during the mass layoff of all residents at Hahnemann, a collective bargaining agreement would not have prevented the residents from losing their positions. The Worker Adjustment and Retraining Notification (WARN) Act requires advance notice in cases of mass layoffs, but it would not have ensured the residents would have continued their GME during that time. They would still have had to find new positions mid-year. Further, certain states and regions of the country are less hospitable to the development of unions than others. In addition, even with a certified union at their workplace, some residents may opt out of joining the union and paying dues, because of a 2018 Supreme Court ruling banning mandatory union fees for public-sector workers;[15] however, all residents would still fall under the collective bargaining agreement including the wages, benefits, and working and safety conditions the resident union obtained in negotiation. Reaching a collective bargaining agreement can be challenging, and employers may stall for years when employees choose to work without a contract instead of going on strike. While a union can provide some level of protection to its members' employment, a union cannot guarantee that residents' future employability would not be jeopardized by their activism. State labor laws and the composition of the NLRB may also affect the ability of a union to provide its members protection from retribution by employers.

A Comparison of Organizations for Residents

The table below provides a high-level perspective of which organizations can assist in protecting the rights and well-being of resident and fellow trainees as detailed in the Residents and Fellows' Bill of Rights.

Table 1. Organizations that can assist resident and fellow physicians with protecting their rights.

Bill of Rights	Governmental Agencies	Resident /Fellow Forum or Resident Medical Staff Organization	Accreditors	Associations	Unions
1. Education	✓	✓	✓	✓	
2. Supervision	✓	✓	✓	✓	✓
3. Assessment & Evaluation		✓	✓	✓	✓
4. Workplace Safety	✓	✓	✓	✓	✓
5. Compensation & Benefits	✓	✓		✓	✓
6. Patient Safety & Resident Well-being	✓	✓	✓	✓	✓
7. Due Process	✓	✓		✓	✓
8. Access & Protection	✓		✓	✓	

Communicating available residency positions to displaced residents

Residents may be displaced because of closure of their program or sponsoring institution or because of circumstances that make continued employment in their residency program untenable. To meet the NRMP Match agreement, Section 6.1.2 (Duty to Act in an Ethical and Professional Manner) and 10.0.b (Binding Commitment) state a resident must enter and remain at their matched training program for 45 calendar days after the start date of the relevant appointment contract. For residents and program directors, there is not a single, unified mechanism for displaced residents to find appropriate residency position vacancies to facilitate a transfer.

While the Match is designed to place residents starting with first-year positions, it does have subcategories such as Physician-R—meaning, reserved for doctors with previous residency experience—and Advanced, which places residents into PGY-2 positions. These positions may present an avenue to transfer through the Match. Program directors may share information about their residents seeking transfers and vacancies at their program through their program director association or informal networks. The AAMC developed FindAResident that compiles listings of potential residency openings, which is accessible for a subscription fee. ResidentSwap is a website providing anonymous listings of positions currently filled by residents who would like to swap their current location or specialty with another resident.

The AMA has been a leader in providing data and information to residents and fellows to support their careers as physicians. The AMA Residency and Fellowship Database, FREIDA™ offers guidance on finding residency programs by helping members compare and rank programs.

Discussion

There is no single organization or government entity suited to being permanently responsible for resident and fellow interests that can hold organizations accountable for fulfilling the Residents and Fellows' Bill of Rights as described in AMA policy. In addition, any organization or governmental entity with the authority to implement such standards will not be free of political influence, given the stakes involved in GME and physician workforce. Residents and fellows must be empowered to be the leading advocates for the Resident and Fellows' Bill of Rights to make this policy a reality.

Residents and fellows have many opportunities as described in this report to advocate for implementing the Residents and Fellows' Bill of Rights at their programs and institutions. What is fundamental to their success is representation and empowerment of residents and fellows to advocate within their institution and more broadly to influence national medical education and workplace policies. The AMA and Federation of Medicine can advocate for resident empowerment, both within our profession and at the residents and fellows' sponsoring institutions to facilitate implementation of the Resident and Fellows' Bill of Rights. In addition, self-advocacy requires protection from retaliation and threats to the careers and livelihood of residents participating in good faith advocacy. As the AMA seeks to empower our physician members to advocate for patients and their practices, the AMA can similarly support resident and fellow physicians doing the same at their hospitals and clinics during training.

Unfortunately, there are sometimes circumstances in a residency program in which the employment situation for a resident or fellow is not sustainable and efforts for change are ineffective or too prolonged. A formal process needs to be developed for resident or fellow physicians to be able to transfer to another GME program without penalty to their education and career. Beyond the Match, transfer seekers are often on their own to secure a position. At the organizational level, the AMA could explore expanding the capacity for FREIDA™ to support program, resident, and fellow postings of available residency and fellowship positions.

Summary and Recommendations

The Council on Medical Education therefore recommends that the following recommendations be adopted in lieu of Resolution 304-A-22 and the remainder of this report be filed:

1. That Our AMA will encourage the formation of peer-led resident/fellow organizations that can advocate for trainees' interests, as outlined by the AMA's Residents and Fellows' Bill of Rights, at sponsoring institutions. (New HOD Policy)

2. That Our AMA will encourage the development of a formal process for resident/fellow physicians to transfer to another graduate medical education program, without penalty, when an employment situation is not sustainable for a trainee and/or program. (New HOD Policy)

3. That Our AMA will investigate promoting the current capacity of FREIDA™ to post open positions and adding the ability for FREIDA™ to facilitate the process of residents and fellows who wish to transfer programs. (Directive to Take Action)

4. That AMA Policy H-310.912, "Residents and Fellows' Bill of Rights," be amended by addition, to read as follows (Modify Current HOD Policy):

"12. Our AMA will distribute and promote the Residents and Fellows' Bill of Rights online and individually to residency and fellowship training programs and encourage changes to institutional processes that embody these principles, including resident/fellow empowerment and peer-selected representation in institutional leadership.

"13. Our AMA encourages development of accreditation standards and institutional policies designed to facilitate and protect residents/fellows who seek to exercise their rights."

Fiscal note: $1000

APPENDIX A: RELEVANT AMA POLICIES

Residents and Fellows' Bill of Rights H-310.912

1. Our AMA continues to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows: a) adequate financial support for and guaranteed leave to attend professional meetings; b) submission of training verification information to requesting agencies within 30 days of the request; c) adequate compensation with consideration to local cost-of-living factors and years of training, and to include the orientation period; d) health insurance benefits to include dental and vision services; e) paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year; and f) stronger due process guidelines.

2. Our AMA encourages the ACGME to ensure access to educational programs and curricula as necessary to facilitate a deeper understanding by resident physicians of the US health care system and to increase their communication skills.

3. Our AMA regularly communicates to residency and fellowship programs and other GME stakeholders this Resident/Fellows Physicians' Bill of Rights.

4. Our AMA: a) will promote residency and fellowship training programs to evaluate their own institution's process for repayment and develop a leaner approach. This includes disbursement of funds by direct deposit as opposed to a paper check and an online system of applying for funds; b) encourages a system of expedited repayment for purchases of $200 or less (or an equivalent institutional threshold), for example through payment directly from their residency and fellowship programs (in contrast to following traditional workflow for reimbursement); and c) encourages training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment in advance or within one month of document submission is strongly recommended.

5. Our AMA will partner with ACGME and other relevant stakeholders to encourage training programs to reduce financial burdens on residents and fellows by providing employee benefits including, but not limited to, on-call meal allowances, transportation support, relocation stipends, and childcare services.

6. Our AMA will work with the Accreditation Council for Graduate Medical Education (ACGME) and other relevant stakeholders to amend the ACGME Common Program Requirements to allow flexibility in the specialty-specific ACGME program requirements enabling specialties to require salary reimbursement or "protected time" for resident and fellow education by "core faculty," program directors, and assistant/associate program directors.

7. Our AMA encourages teaching institutions to offer retirement plan options, retirement plan matching, financial advising and personal finance education.

8. Our AMA adopts the following "Residents and Fellows' Bill of Rights" as applicable to all resident and fellow physicians in ACGME-accredited training programs:

RESIDENT/FELLOW PHYSICIANS' BILL OF RIGHTS
Residents and fellows have a right to:

A. An education that fosters professional development, takes priority over service, and leads to independent practice.

With regard to education, residents and fellows should expect: (1) A graduate medical education experience that facilitates their professional and ethical development, to include regularly scheduled didactics for which they are released from clinical duties. Service obligations should not interfere with educational opportunities and clinical education should be given priority over service obligations; (2) Faculty who devote sufficient time to the educational program to fulfill their teaching and supervisory responsibilities; (3) Adequate clerical and clinical support services that minimize the extraneous, time-consuming work that draws attention from patient care issues and offers no educational value; (4) 24-hour per day access to information resources to educate themselves further about appropriate patient care; and (5) Resources that will allow them to pursue scholarly activities to include financial support and education leave to attend professional meetings.

B. Appropriate supervision by qualified physician faculty with progressive resident responsibility toward independent practice.

With regard to supervision, residents and fellows must be ultimately supervised by physicians who are adequately qualified and allow them to assume progressive responsibility appropriate to their level of education, competence, and experience. In instances where clinical education is provided by non-physicians, there must be an identified physician supervisor providing indirect supervision, along with mechanisms for reporting inappropriate, non-physician supervision to the training program, sponsoring institution or ACGME as appropriate.

C. Regular and timely feedback and evaluation based on valid assessments of resident performance.

With regard to evaluation and assessment processes, residents and fellows should expect: (1) Timely and substantive evaluations during each rotation in which their competence is objectively assessed by faculty who have directly supervised their work; (2) To evaluate the faculty and the program confidentially and in writing at least once annually and expect that the training program will address deficiencies revealed by these evaluations in a timely fashion; (3) Access to their training file and to be made aware of the contents of their file on an annual basis; and (4) Training programs to complete primary verification/credentialing forms and recredentialing forms, apply all required signatures to the forms, and then have the forms permanently secured in their educational files at the completion of training or a period of training and, when requested by any organization involved in credentialing process, ensure the submission of those documents to the requesting organization within thirty days of the request.

D. A safe and supportive workplace with appropriate facilities.

With regard to the workplace, residents and fellows should have access to: (1) A safe workplace that enables them to fulfill their clinical duties and educational obligations; (2) Secure, clean, and comfortable on-call rooms and parking facilities which are secure and well-lit; (3) Opportunities to participate on committees whose actions may affect their education, patient care, workplace, or contract.

E. Adequate compensation and benefits that provide for resident well-being and health.

(1) With regard to contracts, residents and fellows should receive: a. Information about the interviewing residency or fellowship program including a copy of the currently used contract clearly outlining the conditions for (re)appointment, details of remuneration, specific responsibilities including call obligations, and a detailed protocol for handling any grievance; and b. At least four months advance notice of contract non-renewal and the reason for non-renewal.

(2) With regard to compensation, residents and fellows should receive: a. Compensation for time at orientation; and b. Salaries commensurate with their level of training and experience. Compensation should reflect cost of living differences based on local economic factors, such as housing, transportation, and energy costs (which affect the purchasing power of wages), and include appropriate adjustments for changes in the cost of living.

(3) With regard to benefits, residents and fellows must be fully informed of and should receive: a. Quality and affordable comprehensive medical, mental health, dental, and vision care for residents and their families, as well as retirement plan options, professional liability insurance and disability insurance to all residents for disabilities resulting from activities that are part of the educational program; b. An institutional written policy on and education in the signs of excessive fatigue, clinical depression, substance abuse and dependence, and other physician impairment issues; c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined amount of paid vacation leave, sick leave, family and medical leave and educational/professional leave during each year in their training program, the total amount of which should not be less than six weeks; e. Leave in compliance with the Family and Medical Leave Act; and f. The conditions under which sleeping quarters, meals and laundry or their equivalent are to be provided.
F. Clinical and educational work hours that protect patient safety and facilitate resident well-being and education.
With regard to clinical and educational work hours, residents and fellows should experience: (1) A reasonable work schedule that is in compliance with clinical and educational work hour requirements set forth by the ACGME; and (2) At-home call that is not so frequent or demanding such that rest periods are significantly diminished or that clinical and educational work hour requirements are effectively circumvented. Refer to AMA Policy H-310.907, "Resident/Fellow Clinical and Educational Work Hours," for more information.
G. Due process in cases of allegations of misconduct or poor performance.
With regard to the complaints and appeals process, residents and fellows should have the opportunity to defend themselves against any allegations presented against them by a patient, health professional, or training program in accordance with the due process guidelines established by the AMA.
H. Access to and protection by institutional and accreditation authorities when reporting violations.
With regard to reporting violations to the ACGME, residents and fellows should: (1) Be informed by their program at the beginning of their training and again at each semi-annual review of the resources and processes available within the residency program for addressing resident concerns or complaints, including the program director, Residency Training Committee, and the designated institutional official; (2) Be able to file a formal complaint with the ACGME to address program violations of residency training requirements without fear of recrimination and with the guarantee of due process; and (3) Have the opportunity to address their concerns about the training program through confidential channels, including the ACGME concern process and/or the annual ACGME Resident Survey.

9. Our AMA will work with the ACGME and other relevant stakeholders to advocate for ways to defray additional costs related to residency and fellowship training, including essential amenities and/or high cost specialty-specific equipment required to perform clinical duties.

10. Our AMA believes that health care trainee salary, benefits, and overall compensation should, at minimum, reflect length of pre-training education, hours worked, and level of independence and complexity of care allowed by an individual's training program (for example when comparing physicians in training and midlevel providers at equal postgraduate training levels).

11.The Residents and Fellows' Bill of Rights will be prominently published online on the AMA website and disseminated to residency and fellowship programs.

12. Our AMA will distribute and promote the Residents and Fellows' Bill of Rights online and individually to residency and fellowship training programs and encourage changes to institutional processes that embody these principles.

Resident Physicians, Unions and Organized Labor H-383.998

Our AMA strongly advocates for the separation of academic issues from terms of employment in determining negotiable items for labor organizations representing resident physicians and that those organizations should adhere to the AMA's Principles of Medical Ethics, which prohibits such organizations or any of its members from engaging in any strike by the withholding of essential medical services from patients.

1.2.10 Political Action by Physicians

Like all Americans, physicians enjoy the right to advocate for change in law and policy, in the public arena, and within their institutions. Indeed, physicians have an ethical responsibility to seek change when they believe the requirements of law or policy are contrary to the best interests of patients. However, they have a responsibility to do so in ways that are not disruptive to patient care.

Physicians who participate in advocacy activities should:

(a) Ensure that the health of patients is not jeopardized and that patient care is not compromised.

(b) Avoid using disruptive means to press for reform. Strikes and other collection actions may reduce access to care, eliminate or delay needed care, and interfere with continuity of care and should not be used as a bargaining tactic. In rare circumstances, briefly limiting personal availability may be appropriate as a means of calling attention to the need for changes in patient care. Physicians should be aware that some actions may put them or their organizations at risk of violating antitrust laws or laws pertaining to medical licensure or malpractice.

(c) Avoid forming workplace alliances, such as unions, with workers who do not share physicians' primary and overriding commitment to patients.

(d) Refrain from using undue influence or pressure colleagues to participate in advocacy activities and should not punish colleagues, overtly or covertly, for deciding not to participate.

AMA Principles of Medical Ethics: I,III,VI

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

APPENDIX B: CMS Memo on Workplace Violence in Hospitals

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality

Ref: QSO-23-04-Hospitals

DATE: November 28, 2022

TO: State Survey Agency Directors

FROM: Directors, Quality, Safety & Oversight Group (QSOG) and Survey & Operations Group (SOG)

SUBJECT: Workplace Violence-Hospitals

Memorandum Summary

- Workers in hospitals, nursing homes, and other healthcare settings face risks of workplace violence. Many factors contribute to this risk, including working directly with people who have a history of aggressive behavior, behavioral issues, or may be under the influence of drugs.
- An April 2020 Bureau of Labor Statistics Fact Sheet found that healthcare workers accounted for 73 percent of all nonfatal workplace injuries and illnesses due to violence in 2018. This number has been steadily growing since tracking of these specific events began in 2011.
- Exposure to workplace violence hazards come at a high cost; however, with appropriate controls in place, it can be addressed.
- CMS will continue to enforce the regulatory expectations that patient and staff have an environment that prioritizes their safety to ensure effective delivery of healthcare.

Background

CMS believes that healthcare workers have a right to provide care in a safe setting. CMS health and safety requirements do not preclude healthcare workers from taking appropriate action to protect themselves from workplace violence. However, it is incumbent on the leadership at these healthcare facilities to ensure they provide adequate training, sufficient staffing levels, and ongoing assessment of patients and residents for aggressive behavior and indicators to adapt their care interventions and environment appropriately.

Medicare certified hospitals have a regulatory obligation to care for patients in a safe setting under the Medicare Hospital Conditions of Participation (CoPs) at §482.13(c)(2). The intention of this requirement is to specify that each patient receives care in an environment that a reasonable person would consider to be safe. For example, hospital staff should follow current

standards of practice for patient environmental safety, infection control, and security. The hospital must protect vulnerable patients, including newborns and children. Additionally, this standard is intended to provide protection for the patient's emotional health and safety as well as his/her physical safety. Respect, dignity and comfort would also be components of an emotionally safe environment.

In order to provide care in a safe setting, hospitals should identify patients at risk for intentional harm to self or others, identify environmental safety risks for such patients, and provide education and training for staff and volunteers. Patients at risk of suicide (or other forms of self-harm) or who exhibit violent behaviors toward others receive healthcare services in both inpatient and outpatient locations of hospitals. Although all risks cannot be eliminated, hospitals are expected to demonstrate how they identify patients at risk of self-harm or harm to others and steps they are taking to minimize those risks in accordance with nationally recognized standards and guidelines. The potential risks include, but are not limited to, those from ligatures, sharps, harmful substances, access to medications, breakable windows, accessible light fixtures, plastic bags (for suffocation), oxygen tubing, bell cords, etc.

All hospitals are expected to implement a patient risk assessment strategy, but it is up to the hospital to implement the appropriate strategies. For example, a patient risk assessment strategy in a post-partum unit would most likely not be the same risk assessment strategy utilized in the emergency department.

Additionally, under the Medicare Hospital Emergency Preparedness CoP at §482.15(a), a hospital's emergency preparedness plan must be based on, and include, a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. It must also include strategies for addressing emergency events identified by the risk assessment as well as address the patient population, including, but not limited to, persons at-risk.

Hospitals should also provide the appropriate level of education and training to staff regarding the identification of patients at risk of harm to self or others, the identification of environmental patient safety risk factors, and mitigation strategies. Staff would include direct employees, volunteers, contractors, per diem staff and any other individuals providing clinical care under arrangement. The Emergency Preparedness CoP at §482.15(d)(1) contains requirements for hospitals to train staff and to have policies and procedures aimed at protecting both their workforce and their patients.

Hospitals have the flexibility to tailor the training to the particular services staff provide and the patient populations they serve. CMS expects hospitals to provide education and training to all new staff initially upon orientation and whenever policies and procedures change. Additionally, CMS recommends ongoing training at least every two years after initial training.

CMS has cited hospitals in the past for failures to meet these obligations. Examples include a nurse in a unit without adequate staffing who was sexually assaulted by a behavioral health patient who was stopped only through intervention by other patients; a patient who died after hospital staff and law enforcement performed a takedown that resulted in a hospital custodian holding the patient down on the floor with his knee against the patient's back, during which the

patient stopped breathing and died; and a patient who was acting out and shot in his hospital room by off-duty police officers following the failure of hospital staff to perform appropriate assessment and de-escalation of the patient. These cases highlight systemic failures in facilities that place both patients and staff at risk.

CMS will continue to enforce the regulatory expectations that patient and staff have an environment that prioritizes their safety to ensure effective delivery of healthcare.

Contact: Questions about this memorandum should be addressed to [redacted]@cms.hhs.gov.

Effective Date: Immediately. This policy should be communicated to all survey and certification staff and managers immediately.

/s/

[redacted]
Director, Survey & Operations Group

[redacted]
Director, Quality, Safety & Oversight Group

cc: Survey and Operations Group Management
Office of Program Operations and Local Engagement (OPOLE)
Centers for Clinical Standards and Quality (CCSQ)

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Exhibit 26:
SJC-AMA-000000785
Trouble Financing your Move for Medical Residency? Consider this Option

www.ama-assn.org /medical-residents/medical-residency-personal-finance/trouble-financing-your-move-medical-residency

Trouble financing your move for medical residency? Consider this option

The transition to residency can be costly, particularly for those moving long distances.

The American Moving and Storage Association states that the average cost of an interstate household move (long-distance moving) is about $4,300. That doesn't include potential security deposits and other hidden costs.

For physicians who are months removed from medical school, that cost burden might require some extra help. In some instances, it may be worth considering a residency-relocation loan.

AMA Member Benefits PLUS

Membership has its advantages:

- Laurel Road student loan refinance: 0.25% rate discount
- Unlimited access to the JAMA Network®
- Lenovo**:** Save up to 30% off select Lenovo systems, devices, and much more

Discover More Benefits

STRICTLY CONFIDENTIAL - FOR COMMITTEE AND STAFF USE ONLY SJC-AMA-000000785

What are residency-relocation loans?

Residency-relocation loans are personal loans aimed at helping cover the cost of interviewing for and relocating to a residency program. Laurel Road—a preferred provider of the AMA for student-loan refinancing—also offers loans to cover residency relocation.

Borrowing limits can be up to $15,000 for expenses due to residency relocation.As is the case with Laurel Road's student loans, relocation loans can be paid at a low rate while residents are in training. In some instances, residents can pay as little as $25 a month during residency. While there is a payment minimum borrowers can choose to pay more each month without having to worry about a prepayment penalty Borrowers can also pay off the loan at any time with no early payment penalty.

Related Coverage

M4s: Know the do’s and don’ts for homebuying during residency

"If you are moving to a new city, it may be that you need to put down first and last month's rent for a new apartment. It could also be the cost of moving your belongings as well as your family to a new city," said Kaitlin Walsh-Epstein, vice president of marketing at Laurel Road. "The idea is this loan aims to help bridge that big life gap as they are making a big move during a time when new residents don't have a paycheck coming in."

A lower-interest option

Laurel Road works specifically with physician customers and understands their particular needs. Because of that, it is willing to extend loan offers that other banks may not, based on a resident physician's long-term earning potential—rather than their annual salary during training.

"Laurel Road looks at this population through a different lens. We understand the life stage they are at," Walsh-Epstein said. "This is a unique need for many new physicians at a critical juncture in their careers."

Covering the cost of residency relocation with a personal loan is likely to yield a much lower interest rate than doing so with a credit card, according to Walsh-Epstein.

Related Coverage

4 factors to consider when buying a home after medical residency

"In a lot of instances when you take out a credit card, your rates will go up significantly after that introductory period," she said. "This provides you the peace of mind that you have these fixed rates for a longer period of time. Some people can pay these five- or seven-year loans off sooner and that flexibility is appealing to many borrowers."

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The AMA selected Laurel Road as a preferred provider to support you in navigating your financial future. AMA members who take out a personal loan with Laurel Road receive an additional 0.25% rate discount through AMA Member Benefits PLUS.

The 0.25% AMA member interest rate discount is offered for personal loan applications from active AMA members. The AMA discount is applied to your monthly payment and will be reflected in your billing statement. The discount will end if the AMA notifies Laurel Road that the borrower is no longer a member. This offer cannot be combined with other member or employee discounts, except any discount for making automatic payments.

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Exhibit 27:
June 30, 2025
NRMP Statement

The National Resident Matching Program's Supplemental Statement on Congress's Confirmation of Antitrust Status of Graduate Medical Resident Matching Programs

June 30, 2025

I. Introduction and Executive Summary

The National Resident Matching Program® (NRMP®) appreciates the opportunity to provide this supplemental statement to the House Judiciary Committee Subcommittee on Administrative State, Regulatory Reform, and Antitrust (the Subcommittee). NRMP submits this statement following our June 6, 2025 meeting with counsel and professional staff members for the Subcommittee to discuss issues raised during the May 14, 2025 hearing entitled "The MATCH Monopoly: Evaluating the Medical Match Residency Antitrust Exemption."[1]

Consistent with our June 6 discussion, the matters raised during the May 14 hearing primarily concerned aspects of the broader transition to residency and physician pathway within the United States – not the limited scope and purpose of the actual "Match" as administered by NRMP. Congress recognized the importance of The Match in 2004 by granting it an antitrust exemption (the "Matching Algorithm Exemption"). *See* 15 U.S.C. § 37b. Congress's confirmation of the antitrust status of graduate medical resident matching programs (i.e., The Match by NRMP and other independent residency matching programs used by certain medical specialties) is a well-supported and narrowly-tailored means of safeguarding the various pro-competitive benefits of The Match for graduates of medical school, the hospitals that provide graduates vital training, and the patients and payors that depend on well-trained physicians to provide medical services.

Disruption to the matching process, whether by an attempt to repeal the Matching Algorithm Exemption or otherwise, will do nothing to address issues that are outside the confines of The Match and, instead, will cause significant harm to applicants seeking post-graduate training and the supply and distribution of residents to the nation's training institutions. This is particularly true in regard to legitimate discussions regarding resident compensation. As discussed below, resident compensation (in addition to the training, education, and other benefits provided by programs) is primarily dictated by a federal and state regulatory regime that exists independent of The Match. Within this framework, NRMP's policies and processes for The Match allow for vigorous competition, maximize outcomes, and protect applicants from undue coercion.

To further assist the Subcommittee's evaluation of the antitrust status of graduate medical resident matching programs, we address the following points:

- **The Match was created to remedy a chaotic, inefficient process for applicants—not to suppress them.** Before 1952, residency recruitment was characterized by "exploding" offers, opaque information flows, and binding commitments extracted from medical students long before graduation. The NRMP

[1] As discussed during our June 6 meeting, NRMP appreciates the Subcommittee's recognition that many statements made during the May 14 hearing misattributed aspects of the broader transition to residency to the "the Match" or otherwise incorrectly referred to "the Match" when discussing matters that are the responsibility of other, separate organizations within the medical education community. NRMP reiterates that "The Match®" is a registered mark of the National Resident Matching Program and should not be used in connection with other entities, including but not limited to, other matching services and other stakeholders in the transition to residency.

eliminated this race to the bottom by serving as an objective, independent party for both applicants and programs to rank their true preferences confidentially and simultaneously. Decades of outcome data confirm that the algorithm reliably produces stable, preference-maximizing matches that fill nearly all participating residency training positions available across the U.S.

- **Eliminating the Matching Algorithm Exemption will not change the fundamental market factors that drive how resident salaries are funded or determined.** The core drivers of resident salaries are the government programs that view residency programs as part of a physician's graduate medical education and determine the number of federally funded residency positions. Specifically, Medicare, the largest funding source for resident positions, formulaically determines the government payments that are intended to help hospitals and health systems cover the training costs of residency programs. Because the market for residents substantially differs from conventional labor markets, those government payments constrain hospital and program's ability to raise salaries through conventional funding mechanisms. Moreover, with a relatively fixed supply of residency positions and more applicants than available residency positions, the outcome is downward pressure on salaries for residents. Eliminating the exemption will not eliminate these government and market characteristics, both of which tend to put downward pressure on resident salaries.

- **The Matching Algorithm Exemption is narrow and tailored to ensuring the recognized benefits of The Match.** The exemption immunizes the act of sponsoring, conducting, or participating in a matching program that uses an algorithm to pair preferences; it expressly withholds protection from any agreement among programs to fix wages or benefits. Courts are instructed to construe the exemption narrowly, and nothing in its text shields conspiracies over resident stipends, working conditions, or other restraints that are not ancillary to the matching process and its recognized benefits.

- **The Match promotes—rather than reduces—competition and outcomes in a highly regulated labor market.** Through the processes and policies developed by NRMP, The Match fuels competition by affording applicants and programs the ability to discover and express their true preferences. By ensuring that more than 9 out of 10 participating positions are filled, NRMP reduces the risks of private and public investments in residency training and enables the consistent growth in residency positions over time. At the same time, Match processes protect applicants from having their careers derailed by expected hardships or delays. Finally, The Match facilitates a merit-based, level playing field for programs and applicants (including both allopathic and osteopathic candidates) to secure training positions across the country.

- **The Match serves Congressional investments and interests in graduate medical education.** The United States faces an aging population and a projected physician shortfall. NRMP's operation of The Match provides an efficient,

> nationwide allocation mechanism that maximizes the fill rate of federally funded residency positions, which directly advances Congress's interest in safeguarding public health. Threats to this existing process, such as attempts to repeal the Matching Algorithm Exemption, would divert scarce resources from patient care and threaten abandonment of a system that has demonstrably served students, hospitals, and communities for more than seven decades.

In sum, NRMP and The Match deliver pro-competitive benefits, enhance market outcomes, and ensure the intended benefits of substantial federal and private investments in graduate medical education. Calls to repeal the Matching Algorithm Exemption will not raise resident salaries or increase the number of practicing physicians; rather, it would risk the return of higher recruiting costs, decreased resident class sizes across the country, fewer future physicians entering the workforce, and other inefficiencies that The Match successfully eradicated, to the detriment of applicants, programs, and, ultimately, patients.

II. Background of The Match

(a) General

Training for medical students was formalized in the early 1900s (but began in the 1870s) as a critical component of medical education. By the 1930s, a market had formed, and hospitals raced to recruit medical students. As internship positions outnumbered the graduating medical school seniors available to fill them, hospitals extended offers to students (via telegram and, more urgently, by telephone) as early as their second year in medical school. Students had only hours to accept or reject these offers. The competition and absence of structure bred unfairness, inequality, and unwarranted pressure.[2] In 1945, national organizations like the AAMC voted to support a "Cooperative Plan" that, namely, called for a uniform release date for student appraisals (called the "School Date"), which holds a day for uniform release of the MSPE (the Medical Student Performance Evaluation) every October 1 and a uniform "acceptance date" before which students should not be offered internships.[3] Although the Cooperative Plan was an improvement on the process of transitioning students into internships, students still found themselves having to accept offers under increasingly compressed deadlines.[4] In response, a centralized clearinghouse for internship placement was proposed by the National Interassociation Committee on Internships (NICI), which included the AAMC, the AMA's Council on Medical Education, national hospital associations like the American Hospital Association, the American Protestant Hospital Association and the American Catholic Hospital Association, as well as Federal agencies like Offices of the Surgeon General of the U.S. Air Force and the United States Public Health Service.[5]

[2] F.J. Mullin, *A Proposal for Supplementing the Cooperative Plan for Appointment of Interns*, Journal of the Association of American Medical Colleges, 25(6): 437-442 (1950).
[3] Joseph Turner, *Intern Selection: Wanted, An Orderly Plan*, Journal of the Association of American Medical Colleges, 20(1): 26-32 (1945).
[4] Alvin E. Roth, *The Origins, History and Design of the Resident Match*, Journal of the American Medical Association, 289(7):909-912 (2003).
[5] Mullin, *supra* note 1.

The NRMP was created in 1952 as an independent, non-profit organization to establish an orderly and uniform process for medical students to obtain graduate medical education ("GME") positions in U.S. teaching hospitals. This process by NRMP, which may be referred to as "The Match®", connects medical students with residency positions by utilizing its proprietary matching algorithm that pairs preferences of applicants with preferences of training programs.

(b) The Current Matching Process

1. **Registration:** Registering for a Match is an open call to all potential participants and is a separate and voluntary process from applying to training programs. To register for The Match, applicants must complete the registration process in the NRMP's Registration, Ranking, and Results® (R3®) system, sign The Match Participation Agreement, and pay Match fees.

2. **Applying to Programs:** Applicants apply to most training programs through the Electronic Residency Application Service (MyERAS), a service of the Association of American Medical Colleges (AAMC) or through the Residency Central Application Service (ResCAS), a service of Liaison International providing an application platform for the specialties of OB-GYN and Emergency Medicine. The NRMP plays no role in the program application process.

3. **Interviews:** Programs review applications and invite selected candidates for interviews. Electronic interview scheduling and management platforms are provided by AAMC/Thalamus (Thalamus is a private entity that partners with the AAMC) and ResCAS and are independent of the NRMP. Residency interviews usually occur October through January of the fourth year of medical school.[6] The NRMP does not schedule or in any way aid programs in selecting candidates to interview, nor does it restrict conversations about applicant salary, onboarding, or other contractual terms before, during, or after interviews.

4. **Create Rank Order Lists (ROLs):** After registering for The Match and completing interviews, applicants submit to the NRMP a list of programs, ranked in order of preference, where they wish to train. Program directors also submit to the NRMP a list of applicants, ranked in order of preference, whom they have interviewed and wish to train. This time period between applications, interviews, and the ROL deadline provides applicants the ability to review contracts, ask questions, and seek any other information about training conditions from the programs with which they have interviewed.

5. **Match Week:** Match Week for the Main Residency Match takes place the third week in March. It is the period of time beginning at 10:00 a.m. ET on Monday and ending at 12:00 p.m. ET on Friday ("Match Day") when applicants and programs learn the results of The Match.

[6] "The Interview Timeline," AAMC, accessed June 30, 2025, https://students-residents.aamc.org/applying-residencies-eras/publication-chapters/interview-timeline.

Monday of Match Week: At 10:00 a.m. ET, applicants learn if (but not where) they matched.

Monday – Thursday of Match Week: The time between Match Status Notification and Match Day is structured to allow unmatched and partially matched applicants the opportunity to apply and interview for unfilled positions prior to Match Day. This process is called the Supplemental Offer and Acceptance Program® (SOAP®) wherein applicants can view a List of Unfilled Programs in the NRMP's R3 system and then apply for unfilled positions for which they are eligible through MyERAS or ResCAS. Programs review applications, contact applicants of interest, and create preference lists of applicants in the NRMP's R3 system. On Thursday, unfilled positions are offered to eligible applicants on the program's preference list in a series of four rounds.

Friday of Match Week: At 12:00 p.m. ET, Match results are released.

(c) The NRMP's Matching Algorithm

The NRMP's matching algorithm is "applicant proposing," meaning the preferences expressed on the rank order lists submitted by applicants, not programs, initiate placement into training. The matching algorithm attempts to place an applicant (Applicant A) into the program indicated as most preferred on Applicant A's rank order list. If Applicant A cannot be matched to this first-choice program (because the program doesn't also prefer Applicant A or the program has matched to applicants who also preferred the program and were more preferred by the program than Applicant A), an attempt is then made to place Applicant A into the second choice program, and so on, until Applicant A obtains a tentative match, or all of Applicant A's choices have been exhausted (meaning Applicant A cannot be tentatively matched to any program on the ROL). The matching algorithm ensures stability for both applicant and program preferences because no alternative result could yield a more desirable outcome for participants.

(d) The NRMP's Role within the Broader GME Community

The NRMP and The Match exist within a broader transition to residency process alongside several other organizations. In particular, the application and recruitment phase is handled by other GME stakeholders, who maintain various resources applicants can use to investigate residency programs and obtain information including salary information. These resources include the Association of American Medical College's ("AAMC") Residency Explorer Tool (provides program-specific information and data), the AAMC Council of Teaching Hospitals and Health Systems ("COTH") surveys (which collects and reports national salary data), the American Medical Association ("AMA") Fellowship and Residency Electronic Interactive Database ("FREIDA") tool, Texas Star, individual residency program publications and websites, and others. Applicants apply to residency programs either through the AAMC MyERAS application platform or through the Residency Central Application Service ("ResCAS") (OB-GYN and in 2026, Emergency Medicine) platform. Programs and applicants also may use the AAMC/Thalamus (Thalamus is a

private entity that partners with the AAMC) interview platform or the ResCAS interview platform to offer/accept interviews before proceeding with either virtual, in-person, or hybrid interviews.

Similarly, accreditation of programs—including accreditation standard-setting and oversight—is the responsibility of the Accreditation Council for Graduate Medical Education ("ACGME").[7] However, that does not mean that ACGME acts in a vacuum when making accreditation decisions. Rather, its standards are shaped and heavily influenced by the requirements of other major medical organizations. The majority of state medical boards require applicants for unrestricted licensure to complete training in ACGME-accredited programs, prompting ACGME to embed state licensing expectations into its supervision, curricular, and milestone frameworks. Similarly, the American Board of Medical Specialties ("ABMS") and its member boards mostly limit eligibility for board certification to graduates of ACGME-accredited residencies and fellowships, leading ACGME to collaborate closely with ABMS boards to align on "Core Competencies," entrustable professional activities, and case-log thresholds. Though accreditation is a voluntary process, and some residency programs in the U.S. are not accredited,[8] Medicare conditions its GME funding on a hospital's sponsorship of ACGME-accredited programs.[9]

Other stakeholders within the transition to residency include the American Osteopathic Association ("AOA"), which supports training programs dedicated to teaching the principles of osteopathic medicine.[10] The AOA Commission on Osteopathic College Accreditation ("COCA") is given authority by the U.S. Department of Education to accredit DO-granting colleges of medicine.[11] The American Association of Colleges of Osteopathic Medicine ("AACOM") also participates in the transition to residency process.[12] AACOM represents DO-granting medical schools located in the U.S.[13]

As just one of many GME stakeholders, NRMP does not control, dictate, or interfere with the respective responsibilities of its peer organizations. NRMP does not control how many positions are available in a given program, does not control whether an institution participates in The Match, and does not determine any of the terms of employment that are offered by accredited programs that choose to participate in The Match. Nor does NRMP dictate the application and interview decisions of programs and applicants. Rather, NRMP focuses its efforts on operating The Match within the broader transition to residency in a manner that maximizes outcomes for all participants. The enabling processes and policies of The Match ensure a merit-based, competitive process for post-graduate medical education training that is fair, transparent, and free of undue coercion or influence.

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[7] "Overview," ACGME, accessed June 30, 2025, https://www.acgme.org/about/overview/#:~:text=The%20Accreditation%20Council%20for%20Graduate, medical%20care%20to%20all%20Americans.
[8] "ACGME Frequently Asked Questions (FAQs)," ACGME, accessed June 30, 2025, https://www.acgme.org/about/acgme-frequently-asked-questions.
[9] "The Match Terms and Topics," NRMP, accessed June 30, 2025, https://www.nrmp.org/intro-to-the-match/the-match-terms-and-topics/.
[10] *Id.*
[11] *Id.*
[12] *Id.*
[13] *Id.*

(e) The Matching Algorithm Exemption Generally

The Matching Algorithm Exemption provision of the Pension Funding Equity Act of 2004[14], codified at 15 U.S.C. § 37b, was passed into law nearly 50 years after The Match began operating. The Exemption states that:

> It shall not be unlawful under the antitrust laws to sponsor, conduct, or participate in a graduate medical education residency matching program, or to agree to sponsor, conduct, or participate in such a program. Evidence of any of the conduct described in the preceding sentence shall not be admissible in Federal court to support any claim or action alleging a violation of the antitrust laws.[15]

The term "graduate medical education residency matching program" is defined as "a program (such as those conducted by the National Resident Matching Program) that, in connection with the admission of students to graduate medical education programs, ***uses an algorithm*** and matching rules to match students in accordance with the preferences of students and the preferences of graduate medical education programs."[16]

III. Eliminating the Matching Algorithm Exemption Will Not Remove the Market Factors that Put a Downward Pressure on Resident Salaries

(a) The Market for Residents Differs from Conventional Labor Markets

To obtain a license to practice medicine in the United States, medical school graduates must, among other licensing requirements, take part in a residency program in their chosen specialty (such as internal medicine, family medicine, or obstetrics and gynecology).[17] These residency programs typically last between three and seven years and are a form of hands-on training and education under the supervision of experienced physicians.[18]

Residency programs operate through hospitals and clinics. The hospitals and clinics usually serve as the employer and are responsible for paying their residents, and to do so, they generally receive funding from the government.[19] Due in part to statutory limits on the number of government-funded residency positions, there are a limited number of residency positions available, and the number of applicants exceeds the number of residency positions available for first-year residents

[14] Pension Funding Equity Act of 2004, Pub. L. No. 108–218, § 207, 118 Stat. 596 (codified at 15 U.S.C. § 37b).
[15] 15 U.S.C. § 37b(b)(2).
[16] *Id.* at § 37b(b)(1)(C).
[17] "About Physician Licensure," Federation of State Medical Boards, accessed June 20, 2025, https://www.fsmb.org/u.s.-medical-regulatory-trends-and-actions/guide-to-medical-regulation-in-the-united-states/about-physician-licensure/.
[18] "What is residency," AMA, May 20, 2024, https://www.ama-assn.org/medical-students/preparing-residency/what-residency.
[19] U.S. Congress, *Medicare Graduate Medical Education Payments: An Overview,* (Washington, D.C.: Library of Congress, 2022), https://www.congress.gov/crs-product/IF10960.

in a given year. For example, in 2025 there were 47,208 applicants and only 40,041 positions available for first-year residents.[20]

The market for residency programs differs from that of conventional employment arrangements in several ways, which are outlined below.

1. Residency programs are a supervised clinical training period.

Because the government views residency programs as a form of training, training institutions are only able to bill for services provided by residents using the Medicare Physician Fee Schedule if a fully licensed and credentialed physician is present during critical parts of the service or if they are providing evaluation and management services within a program that has a primary care exception.[21] Unlike residency programs, certified physicians usually bill for the services that they provide their patients. Physicians perform medical procedures (including screenings, diagnoses, etc.) and they bill for these services accordingly.[22] Physicians are then compensated, in part, based on both the volume of their services as well as the revenues that their services generate.[23]

The way physicians (but not residents) are compensated is similar to the way employees and individuals are compensated in conventional labor markets. A lawyer, for example, will bill for the services that she provides her clients, usually based on the number of hours that she worked for the client, the percentage of the award won by the client, or the value of the services that are provided. This is the case for first-year lawyers, as well as for senior partners. Lawyers, at all levels, are then likely to receive compensation that is, at least in part, based on the value of the services that they performed. Even in conventional labor markets where an employee receives a salary, the salary level is usually related to some measure of employee performance (for example, the number of hours worked or the value of the services provided). And in cases where an employee is paid a salary and a bonus, it is the bonus component that reflects the value of the services provided (for example, the amount of sales that a sales representative made or the hours that an employee worked).

In contrast, residents are not compensated based on their performance, hours worked, or the volume or value of services they provide. This is not because they do not provide value to patients or to their employer, but rather because residents' employers (unlike employers in conventional labor markets) are not able to bill fully for all of the services that residents provide.

[20] 47,208 applicants refers to National Resident Matching Program (NRMP) applicants. *See*, "NRMP Releases 2025 Main Residency Match Results and Data Report, Providing In-Depth Insight into the Largest Residency Match in History," NRMP, May 29, 2025, https://www.nrmp.org/about/news/2025/05/nrmp-releases-2025-main-residency-match-results-and-data-report-providing-in-depth-insight-into-the-largest-residency-match-in-history/.
[21] "Guidelines for Teaching Physicians, Interns & Residents," *Centers for Medicare and Medicaid Services,* November 2024, https://www.cms.gov/files/document/guidelines-teaching-physicians-interns-residents.pdf.
[22] David E. Beck and David A. Margolin, "Physician Coding and Reimbursement," *The Ochsner Journal* 7, no. 1 (Spring 2007): 8-15, https://pmc.ncbi.nlm.nih.gov/articles/PMC3096340/.
[23] Rachel O. Reid, et al, "Physician Compensation Arrangements and Financial Performance Incentives in US Health Systems," *JAMA Health Forum* 3, no. 1 (January 28, 2022): e214634, doi:10.1001/jamahealthforum.2021.4634.

2. Salaries for residents are largely funded by Medicare.

Medicare is the largest funding source for GME in the United States,[24] distributing funds to qualified hospitals that trains residents in an approved residency program.[25] There are two separate funding streams for GME payments: direct GME ("DGME") and indirect GME ("IME") payments. DGME is the funding stream that covers the *direct* costs associated with training residents, including salaries.[26] Other funding sources include Medicaid, private payors, the Health Resources and Services Administration, the Veterans Health Administration, and the Department of Defense.[27] Thus, the most significant funding source for resident compensation does not come from the residents' employers (e.g., the hospitals or health systems that hire and train residents), but from a third party payor (i.e., the U.S. government).

The same is not true for conventional labor markets. There, employee compensation is generated from the revenues earned by the employer. If revenues are short, an employer in a conventional market may have to cut bonuses or ask employees to work fewer hours. Government employees are funded by the government because the government is the employer. But for private sector employers, employee salaries and wages are funded by the revenues that the employer earns. This market factor also makes the market for residents different from conventional markets.

3. Funding for medical residences is formulaically determined.

In the market for residents, government funding for medical residencies (which includes a stipend as compensation paid to the residents) is formulaically determined based on the hospital's historical costs, the number of residents each hospital trains (up to a certain hospital-specific limit), as well as the percent of the hospital's inpatient population that is Medicare beneficiaries.[28] Thus, the principal amount of compensation paid to residents in government-funded positions is not determined by the employer.

In a conventional labor market, however, the employer determines the amount of compensation that employees receive. The amount may be based on a number of factors, such as performance, seniority, title, and the like. A law firm, for example, sets the base salary and bonus structure for its lawyers. A hospital does the same for its employed physicians. Indeed, there is no national formula that governs the amount of compensation that a conventional employer has available to pay its employees. Again, this market factor makes the market for residents different from conventional markets.

[24] "Graduate Medical Education Funding," *National Conference of State Legislatures*, last modified January 9, 2024, https://www.ncsl.org/health/graduate-medical-education-funding.
[25] Association of American Medical Colleges, *Medicare Payments for Graduate Medical Education: What Every Medical Student, Resident, and Advisor Needs to Know*, April 2025, https://www.aamc.org/media/71701/download?attachment.
[26] "Graduate Medical Education Funding," *supra* note 24.
[27] *Id.*
[28] *Medicare Payments for Graduate Medical Education*, *supra* note 25.

4. In the market for residents the number of Medicare-funded positions is capped by Congress.[29]

Medicare-funded positions are allocated to hospitals based on a combination of factors, namely how many residents trained at that hospital in 1996.[30] The cap on Medicare-funded positions was instituted in 1997 as part of Congress' Medicare Balanced Budget Act, and there were not additional Medicare-funded residency positions added again until the 2020 when Congress passed legislation to add 1,000 new Medicare-funded positions.[31] The 2020 legislation also expanded eligibility for rural training track funding, which helps address physician shortages in rural areas by encouraging physicians to train (and hopefully practice) in these areas.[32] This, too, is another market factor that makes the market for residents different from conventional markets.

In a conventional labor market, employers can decide how many employees they want to hire. They can hire more employees if demand increases (say, by offering hiring salaries) and they can slow down their hiring as demand falls. A law firm that gets more clients will want to hire more lawyers; a hospital that has more patient volume will want to hire more certified physicians. In both cases, these hires are incentivized and supported by opportunities for greater revenue. Thus, in conventional markets, employers can increase or decrease the supply of hiring opportunities as they see fit and by virtue of increases or decreases in their revenue opportunities. This is not the case for hospitals and health systems when it comes to the opportunity to hire residents. Due to limitations on the number of Medicare-funded positions, training obligations, and residents' ability to generate revenues, a hospital that sees an increase in patient cases cannot easily increase the number of residents that it hires.

(b) The Implications of These Market Factors for Resident Salaries

The discussion above explains how funding for residencies is determined and how resident compensation is shaped by a number of important market institutional factors, which differ from a conventional labor market: (a) residents are still in a graduate education phase of their training, (b) residents cannot bill fully for their services, (c) the substantial majority of resident compensation is not funded by employers, and (d) employers do not have full control of how many residents they can hire. Notably, there is no Match policy that sets or provides guidance over salaries offered to residents.[33] Nor does The Match determine whether residents can bill for their

[29] "Graduate Medical Education Funding," *supra* note 24.
[30] Laura Gillenwater and Will Carter, *IME/GME Payments Overview, Common Issues, & Current Updates*, (Horne, 2022), https://www.ompw.org/OMPW/files/IME.GME-Updates.pdf.
[31]Kristin Schleiter Hitchell and Lauren Johnson, "CMS Finalizes Rules for Distribution of 1000 New Medicare-Funded Residency Positions and Changes to Rural Training Track Programs," *Journal of Graduate Medical Education* 14, no. 2 (April 2022): 245, doi:10.4300/JGME-D-22-00193.1.
[32] Association of American Medical Colleges, *Rural Track Programs: A Guide to the Updated Medicare Requirements*, (Association of American Medical Colleges, 2023), https://store.aamc.org/downloadable/download/sample/sample_id/587/.
[33] Avery Hurt, "Residency Match Process Under Scrutiny Again, This Time by AMA," *Medscape*, June 29, 2023, https://www.medscape.com/viewarticle/993860. (Dr. Donna Lamb, President and CEO of NRMP, confirmed that '"[t]he NRMP has no role in determining, publishing, or setting resident salaries nor does the NRMP have a role in the contracting or employment of residents and it never has.'") *See also*, National Resident Matching Program, "2026 Match Participation Agreement for Programs," April 24, 2025, https://www.nrmp.org/policy/2026-match-

services or the number of medical residency spots that are available in any given specialty or at any given hospital. The Match, however, does require residency programs to provide applicants with a contract (either the contract they would be expected to sign if a match were to take place, or the contract currently in use) prior to submitting rank order lists.[34] This policy benefits applicants by ensuring they can consider the amount of compensation offered by a program before submitting their rank ordered lists and thereby fosters competition between programs over resident compensation.

The four factors that make the market for residents different from conventional labor markets also shape the role of salaries as a competitive tool. In conventional markets, a company's salary or wages offered would be one tool that an employer can use to attract the best and most productive workers to the firm.[35] If there is a shortage of workers, for example, market driven salaries increase to entice more workers to enter the market.[36] But in the market for residents, the costs of training are greater than the revenue generated and so hospitals and clinics would not have a profit-maximizing incentive to increase salaries in order to hire.[37] Thus, the amount of compensation to be paid to residents is not a plausible competitive tool for their employers.

As a result, the core drivers of competition for residents are largely shaped by the government and the nature and purpose of medical residency programs. There are two core drivers of medical residency salaries, and both are likely to put downward pressure on resident compensation.

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participation-agreement-for-programs/. ("The NRMP is not an employment service and does not oversee the terms of any contract between programs and applicants.")

[34] National Resident Matching Program, "2026 Match Participation Agreement for Programs." ("The omission of information pertinent to an applicant's decision to rank a program may be deemed a violation of this Agreement. Before the Rank Order List Certification Deadline, or the offering of a position through SOAP, the program shall: Provide a copy of the appointment agreement that matched applicants will be expected to sign if such an agreement is available, or a copy of the agreement currently in use.") *See also*, UW School of Medicine Career Advising, "Residency Contracts," accessed June 20, 2025, https://education.uwmedicine.org/career-advising/applying-to-residency/residency-contracts/ (In addition to it "clearly spell[ing] out the terms of your employment," "[e]mployment agreements will also include the details of your salary."); Marshfield Clinic Division of Education, "Match Participation Agreement for Program," accessed June 20, 2025, https://www.marshfieldclinic.org/education/_acknowledgement ("In accordance with the NRMP Match Participation Agreement, we provide you access to the following four documents: 1) Benefit Program Summary; 2) Sample Agreement of Appointment; 3) Eligibility and Resident Selection; 4) Salaries and Benefits.").

[35] Other tools would include the quality of the firm's product, the expected growth of the firm, the firm's reputation, and the like.

[36] GEORGE J. BORJAS, LABOR ECONOMICS 145 (9th ed. 2024).

[37] If hospitals did have a profit-maximizing incentive to hire, they would cover the costs of additional residency programs themselves and increase the number of available positions beyond what the government funds until every qualified graduate of medical school had a position. However, in practice it is the case that "[w]hile medical school enrollment has grown 33% since 2002, the number of graduate medical education opportunities needed for those graduates to become licensed physicians has not kept pace. The United States is estimated to have a shortage of 81,180 full-time physicians by 2035." "Graduate Medical Education Funding," *supra* note 24. The American Medical Association points to more GME funding as necessary to curb this projected physician shortage. *See*, also, American Medical Association, *Addressing Physician Workforce Shortages With Bipartisan Graduate Medical Education Legislation,* 2025, https://www.ama-assn.org/system/files/2025-mac-gme-funding-issue-brief.pdf. Thus, without sufficient external funding, it is clear that market forces do not create sufficient profit-maximizing incentives for hospitals to supply the optimal number of residency positions.

- There is no real salary competition because salaries are largely influenced by the government and a government program that views medical residency programs as part of a physician's graduate medical education. More specifically, Medicare, the largest funding source for resident positions, formulaically determines DGME payments that are intended to help hospitals and health systems cover the training costs of residency programs (including the portion of costs paid as resident compensation). Even if a hospital or health system wanted to raise medical residency salaries, their reliance on government funding (driven by the fact that residents do not generate revenue in the same way as licensed, practicing doctors) may prevent them from doing so.

- The supply of Medicare-funded medical residency positions is also set by the government. Given these funding constraints, hospitals and health systems cannot easily increase the supply of available positions in the market, which in conventional markets is a fundamental foundation for labor market competition. This is particularly important in this setting because with a relatively fixed supply of medical residency positions and excess demand for these spots (i.e., more applicants than residency positions), the outcome is downward pressure on salaries for residents.[38]

(c) The Elimination of the Matching Algorithm Exemption Will Not Remove the Market Factors that Tend to Put a Downward Pressure on Resident Salaries

As shown above, there are a number of market factors that result in the market for medical residencies to be different from conventional labor markets. These market characteristics are largely shaped by the government, which (a) provides the vast majority of funds for medical residency positions and sets limits on those funds based on the view that medical residencies are part of a physician's graduate medical education and training and (b) determines the number of available Medicare-funded medical residency positions in the market. These dynamics shape the market for residents and in a market where there is an excess supply of applicants for medical residency positions, there is (a) little pressure for resident salaries to rise to levels similar to that of certified physicians or other advanced practice providers and (b) strong downward pressures on medical residency salaries. None of these forces disappear if the Matching Algorithm Exemption were eliminated.

IV. The Matching Algorithm Exemption is Unique

Statutory antitrust exemptions and immunities play a significant role in U.S. competition law when the existence of desirable conduct necessitates collective action that could be subject to repetitive challenges under the antitrust laws. There are important, recognized benefits of antitrust exemptions such as promoting effective and stable functioning in certain industries, and most importantly, supporting valuable social, economic, and/or policy goals. Even those skeptical of antitrust exemptions recognize that certain exemptions should be granted and/or remain in place when the exemption is narrowly tailored and achieves a Congressional goal. At the end of the day,

[38] "New AAMC Report Shows Continuing Projected Physician Shortage," *AAMC,* March 21, 2024, https://www.aamc.org/news/press-releases/new-aamc-report-shows-continuing-projected-physician-shortage.

it is well established that "[i]t is obviously not the purpose of the antitrust laws to condemn collaborations producing socially desirable results."[39]

The Matching Algorithm Exemption is the quintessential example of an antitrust exemption that belongs on the books, as it is narrowly tailored to achieve the pro-competitive benefits of The Match and reflects the public importance of ensuring a full utilization of congressionally funded residencies to train this country's physicians. In other words, the Matching Algorithm Exemption represents the societal importance of medical residency training and acknowledges the beneficial role that The Match algorithm plays in that process by maximizing efficiency in a highly regulated market. In fact, The Match's processes and policies work to increase competition within this regulated framework, as programs compete against one another to fill residency positions with their most preferred applicants. For these reasons, the Matching Algorithm Exemption is reflective of a more modern approach to antitrust exemptions in which Congress correctly recognized the extremely unique nature of post-graduate medical training in the United States and the significant, pro-competitive benefits that a matching process provides to its participants.

(a) The Matching Algorithm Exemption is Narrowly Tailored to Achieve the Pro-Competitive Benefits of The Match.

The Matching Algorithm Exemption is narrowly tailored to safeguard only the pro-competitive benefits that The Match offers. The Matching Algorithm Exemption does not encompass the entirety of the transition to residency or the full physician training pathway, as discussed above. Rather, it is limited to the graduate medical education residency matching process itself (i.e., a program that utilizes an "algorithm and matching rules"). The Matching Algorithm Exemption is limited to those individuals and entities that "sponsor, conduct, or participate" in a matching program. And to be sure, such individuals and entities are not granted total immunity under the antitrust laws. Rather, they are immunized in specific regard to their "sponsor[ing], conduct[ing], or participat[ing] in a graduate medical education residency matching program."

Additionally, the Matching Algorithm Exemption explicitly states that "[n]othing in this section shall be construed to exempt from the antitrust laws any agreement on the part of 2 or more graduate medical education programs to fix the amount of the stipend or other benefits received by students participating in such programs." As NRMP has repeatedly stated to the Subcommittee, The Match has no role in how programs independently determine their residents' compensation and benefits. But even if a program wrongly attempted to claim they engaged in price-fixing "while participating in The Match," allegations of wage fixing by programs do not benefit from the Exemption and the Exemption does not prohibit the use of evidence, such as evidence of communications between programs relating to wages, to prove a claim against a program. Further, the Supreme Court has repeatedly advised lower courts that exemptions to the antitrust laws must be narrowly construed.[40] Therefore, far from providing broad, overreaching immunity from antitrust scrutiny, the Matching Algorithm Exemption was drafted by Congress in an intentional

[39] Philip E. Areeda & Herbert Hovenkamp, ANTITRUST LAW: AN ANALYSIS OF ANTITRUST PRINCIPLES AND THEIR APPLICATION ¶ 1504 (2017)

[40] *See Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 126 (1982) ("[O]ur precedents consistently hold that exemptions from the antitrust laws must be construed narrowly."); *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 231 (1979) ("It is well settled that exemptions from the antitrust laws are to be narrowly construed.").

way to carefully narrowly tailor the use of a matching algorithm to the pro-competitive benefits of The Match, which are detailed immediately below.

1. **The Match affords applicants and programs the ability to discover and express their true preferences.**

Competitive markets "are improved by more rather than less price and quality information."[41] With increased information, competitive markets match inputs where they are most highly valued. Here, The Match reduces information asymmetries by establishing staggered deadlines and utilizing its algorithm based on ROLs in order to afford applicants ample opportunities to gather information and match applicants to their true preferences for residency.

After having time to research and evaluate various programs, applicants submit applications to their prospective programs typically in September of their fourth year of medical school. Applicants then engage in interviews in October through January. Next, applicants and programs must submit their ROLs in early March, which is the foundation of The Match algorithm and represents the core of applicant and program preferences, which determines The Match outcome. This series of deadlines affords applicants ample opportunity to research programs, attend interviews, and engage in bilaterial negotiations to determine their top preferences for residency prior to Match day.

In 2025, matched applicants submitted ROLs that averaged twelve (12) programs; well below the $70 standard registration fee for The Match that affords applicants up to 20 ranks.[42] This presumes that most applicants attended twelve (12) interviews, as applicants do not typically rank programs with which they have not interviewed. In a market without the matching algorithm, applicants would not have the time or ability to attend anywhere near this number of interviews because of the temptation of accepting early or "safe" offers. The NRMP's processes avoid this undesirable scenario because applicants are afforded sufficient time – through a standardized set of deadlines applicable to all match participants – to conduct interviews and consider their options before the ROL deadline. Similarly, without the matching algorithm, applicants would not have the time or ability to obtain their best possible outcome in between the end of the fourth year of medical school and the standard July 1 start date for training (not including orientation). For instance, if Applicant A's first choice was not available and Applicant A's second choice had an outstanding offer to Applicant B, then Applicant A would be forced to move on to their third or fourth choice program. The Match's algorithm avoids this scenario completely by matching applicants, at a single point in time, with their most preferred program that also prefers them.

In addition to The Match deadlines and algorithm, Match policies further provide applicants the ability to discover their true preferences for residency by ensuring that applicants can engage in the decision-making process carefully and without fear of persuasion or coercion from programs.

[41] *See* Philip E. Areeda & Herbert Hovenkamp, FUNDAMENTALS OF ANTITRUST LAW §20.04(C)(1) (4th ed. 2025).
[42] Impact of Length of Rank Order List on Match Results: 2006-2025 Main Residency Match, NRMP, updated March 21, 2025, https://www.nrmp.org/wp-content/uploads/2025/03/Impact-Data_2025.pdf.

For example, pursuant to The Match Participation Agreement, Programs are not authorized at any time during the interview, matching, or onboarding processes to:

- Request that applicants reveal the names, specialties, geographic locations, or other identifying information about the program(s) to which they have or may apply;
- Request that applicants reveal preference signal(s) if in a specialty participating in preference signaling (a function of MyERAS);
- Request that applicants reveal any information pertaining to the interviews they were offered, accepted, declined, or attended;
- Request that applicants reveal ranking preferences; or
- Suggest or inform applicants that placement on a rank order list or a SOAP preference list is contingent upon submission of a verbal, electronic, or written statement indicating the applicant's preference.[43]

Without these protections, applicants would face unwarranted pressure to commit to certain programs, specialties, or geographic regions or potentially be coerced into altering their rank order preferences in hopes of gaining favor with certain programs.

In sum, The Match process, including its ROL, algorithm, and policies, allow applicants ample time to consider and craft their options for future medical training. The result is that applicants are afforded the best available opportunity to train in a program where they are most valued and similarly, programs are able to train students they believe will best excel in their program. Without the stability of The Match and its algorithm, applicants would be pressed to accept early or "safe" offers to avoid the possibility of being unable to secure a residency position.

2. The Match enables growth in residency positions by reducing the risks of private and public investments in residency training.

As discussed above, GME is funded through various sources, but "Medicare is the largest funding source for graduate medical education, accounting for $16.2 billion in GME payments in 2020."[44] Under the Balanced Budget Act of 1997, Congress capped the number of full-time equivalent ("FTE") residents that a hospital can have, and "most hospitals would receive DGME and IME support only for the number of allopathic and osteopathic FTE residents it had in training in 1996."[45]

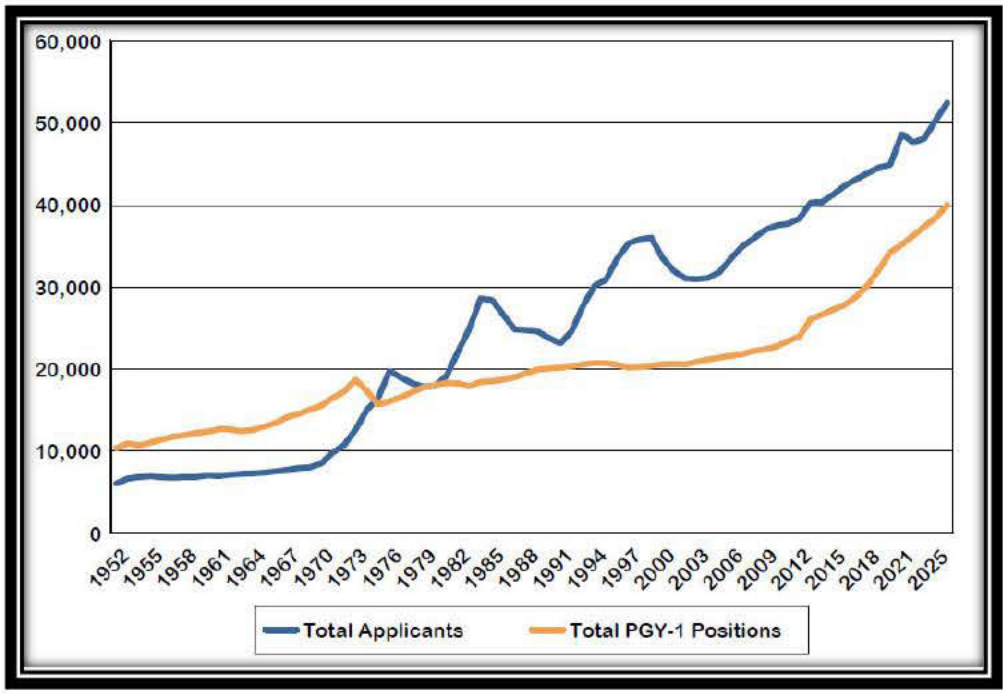
Today, most residency programs are in excess of their Medicare-funded position allocation. A 2021 report from the Government Accountability Office found that based on Medicare data, **70% of hospitals were over one or both caps on Medicare-funded resident positions.**[46] These

[43] "2025 Match Participation Agreement for Programs," NRMP, November 21, 2024, https://www.nrmp.org/policy/2025-match-participation-agreement-for-programs/.
[44] "Graduate Medical Education Funding," National Conference of State Legislatures, updated January 9, 2024, https://www.ncsl.org/health/graduate-medical-education-funding.
[45] Elayne J. Heisler, et al., "Federal Support for Graduate Medical Education: An Overview," December 27, 2018, https://www.congress.gov/crs-product/R44376.
[46] "Physician Workforce: Caps on Medicare-Funded Graduate Medical Education at Teaching Hospitals," GAO, May 21, 2021, https://www.gao.gov/products/gao-21-391.

programs must now rely on funding through other private and public channels, such as a hospitals' own revenues. The Match reduces the risks associated with those investments by providing a process that minimizes the transaction costs and risk of allocating scarce sources to fund additional resident positions. Antitrust and economic theory generally recognizes increased supply and lower costs as pro-competitive benefits, while unpredictability and high risk deter investment.[47] This is especially true in the medical residency labor market where maximizing the number of filled residency positions with the lowest associated transaction costs is essential to combating a physician shortage.

As shown in Figure A below, the number of post graduate year one (PGY-1) positions in The Match has increased since The Match's inception in 1952.[48]

Figure A - Post Graduate Year One Positions Over Time



But this growth in positions would do little to address the physician shortage if programs were unable to consistently fill them. This is one of the key benefits of The Match. Even as new positions are added, The Match allows programs to be confident they can fill their available positions. As reflected in Table 1, below, the program fill rate at the conclusion of The Match is consistently near 100%.[49]

[47] *See* Philip E. Areeda & Herbert Hovenkamp, ANTITRUST LAW: AN ANALYSIS OF ANTITRUST PRINCIPLES AND THEIR APPLICATION ¶ 2111b2 (4th and 5th eds. 2025) ("Good market information reduces search costs and minimizes price disparities and unpredictability.").
[48] Results and Data 2025 Main Residency Match, NRMP (May 2025).
[49] Results and Data: 2023-2025 Main Residency Match, NRMP.

Table 1 - Program Fill Rates (2023-2025)

2023	2024	2025
99.1%	99.6%	99.4%

Participating programs need only pay marginal costs to add additional positions into The Match and based on the data, new positions are effectively guaranteed to be filled via The Match. Therefore, The Match allows for the growth of residency positions while simultaneously reducing the risk of private and public investment in residency training.

3. The Match protects applicants from having their careers derailed by unexpected hardships or delays.

Economic theory broadly recognizes the value of preventing complete market failures or "complete losses," where a participant exits a market or forgoes productive output due to structural inefficiencies or coordination breakdowns.[50] In the context of graduate medical education, this principle has particular force: it would be a systemic failure—not only for the applicant but for society—if a medical school graduate, having accrued hundreds of thousands of dollars in educational debt, failed to enter the physician workforce because of an obstacle encountered prior to starting their residency. The NRMP helps mitigate this risk through structured mechanisms such as its deferral and waiver processes, which provide flexibility for applicants facing exceptional personal or professional circumstances. These policies reduce the incidence of stranded medical talent and promote efficient allocation of healthcare resources—outcomes that align with both antitrust values and the public interest.

Under The Match's policies, applicants and programs can apply to the NRMP for a deferral of a binding match commitment. A deferral is a one-year delayed start of training mutually agreed to by the matched applicant and the program.[51] Deferrals will only be granted by the NRMP if both parties agree to delay the start of training.[52]

Applicants and programs can also apply to the NRMP for a waiver of a binding match commitment under certain circumstances. A waiver is the release of Match participants from the binding match commitment following a Match or acceptance of an offer through SOAP.[53] The NRMP will grant a waiver in three circumstances: (1) the applicant is confirmed to be ineligible to begin training in the matched position(s) by the start date; (2) the NRMP determines that the fulfillment of the commitment would cause unanticipated, serious, and extreme hardship; or (3) an applicant has elected to change specialties or leave medicine.[54]

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[50] *See* John. O. Ledyard, *Market Failure*, in THE NEW PALGRAVE DICTIONARY OF ECONOMICS (2018) ("Market failure occurs when there are too few markets, non-competitive behaviour, or non-existence, leading to inefficient allocations."); *see also* Francis M. Bator, *The Anatomy of Market Failure*, 72 Quarterly J. of Economics 351, 351 (1958) (discussing market failure).
[51] Match Waiver and Deferral Policy § 3(a).
[52] *Id.* § 4(g).
[53] *Id.* § 3(h).
[54] *Id.* § 4(d).

For instance, in 2024, The Match granted deferral requests for an individual to support his spouse diagnosed with cancer and for another individual to take time to seek treatment for a substance use disorder. Similarly, The Match granted a waiver for another individual to seek training in a program that was closer to their hometown to be able to care for aging family members. Outside of the personal issues or tragedies, The Match granted an individual who sought a waiver to pursue a different specialty in internal medicine, for example. The Match heavily considers individualized factors such as these in making waiver and deferral determinations, which is showcased by its waiver and deferral statistics. For example, in 2024, NRMP granted 104 applicant waiver requests and denied only three applicant waiver requests.

In a market without The Match, applicants would not have the same opportunities to secure a deferral or waiver. In fact, in some of the most trying times of their lives, applicants like those in the examples above would lose their opportunity to participate in a residency program and may face barriers or be deterred from ever participating again. Especially given the Subcommittee's concerns regarding the physician shortage facing this country, The Match's policies and processes must be protected for the good of residents and the growing need for their services.

4. The Match provides a level playing field for programs and applicants to fill and obtain training positions across the country.

Efficiency is a hallmark of a competitive market,[55] and this principle includes the efficient distribution of labor. The Match promotes efficiency by leveling the playing field for applicants and programs, whether it be for primary care positions, underserved and rural programs, or osteopathic residents. The Match is a merit-based process due to ROLs and the matching algorithm. Because the matching algorithm uses ROLs submitted by applicants and programs to match applicants and programs to achieve the most desirable outcomes, both groups are incentivized to correctly state their ROLs in a truthful manner. Neither applicants nor programs can benefit by misrepresenting or strategizing over what ROL to submit.

For example, primary care specialties offered a record-high number of positions in 2025, including positions in underserved and rural locations. However, as shown by Table 2, these programs would likely have unfilled positions left at the start of the residency term without NRMP's SOAP process.[56]

[55] Philip E. Areeda & Herbert Hovenkamp, FUNDAMENTALS OF ANTITRUST LAW § 9.02a (4th ed. 2025) ("[A] major benefit of competition is the efficient organization and management of productive resources.").
[56] Results and Data 2025 Main Residency Match, NRMP (May 2025).

Table 2 - Primary Care Positions Filled in SOAP (2025)

Primary Care Specialty	Positions in SOAP	Positions Filled in SOAP
Internal Medicine	372	360
Internal Medicine (1-yr Prelim)	146	125
Family Medicine	805	753
Pediatrics (C/M)	148	142
Pediatrics (1-yr Prelim)	1	1

Indeed, applicants may not even know about available positions at these programs (let alone apply to them) if it was not for SOAP. NRMP's policies and processes avoid this dilemma and ensure unfilled programs in addition to underserved and rural locations have access to available applicants. Through the combined efforts of NRMP's Main Residency Match and SOAP, nearly all of these positions were filled by the end of Match Week, as reflected in Table 3 below.[57]

Table 3 - Primary Care Positions and Fill Rates (2025)

Primary Care Specialty	Positions in The Match	Overall Fill Rate
Internal Medicine (C/M)	11,432	99.8%
Internal Medicine (1-yr Prelim)	1,600	98.5%
Family Medicine	5,357	99.0%
Pediatrics (C/M)	3,270	99.7%
Pediatrics (1-yr Prelim)	25	96.0%

C – categorial; M – primary

The Match also ensures that U.S. osteopathic (DO) seniors become physicians demonstrating outcomes equal to or better than MD seniors. As shown by the comparison in Table 4, the placement rate for DO seniors is comparable to that of MD seniors under the single match that followed the transition to a single accreditation system.[58]

Table 4 – Active Applicant Placement Rates (2023-2025)

Applicant Type	2023	2024	2025
DO Seniors	98.7%	98.5%	98.4%
MD Seniors	98.2%	97.9%	97.8%

In summary, The Match and its policies and processes are critical to achieving outcomes where primary care and rural programs are filled at a high rate and U.S. MDs and DOs match at nearly

[57] *Id.*
[58] *Id.*

equal rates. The efficiency and successes from The Match are a result of its algorithm and the SOAP process, both of which would not be present in a "free market" without The Match.

(b) The Matching Algorithm Exemption Safeguards Congress's Significant Interests in the Supply and Quality of Well-Trained Physicians.

In its Matching Algorithm Exemption, Congress acknowledged that before The Match was instituted, medical students were engaged in a race to the bottom characterized by exploding offers and undue pressure from programs which resulted in medical students making binding commitments before being able to make an informed decision about a medical specialty or a residency program. Congress recognized "[t]his situation was inefficient, chaotic, and unfair and it often led to placements that did not serve the interests of either medical students or residency programs."[59] Congress further recognized that The Match was created to remedy these issues, and that The Match's algorithm has been highly effective in matching students with their highest preferences for residency positions.[60] As a result, Congress found that The Match has been an "integral part of an educational system that has produced the finest physicians and medical researchers in the world."[61]

Consistent with these findings, Congress delineated its goal of the Matching Algorithm Exemption as follows:

> ***Antitrust lawsuits challenging the matching process***, regardless of their merit or lack thereof, have the potential to ***undermine this highly efficient, pro-competitive, and long-standing process.*** The costs of defending such litigation would divert the scarce resources of our country's teaching hospitals and medical schools from their crucial missions of patient care, physician training, and medical research. In addition, ***such costs may lead to abandonment of the matching process, which has effectively served the interests of medical students, teaching hospitals, and patients for over half a century***.[62]

Congress's decision to enact an antitrust exemption for graduate medical education matching programs reflects its broader commitment to ensuring a stable, high-quality healthcare workforce. As the nation's single largest payor for healthcare—primarily through Medicare and Medicaid—Congress has a direct and ongoing interest in maintaining an efficient, cost-effective pipeline for training physicians who serve in hospitals, rural clinics, community health centers, and Veterans Affairs facilities. The Match supports this interest by facilitating the timely and equitable placement of thousands of medical graduates into residency programs, which are prerequisites for medical licensure, board certification, and independent clinical practice. Without The Match, the disorganized hiring practices that predated its creation would not only reemerge but would inject

[59] 15 U.S.C. § 37b(a)(1)(B).
[60] *Id.* at § 37b(a)(1)(E).
[61] *Id.* at § 37b(a)(1)(A).
[62] *Id.* § 37b(a)(1)(E).

unnecessary uncertainty and volatility into the physician workforce at a time when demand for medical services is accelerating due to population aging and rising chronic disease burden.

Moreover, the Matching Algorithm Exemption reinforces Congress's parallel interest in safeguarding the quality of physician training. Teaching hospitals that sponsor residency programs serve as engines of clinical education, research, and innovation. Congress, through Medicare's GME funding, invests over $16 billion annually in residency programs across the country. This funding is explicitly intended to support the dual mission of patient care and physician education. Permitting antitrust litigation to destabilize The Match would undermine this federally supported infrastructure, siphoning resources away from direct care and academic instruction. As Congress recognized, the risk of such litigation—even if ultimately unsuccessful—poses a chilling effect on participation in The Match and threatens to erode the carefully calibrated balance that underpins the U.S. physician training model.

Finally, the Matching Algorithm Exemption reflects Congress's judgment that certain forms of coordination—particularly those that promote fair access, transparency, and long-term societal benefit—are not antithetical to competition but essential to it. The Match ensures that all applicants, regardless of medical school attended, socioeconomic status, or geographic location, have a fair and structured opportunity to compete for training positions nationwide. Congress's Matching Algorithm Exemption is thus not a repudiation of competition principles but a recognition that the transition to residency must accommodate efficiency, fairness, and promote the public good. It is a policy judgment well within Congress's authority and one that continues to serve the national interest.

(c) The Matching Algorithm Exemption Facilitates Efficient Coordination Among Competing Residency Programs.

For The Match to function at all and thereby achieve the procompetitive benefits and Congressional interests discussed above, participants must engage in a limited form of collaboration: they must agree to submit ranked preference lists pursuant to The Match's deadlines and to abide by the results generated by the NRMP's applicant-proposing algorithm. This synchronized participation is indispensable because, without a common timetable and a binding commitment to honor algorithmic outcomes, participants would not be able to pursue and express their true preferences, the very dynamic that produced chaos, inequity, and market unraveling before The Match was created in 1952.

Similar forms of limited, structured coordination are present in various markets and industries, particularly where such collaboration is necessary to prevent market failures, to ensure efficient distributions of products and services, or to allow for certain desirable outcomes to exist at all. For example, the NFL and other professional sports leagues, Copyright Collectives and Clearinghouses, joint purchasing cooperatives, Airline Code-Sharing Alliances, and standard-setting organizations all require competitors to coordinate on certain operational rules or shared platforms to avoid market breakdowns, promote transparency, and maximize overall welfare—while still preserving robust competition on price, quality, and service. In each case, competitors coordinate on one aspect of conduct to enable or enhance competition on all others. Accordingly,

courts and regulators have recognized that narrowly tailored coordination can be pro-competitive when it addresses unique market dynamics and serves the public interest.

The same is true of graduate medical education matching programs: the Matching Algorithm Exemption reflects Congress's recognition that coordination on this single dimension—the centralized matching process—is a necessary mechanism to support a merit-based, efficient, and equitable market for medical school graduates to continue their education and training. This narrow coordination enables a broader, procompetitive outcome, as it preserves transparency, prevents strategic misrepresentation of preferences, and ensures that virtually every available residency position is filled efficiently. And importantly, because the Matching Algorithm Exemption is narrowly tailored, it does not alter or impair the many other ways in which residency programs compete for applicants, including salary, benefits, work environment, geographic location, clinical specialties, and research opportunities. Thus, The Match exemplifies how carefully scoped coordination can serve competition, not stifle it.

V. Conclusion

The NRMP appreciates the Subcommittee's attention to these critical issues and stands ready to provide any additional information or testimony that may assist in the continued oversight of America's physician training infrastructure.

Exhibit 28:
March 28, 2025
Letter from Dr. David J. Skorton to Representative Scott Fitzgerald

Association of
American Medical Colleges
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David J. Skorton, MD
President and Chief Executive Officer

March 28, 2025

The Honorable Scott Fitzgerald
Chairman
Subcommittee on the Administrative State, Regulatory Reform, and Antitrust
Committee on the Judiciary
House of Representatives
2138 Rayburn House Office Building
Washington, DC 20515-6216

Dear Chairman Fitzgerald:

The Association of American Medical Colleges (AAMC) is writing in response to the Subcommittee's letter and record request dated March 14, 2025 (March 14th letter), **Exhibit 01**. We appreciate the opportunity to speak with professional staff of the Committee on the Judiciary on Wednesday March 19, 2025, regarding the Subcommittee's examination of the 2004 medical residency antitrust exemption[1] and whether it reduces competition in the medical residency market, adversely affecting residents or patient care – or conversely, plays a proper and important role in graduate medical education and the delivery of health care.

During the call, it was requested AAMC provide a written overview of graduate medical education, licensure, and a medical student's transition from undergraduate medical education (UME) to graduate medical education (GME) (the "transition to residency").

This letter constitutes AAMC's response to the March 14th letter as well as requests for information made during the March 19th meeting. The information provided below includes:

- Background information on AAMC and our relationships with other organizations identified in the March 14th letter;
- An overview of graduate medical education and licensure;
- A timeline for the transition to residency;
- Descriptions of relevant AAMC offerings; and
- List of AAMC documents responsive to your record request and attached Exhibits.

Background

The AAMC (Association of American Medical Colleges) is a nonprofit association dedicated to improving the health of people everywhere through medical education, health care, biomedical research, and community collaborations. Its members are all 160 U.S. medical schools accredited by the Liaison Committee on Medical Education; 12 accredited Canadian medical schools; nearly 500 academic health systems and teaching hospitals, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools, academic health systems and teaching hospitals, and the millions of individuals across academic medicine, including more than 210,000 full-time faculty members, 99,000 medical students, 162,000 resident physicians, and 60,000 graduate students and postdoctoral researchers

[1] *See* 15 U.S.C. § 37b ("Confirmation of antitrust status of graduate medical resident matching programs").

in the biomedical sciences. Through the Alliance of Academic Health Centers International, AAMC membership reaches more than 60 international academic health centers throughout five regional offices across the globe. Learn more at aamc.org.

AAMC Relationships with Other Organizations Identified in the March 14th letter

The AAMC, National Resident Matching Program (NRMP), Accreditation Council for Graduate Medical Education (ACGME), and American Medical Association (AMA), are all separate, independent legal entities.

While NRMP previously engaged AAMC to assist with operations under a management agreement, NRMP has managed its affairs, including but not limited to The Match, independently since 2014. AAMC does not have a role in NRMP governance[2] or its day-to-day operations. AAMC provides operational support for the NRMP's Supplemental Offer and Acceptance Program (SOAP) that facilitates unmatched residency applicants obtaining unfilled residency positions during Match Week.

AAMC is an ACGME *member* organization. Our primary responsibility as a member of ACGME is to nominate individuals to be considered for the ACGME Board of Directors.[3] AAMC does not have a role in ACGME's governance[4], day-to-day operations or decisions, and it does not participate in ACGME accreditation.[5]

The AMA and AAMC jointly conduct the National GME Census,[6] an annual survey that collects information on residents and residency programs, through AAMC's GME Track tool. AMA populates some of the National GME Census data into the Fellowship and Residency Electronic Interactive Database (FRIEDA), which it owns and operates.[7]

Overview of Graduate Medical Education and Licensure

Residency is the second step of the medical education training program, starting when students in their final year of medical school transition from their undergraduate medical education (medical school) to graduate medical education (residency). In your letter you expressed concern regarding the number of medical school graduates who do not match with a residency. Graduates of U.S. MD-granting medical schools[8] have a very high level of success in securing residency placement. According to a 2015 study, between academic years 2004-2005 to 2014-2015 the mean percentage of graduates of U.S. MD-granting medical schools unplaced in GME during the academic year of their graduation from medical school was only 3%.[9] Therefore, the mean percentage of U.S. MD-granting medical school graduates placed in GME within the year of their graduation was 97% for those graduating between 2004-2005 to 2014-2015. And within six years of their medical school graduation, more than 99% of all MD-granting medical school graduates entered GME.[10] According to a 2025 study, between academic years 2015-2016 to 2021-2022 the mean percentage of graduates of U.S. MD-granting medical schools placed in GME at graduation was 97.1%.[11]

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[2] AAMC receives an NRMP Board of Directors nomination request annually. AAMC submits 1-3 names for NRMP's consideration depending on how many seats need to be filled.
[3] Member Organizations, ACMGE, https://www.acgme.org/about/member-organizations/ (last visited Mar. 28, 2025).
[4] At ACGME's request, there is an AAMC liaison to the ACGME board.
[5] ACGME Member Organizations, *supra* note 3.
[6] GME Track, AAMC, https://www.aamc.org/data-reports/students-residents/report/gme-track (last visited Mar. 28, 2025).
[7] FREIDA, AMA, https://freida.ama-assn.org/ (last visited Mar. 28, 2025).
[8] U.S. MD-granting medical schools are AAMC member institutions.
[9] Sondheimer HM, Xierali IM, Young GH, Nivet MA. Placement of US Medical School Graduates Into Graduate Medical Education, 2005 Through 2015. JAMA. 2015;314(22):2409–2410. doi:10.1001/jama.2015.15702.
[10] *Id.*
[11] Andriole, Dorothy A. MD; Grbic, Douglas PhD; Jurich, Daniel P. PhD; Mechaber, Alex J. MD; Roskovensky, Lindsay; Young, Geoffrey H. PhD. U.S. Medical School Graduates' Placement in Graduate Medical Education: A National Study. Academic Medicine 100(2):p 158-169, February 2025. | DOI: 10.1097/ACM.0000000000005893.

Residency is a time of intense training, a continuation of the learning that is required to become a physician. Most residency programs choose to become an accredited program with the quality of their education program closely monitored.[12] Individual programs establish resident compensation, benefits, and working conditions.

In a cohort, residents train as part of a patient care team alongside other health practitioners and under the supervision of attending physicians.[13] Residency training is three to seven years depending on specialty.[14] Some physicians choose to undertake a fellowship after completing their residency, adding one to three years of study in a subspecialty.[15] After completing residency or fellowship training many physicians also become board certified in their chosen specialty or subspecialty.[16] Many hospitals require board certification, among other documentation, to be granted hospital credentials and privileges.[17] State medical boards determine when a resident may apply for an unrestricted medical license.[18] All states require at least one year of postgraduate training (i.e. residency).[19]

The federal government is the largest contributor to GME funding.[20] Residency programs that are ACGME-accredited receive Medicare funding through CMS for Direct Graduate Medical Education (DGME) and Indirect Medical Education (IME).[21] DGME payments are for the direct cost of residency training, including salaries and fringe benefits for faculty and residents.[22] IME payments help offset the significantly higher patient care costs of teaching hospitals relative to non-teaching hospitals.[23] Generally, Medicare caps the number of residents it will fund for each hospital.[24] Seventy percent of hospitals were over their DGME or IME funding caps, meaning the hospitals self-funded the additional training positions.[25] For both DGME and IME, hospitals funded significantly more residency slots over the cap than they left unfilled.[26] Residents must be fully licensed in the state where they provide services for Medicare to pay for services using the Medicare Physician Fee Schedule.[27]

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[12] Common Program Requirements, ACGME, https://www.acgme.org/programs-and-institutions/programs/common-program-requirements/ (last visited Mar. 28, 2025).
[13] AAMC, *The Road to Becoming a Doctor* (Nov. 2020), (available at https://www.aamc.org/media/36776/download).
[14] *Id.*
[15] *Id.*
[16] Member Board Requirements for Initial Certification in a Specialty, American Board of Medical Specialties, https://www.abms.org/wp-content/uploads/2023/11/abms-member-board-requirements-for-initial-certification-in-a-specialty.pdf (last visited Mar. 28, 2025); Board Certification, AOA, https://certification.osteopathic.org/ (last visited Mar. 28, 2025).
[17] How to Obtain Credentials and Privileges, American Academy of Family Physicians, https://www.aafp.org/family-physician/practice-and-career/managing-your-career/scope-of-practice/privileging-and-credentialing/steps-to-hospital-credentialing.html (last visited Mar. 28, 2025).
[18] State Specific Requirements for Initial Medical Licensure, Federation of State Medical Boards, https://www.fsmb.org/step-3/state-licensure/#:~:text=Minimum%20Postgraduate%20Training%20Required%20*%201%20year,*%202%20years%20ACGME%20training%20for%20IMG's (last visited Mar. 28, 2025).
[19] *Id.*
[20] Where do Sponsoring Institutions and programs get funding for residents/fellows? ACGME, https://www.acgme.org/about/acgme-frequently-asked-questions/#fund (last visited Mar. 28, 2025).
[21] Are all residency and fellowship programs in the US ACGME-accredited? ACGME, https://www.acgme.org/about/acgme-frequently-asked-questions (last visited Mar. 28, 2025).
[22] Medicare Learning Network. *Guidelines for Teaching Physicians, Interns & Residents* (Nov. 2024) (available at https://www.cms.gov/files/document/guidelines-teaching-physicians-interns-residents.pdf).
[23] Indirect Medical Education, CMS, https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/indirect-medical-education-ime (last visited Mar. 28, 2025).
[24] Government Accountability Office. *Physician Workforce: Caps on Medicare-Funded Graduate Medical Education at Teaching Hospitals* (May 21, 2021) (available at https://www.gao.gov/products/gao-21-391); (For most hospitals, Medicare caps the number of residents it will fund per hospital based on how many residents it funded in 1996).
[25] *Id.*
[26] *Id.*
[27] Medicare Learning Network, *supra* note 22.

Transition to Residency Timeline
The transition to residency is typically an 18+ month process. Below is a high-level timeline for first-time residency applicants.

Winter –	Medical specialty societies may make recommendations to programs as to which application and matching services to use. Presently, there are at least four application services and at least three matching services (not including the Military Match).
Spring –	Residency programs register with the application and matching service of their choice.
Summer –	Applicants identify which specialties and programs they wish to apply for and register for the appropriate application and matching services. Applicants begin filling out their applications and coordinating the submission of required documents, such as transcripts and letters of recommendation.
Sept –	Applicants complete their application(s). Applicants may apply to as many programs and specialties as they wish. The application service transmits their application to the programs of their choice.
Oct – Jan	Programs select which applicants they wish to interview. Applicants accept or decline the interview invites. Interviews occur. Application services may offer tools to assist administratively.
Nov – Feb	Programs and applicants submit their rank order list, a ranked list of preferences, to the appropriate matching service.
Dec – Mar	Programs and applicants learn of their match. Timing of notification is based on the matching service. Once matched, that program position and applicant are ineligible for additional matches.
Feb – May	Unfilled program positions and unmatched applicants may participate in supplemental processes to secure a match. Application services typically remain open to allow programs to post a position and applicants to apply.
July 1	On or around July 1, first year residents start their graduate medical education training.

Relevant AAMC Offerings
AAMC offers a wide range of services and resources to medical schools, medical students, advisors, teaching hospitals, academic health centers, residency programs and directors, and health care professionals. We are most known for the Medical College Admission Test (MCAT).

For the sake of clarity, AAMC does not offer a resident matching service or set resident compensation, working conditions, or hiring restrictions.

Below are descriptions of AAMC offerings relevant to this inquiry about residency matching and compensation.

Council of Teaching Hospitals (COTH)
This description is provided as the March 14th letter included references to COTH. Per AAMC Bylaws, AAMC has three councils. The chair and chair-elect of each council serve on AAMC Board of Directors.

The Council of Teaching Hospitals (COTH)[28] was one such council, consisting of one representative from each AAMC Teaching Hospital and Health System Member institution. Effective November 3, 2023, COTH became the Council of Academic Health System Executives (CAHSE).[29] This change reflects the increasing prevalence of academic health systems as sponsors of graduate medical education. CAHSE consists of one representative from each Academic Health System and Teaching Hospital member institution.

The "COTH Surveys" referenced in your letter are AAMC surveys fielded to teaching hospital and health system members about resident compensation. These surveys – the National GME Census and the Survey of Resident/Fellow Stipends and Benefits – are discussed below.

Electronic Residency Application Service (ERAS)

The ERAS suite of services[30] includes a residency application service and is the largest such service by number of participating specialties, programs,[31] and applicants. The ERAS application streamlines the residency application process for applicants, their medical schools, letter of recommendation authors, and residency program directors. By providing applicants the ability to build and deliver their application and supporting materials individually or as a package to programs, the ERAS system provides a centralized and flexible solution to the residency applicant and documents distribution process.

ERAS participating programs do not need to be accredited by a particular body or registered with a particular matching service. ERAS participating applicants may submit applications using other application services.

Until recently, AAMC saw the average number of residency program applications submitted by an applicant significantly increase year over year. The increase in applications was at a financial cost to applicants and time cost to programs. To address this issue, for the last several years, AAMC has piloted features such as program signaling[32] and geographic preference.[33] These optional features provide an opportunity for applicants to indicate preferences earlier in the application process, information that is often used by the program when evaluating applicants. So far, these features appear to be working and there has been a decrease in the average number of applications by applicant.[34]

FindAResident

The FindAResident search tool is a year-round service designed to help (a) applicants find and apply to open residency positions[35] and (b) administrators and program directors[36] fill open residency positions for post graduate year one through post graduate year six. Programs post vacancies as they become available, supplementing the matching process to fill unexpected vacancies.

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[28] History of the Council of Teaching Hospitals, AAMC, https://www.aamc.org/who-we-are/aamc-history/coth (last visited Mar. 28, 2025).
[29] CAHSE, AAMC, https://www.aamc.org/career-development/affinity-groups/cahse (last visited Mar. 28, 2025).
[30] Applying to Residencies with the ERAS System, AAMC https://students-residents.aamc.org/applying-residencies-eras/applying-residencies-eras-system (last visited Mar. 28, 2025).
[31] ERAS 2025 Participating Specialties & Programs, AAMC, https://systems.aamc.org/eras/erasstats/par/index.cfm.
[32] Program Signals Overview for ERAS Applicants, AAMC, https://students-residents.aamc.org/applying-residencies-eras/publication-chapters/program-signals-overview-eras-applicants (last visited Mar. 28, 2025).
[33] AAMC, *Decoding Geographic and Setting Preferences in Residency Selection* (Jan. 18, 2024) (available at https://students-residents.aamc.org/applying-residencies-eras/publication-chapters/program-signals-overview-eras-applicants).
[34] AAMC, *The AAMC is leading dramatic improvements in the transition to residency* (Jan. 9, 2025) (available at https://www.aamc.org/about-us/aamc-leads/aamc-leading-dramatic-improvements-transition-residency-just-start#:~:text=Preliminary%20data%20from%20the%202024%2D2025%20application%20cycle%20shows%20a,drop%20of%2030%2D45%25).
[35] FindAResident for Applicants, AAMC, https://students-residents.aamc.org/findaresident/findaresident-search-tool (last visited Mar. 28, 2025).
[36] FindAResident for Program Directors, AAMC, https://www.aamc.org/services/find-a-resident (last visited Mar. 28, 2025).

FindAResident is open to accredited programs from ACGME-accredited specialties and select non-ACGME accredited specialties.

National GME Census

The National GME Census is jointly conducted by AAMC and AMA, through AAMC's GME Track tool.[37] Launched in 2000, the National GME Census reduced duplicative reporting by replacing AAMC's and AMA's previously separate GME surveys. Resident data and program data are confirmed annually, and the survey cycle can be updated between May and the following February, while the GME Track tool is open. The 2024 GME Track Program Survey instrument, **Exhibit 02**. And the 2024 GME Track Resident Roster survey instrument, **Exhibit 03**.

Medical schools have access to the GME Track tool to view and download their graduates' GME (non-compensation) data. Programs have access to the GME Track tool to view and print their resident information and program rosters.

National GME Census data from the GME Track Program Survey instrument is used to populate the AAMC Residency Explorer and AMA FRIEDA tools.

OpFin Annual Survey and COTH Data Tool Supplement

This description is provided as the March 14th letter included reference to the 2024 OpFin Annual Survey and COTH Data Tool Supplement in footnote 15.

The OpFin Annual Survey is fielded in the Spring of each year to collect operational, financial, educational, and staffing characteristics for the prior fiscal year. All non-federal AAMC academic health system and teaching hospital members are eligible to participate.

The data is reported in the COTH Data Tool. Survey respondents have access to this Excel-based, benchmarking and data analysis application.[38]

The OpFin Annual Survey questions about residents are limited to FTE counts. The OpFin Annual Survey does not collect resident compensation data, information about resident working conditions, or information on any resident hiring requirements.

Residency Explorer

The Residency Explorer tool[39] is free and publicly available (with a free AAMC account).

The Residency Explorer tool is a collective effort by nine GME-related organizations – including ACGME, AMA, and NRMP – of whom AAMC solicits feedback about the tool. AAMC owns and operates the Residency Explorer tool. ACGME and NRMP provide non-compensation data for inclusion in the tool.

The Residency Explorer tool empowers prospective applicants to explore and identify residency programs where they are likely to be a competitive candidate and to find programs that fit their personal and professional needs and interests. The tool displays program characteristics and offers, as well as information about an applicant's likely competitiveness based on information they enter into their profile. Since 2020, the Residency Explorer tool includes compensation data as reported by programs via the National GME Census.

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[37] GME Track, *supra* note 6.
[38] 2024 OpFin Annual Survey and COTH Data Tool Supplement, AAMC, https://www.aamc.org/data-reports/teaching-hospitals/report/opfin-report (last visited Mar. 28, 2025).
[39] Residency Explorer, AAMC, https://www.residencyexplorer.org/ (last visited Mar. 28, 2025).

The Residency Explorer tool opens for each application cycle in June. Program data (including compensation data) are refreshed in early August and mid-February if the program chooses to update their GME Track Survey submission. Resident compensation and working conditions reported in the Residency Explorer tool are generally available on the residency programs' websites. A screenshot of a Residency Explorer program profile, **Exhibit 04**.

Resident/Fellow Stipend and Benefits Report

Data from the annual AAMC Survey of Resident/Fellow Stipends and Benefits is free and publicly available, including to the applicants themselves.[40] The AAMC Resident/Fellow Stipends and Benefits Report is a look-back tool, meaning that it provides historic information. AAMC has published the then-current version of the AAMC Resident/Fellow Stipends and Benefits Report since 1968. In 1996, the report was moved online, making it more readily available to prospective residents.

All ACGME-accredited sponsoring institutions are invited to participate in the survey, regardless of AAMC member status. The survey fields annually and invitations are sent in mid-July. Data collected is "as of July 1". A report of aggregated survey results is typically available by mid-November, once data being shared is more than 90 days old. The 2024 Survey of Resident Fellow Stipends and Benefits instrument, **Exhibit 05**.

AAMC offers custom reports of data from the annual AAMC Survey of Resident/Fellow Stipends and Benefits to members. Custom reports are often used by programs for H-1B visa justification as employers must demonstrate that they will pay the prevailing wage to similarly employed works in the geographic area of employment.[41]

AAMC followed Statement 6 of the U.S. Department of Justice (DOJ) Antitrust Division and the Federal Trade Commission (FTC) 1996 Statements of Antitrust Enforcement Policy in Healthcare[42] until it was withdrawn in 2023.[43] AAMC now follows the DOJ and FTC 2016 Antitrust Guidance for Human Resource Professionals for all compensation reports, including custom reports.[44] The 2016 federal guidance for sharing compensation data echoes the 1996 guidance. AAMC practices are:

- to be the third party that administers the survey;
- the published data is no less than 90 days old;
- the data is aggregated so that it does not allow reidentification of compensation data of a particular institution; and
- there are at least five institutions reporting data and no one institution represents more than 25% of the applicable statistic.

[40] Resident/Fellow Stipend and Benefit Survey, AAMC, https://www.aamc.org/data-reports/students-residents/report/aamc-survey-resident/fellow-stipends-and-benefits (last visited Mar. 28, 2025).
[41] U.S. Department of Labor, *Fact Sheet #62G: Must an H1-B worker be paid a guaranteed wage?* (Rev. Jul 2008) (available at https://www.dol.gov/agencies/whd/fact-sheets/62g-h1b-required-wage).
[42] DOJ and FTC, *Statements of Antitrust Enforcement Policy in Health Care* (Aug. 1996) (available at https://www.ftc.gov/system/files/attachments/competition-policy-guidance/statements_of_antitrust_enforcement_policy_in_health_care_august_1996.pdf).
[43] Withdrawal of the 1996 *Statements of Antitrust Enforcement Policy in Health Care,* DOJ (Feb. 3, 2023) (available at https://www.justice.gov/archives/opa/speech/principal-deputy-assistant-attorney-general-doha-mekki-antitrust-division-delivers-0); *See also,* FTC withdrawal (Jul. 14, 2023) (available at https://www.ftc.gov/news-events/news/press-releases/2023/07/federal-trade-commission-withdraws-health-care-enforcement-policy-statements).
[44] DOJ and FTC, *Antitrust Guidance for Human Resource Professionals* (Oct. 2016) (available at https://www.justice.gov/atr/file/903511/dl).

Summary of responsive AAMC documents
In the March 14th letter, the Subcommittee requested production of certain documents. A summary of various responsive documents that we have identified is provided below, organized by the record request prompts in your letter. All **Exhibits** will be submitted with this response.

We note in this regard that your letter asked AAMC to produce "[a]ll documents and communications" "relating or referring" to a broad range of topics and covering a period of over four years. Doing so would require hundreds of hours of staff time, if not more. Therefore, while we have attempted to provide documents that address all of the topics referenced in your letter, we have not attempted to locate and produce every document or communication that might refer or relate to those topics from the requested period.

Exhibits identified above:

Exhibit 01.	March 14, 2025 Subcommittee Letter
Exhibit 02.	2024 GME Track Program Survey instrument
Exhibit 03.	2024 GME Track Resident Roster survey instrument
Exhibit 04.	Screenshot of a Residency Explorer program profile
Exhibit 05.	2024 Survey of Resident/Fellow Stipends and Benefits instrument

All documents and communications from January 1, 2021 to present referring to or relating to:

1. **The fairness or complaints about the NRMP matching algorithm.**
   To the best of our knowledge and recollection, AAMC has not received any complaints within the referenced time period from any residency applicants or residency programs regarding the NRMP matching algorithm. As noted above, NRMP is a separate legal entity and operates its matching algorithm without input or oversight by AAMC. Therefore, AAMC would not be the appropriate institution to receive or act upon complaints about the NRMP matching algorithm.

2. **Exchange of compensation and employment-related information among the ACGME, the NRMP, or medical residency programs, including but not limited to COTH and FREIDA.**
   AAMC (COTH) does not share non-public, institution-identifiable, employment-related information with the ACGME, NRMP, or medical residency programs.

   The AAMC Survey of Resident Fellow Stipends and Benefits Report and Residency Explorer tool are free, publicly available tools. AAMC provided the following documents in response to this request:

   Residency Compensation Surveys.

Exhibit 06.	2021 Survey of Resident Fellow Stipends and Benefits Report.
Exhibit 07.	2022 Survey of Resident Fellow Stipends and Benefits Report.
Exhibit 08.	2023 Survey of Resident Fellow Stipends and Benefits Report.
Exhibit 09.	2024 Survey of Resident Fellow Stipends and Benefits Report.
Exhibit 10.	Example Resident Stipend Survey Custom Report.

   National GME Census / Residency Explorer.
   We are providing the Residency Explorer Excel files that include the compensation, benefits, and working conditions fields rather than PDFs of the full program profiles as we believe the Excel files will be more useful for your review.

Exhibit 11. February 2021 Residency Explorer Program Information
Exhibit 12. April 2021 Residency Explorer Program Information
Exhibit 13. July 2021 Residency Explorer Program Information
Exhibit 14. August 2021 Residency Explorer Program Information
Exhibit 15. February 2022 Residency Explorer Program Information
Exhibit 16. April 2022 Residency Explorer Program Information
Exhibit 17. July 2022 Residency Explorer Program Information
Exhibit 18. August 2022 Residency Explorer Program Information
Exhibit 19. February 2023 Residency Explorer Program Information
Exhibit 20. April 2023 Residency Explorer Program Information
Exhibit 21. July 2023 Residency Explorer Program Information
Exhibit 22. August 2023 Residency Explorer Program Information
Exhibit 23. May 2024 Residency Explorer Program Information
Exhibit 24. July 2024 Residency Explorer Program Information
Exhibit 25. August 2024 Residency Explorer Program Information
Exhibit 26. February 2025 Residency Explorer Program Information

3. **The creation and enforcement of rules that require, incentivize, or encourage residents or residency programs to participate in the NRMP.**
During the time period requested, AAMC has not been involved in the creation or enforcement of NRMP rules.

In ERAS communications, AAMC includes reminders for applicants and programs to register with NRMP if they wish to participate in The Match. Below is a representative sample of such communications.

Exhibit 27. ERAS Applicant Communication September 11, 2024
Exhibit 28. ERAS Applicant Communication January 31, 2025
Exhibit 29. ERAS Program Communication March 21, 2025
Exhibit 30. FindAResident FAQs as of March 27, 2025

4. **Complaints or concerns from residents or residency programs regarding NRMP or ACGME.**
To the best of our knowledge and recollection, AAMC has not received complaints or concerns within the referenced time period from residents or residency programs regarding NRMP or ACGME. As noted above, NRMP and ACGME are separate legal entities and AAMC has no authority or oversight regarding the operations of these entities or their services. Therefore, AAMC would not be the appropriate institution to receive or act upon complaints about NRMP or ACGME.

In 2024, ACGME opened a request for comment on proposed revisions to the ACGME Sponsoring Institution Requirements. AAMC provided the following documents in response to this request:

Exhibit 31. AAMC Comment Letter to ACGME October 8, 2024
Exhibit 32. AAMC Comments to the ACGME regarding proposed Institutional Requirements revisions October 10, 2024

5. **Resident compensation limits, resident working conditions, or resident hiring restrictions.**
AAMC does not set resident compensation, working conditions, or hiring restrictions.

Various responsive documents are identified above in our response to Request 2. In addition, AAMC publishes articles and hosts sessions with topics on issues of resident working conditions. Examples include:

Exhibit 33. AAMC News: Thousands of medical residents are unionizing June 7, 2022
Exhibit 34. Webinar: How to Advocate for Resident Education and Wellbeing at your Institution February 16, 2023
Exhibit 35. Webinar: Resident Unionization October 10, 2023
Exhibit 36. AAMC News: Medical Schools work to end student mistreatment June 4, 2024

6. **The movement of physician residents among residency positions, including transfers, withdrawals, or reassignments.**
AAMC does not make decisions in the movement of physician residents among residency positions, including transfers, withdrawals, or reassignments. The AAMC FindAResident tool allows programs to post vacancies as they become available, supplementing the matching process to fill unexpected vacancies and applicants may apply.

Exhibit 37. FindAResident Open Positions as of March 27, 2025

7. **The removal or denial of ACGME accreditation.**
ACGME is a separate legal entity and operates its medical residency accreditation program without input or oversight by AAMC. Therefore, to the best of our knowledge and recollection, AAMC does not have records from the referenced time period associated with the removal or denial of ACGME accreditation.

Thank you for the opportunity to discuss AAMC's role in the transition to residency. Please feel free to be in contact with [redacted], [redacted]@aamc.org) if you wish to learn more about AAMC offerings or require anything further related to this request.

Sincerely,

David J. Skorton, MD
President and CEO

CC: The Honorable Jerrold Nadler
Ranking Member, Subcommittee on the Administrative State, Regulatory Reform, and Antitrust