HOUSE JUDICIARY COMMITTEE

Chairman Jim Jordan

MEDICAL MIS-MATCH: HOW A RESIDENCY HIRING MONOPOLY HARMS PATIENTS, DOCTORS, AND THE AMERICAN PUBLIC

Interim Staff Report

Committee on the Judiciary
Chairman Jim Jordan

Subcommittee on the Administrative State, Regulatory Reform, and Antitrust
Chairman Scott Fitzgerald

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EXECUTIVE SUMMARY

The Committee on the Judiciary has jurisdiction over the "[p]rotection of trade and commerce against unlawful restraints and monopolies."[1] On March 14, 2025, the Committee and its Subcommittee on the Administrative State, Regulatory Reform, and Antitrust opened an investigation into anticompetitive conduct and monopoly power within the medical residency market in the United States.[2] The Committee and Subcommittee received 1,580 documents from five standard-setting organizations that govern the medical residency market and four teaching hospitals that operate medical residency programs.[3] The Committee and Subcommittee also conducted transcribed interviews of two doctors about their experiences participating in the medical residency market and the ways in which anticompetitive conduct within this market harms both patients and residents.[4]

Through this oversight, the Committee and Subcommittee have uncovered evidence that the "Match," a placement system for resident physicians, operated by the National Resident Matching Program (NRMP), exercises monopolistic control over America's medical residency market, resulting in anticompetitive conduct and burdensome restraints on medical residents.[5] Both the transcribed interviews and the documents and communications produced to the Committee and Subcommittee show that:

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[1] Rules of the House of Representatives R. X (2025).

[2] *See* Letter from Rep. Scott Fitzgerald, Chairman, Subcomm. on the Admin. State, Regul. Reform, and Antitrust, to Dr. David Skorton (Mar. 14, 2025); Letter from Rep. Scott Fitzgerald, Chairman, Subcomm. on the Admin. State, Regul. Reform, and Antitrust, to Dr. Debra Weinstein (Mar. 14, 2025); Letter from Rep. Scott Fitzgerald, Chairman, Subcomm. on the Admin. State, Regul. Reform, and Antitrust, to Dr. Bruce Scott (Mar. 14, 2025); Letter from Rep. Scott Fitzgerald, Chairman, Subcomm. on the Admin. State, Regul. Reform, and Antitrust, to Dr. Teresa Hubka (Mar. 14, 2025); Letter from Rep. Scott Fitzgerald, Chairman, Subcomm. on the Admin. State, Regul. Reform, and Antitrust, to Ms. Donna Lamb (Mar. 14, 2025); Letter from Rep. Scott Fitzgerald, Chairman, Subcomm. on the Admin. State, Regul. Reform, and Antitrust, to Dr. Craig Albanese (Mar. 14, 2025); Letter from Rep. Scott Fitzgerald, Chairman, Subcomm. on the Admin. State, Regul. Reform, and Antitrust, to Dr. Lisa Boyle (Mar. 14, 2025); Letter from Rep. Scott Fitzgerald, Chairman, Subcomm. on the Admin. State, Regul. Reform, and Antitrust, to Dr. Jay Feldstein (Mar. 14, 2025); Letter from Rep. Scott Fitzgerald, Chairman, Subcomm. on the Admin. State, Regul. Reform, and Antitrust, to Mr. David Entwistle (Mar. 14, 2025).

[3] These organizations include the Association of American Medical Colleges, the Accreditation Council for Graduate Medical Education, the American Medical Association, the American Osteopathic Association, and the National Residency Matching Program as well as Duke University Health System, MedStar-Georgetown Hospital Medical Center, Philadelphia College of Osteopathic Medicine, and Stanford University Medical Center. *Id.*

[4] Transcribed Interview of Dr. Jason Melehani, Former Internal Medicine Resident and Rheumatology and Pulmonary Medicine Fellow, Stanford University (July 25, 2025); Transcribed Interview of Dr. Aamir Hussain, Former Resident and Member of the Admissions Committee, Georgetown University Dermatology Residency Program (July 18, 2025).

[5] *See* Jeffrey A. Singer & Spencer Pratt, *infra* note 58; Transcribed Interview of Dr. Jason Melehani, *supra* note 4; Transcribed Interview of Dr. Aamir Hussain, *supra* note 4; *The MATCH Monopoly: Evaluating the Medical Residency Antitrust Exemption*, *Hearing Before the Subcomm. on the Administrative State, Regulatory Reform, and Antitrust of the H. Comm. on the Judiciary*, 119th Cong. (2025) (submitted written statement of Sherman Marek) [hereinafter "Marek Written Statement"]; *The MATCH Monopoly: Evaluating the Medical Residency Antitrust Exemption*, *Hearing Before the Subcomm. on the Administrative State, Regulatory Reform, and Antitrust of the H. Comm. on the Judiciary*, 119th Cong. (2025) (submitted written statement of Jeffrey A. Singer) [hereinafter "Singer Written Statement"].

- Medical residency is an important part of the process for training physicians within the United States.[6] Under the supervision of experienced doctors, residents care for patients, gain specialty-specific expertise, and gradually take on greater responsibility until they are able to practice medicine independently.[7] American physicians must participate in a residency program before they can obtain a state license or board certification.[8] Residents provide a significant amount of the patient care in teaching hospitals, help to train medical students, and improve access to health services.[9] The quality of residency training, therefore, has major consequences for the future of the physician workforce and for patient care across the United States.[10]

- Medical institutions created the Match so that residency programs would not "have to compete as hard . . . as they otherwise would have in a free market."[11] By design, "the Match severely constrains competition, resulting in feeble wage growth, and inflat[ing] expenses for medical residents."[12] As a result, the Match "exacerbate[s] 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."[13]

- The Match exercises monopolistic power over the medical residency market.[14] The Match achieved its power over the residency market by instituting an "All In" policy that requires Match-participating residency programs to "register and attempt to fill all positions through the Match or another national matching plan" and then merging with its largest competitor.[15] According to one doctor, 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."[16]

- By prohibiting employment commitments and forcing residents to accept whatever position they are assigned, the Match prevents applicants from negotiating the terms of their employment.[17] Doctors explained to the Committee and Subcommittee how these restrictions "create[] a lot of ambiguity in the [hiring] process"[18] and "directly incentivize programs to provide less information about what they'd like in an applicant."[19]

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[6] AOA Production – Part 3 – Final, at 295.
[7] *Id.*
[8] *Id.*; Jeffrey A. Singer & Spencer Pratt, *infra* note 58; *Licensing and board certification: What residents need to know,* AMA (May 22, 2019).
[9] Creasman, *infra* note 59, at 1443; Tomei et al., *infra* note 60, at 1594-95.
[10] *Id.*
[11] Transcribed Interview of Dr. Aamir Hussain, *supra* note 4, at 35.
[12] Transcribed Interview of Dr. Jason Melehani, *supra* note 4, at 9.
[13] *Id.* at 12.
[14] *See* Jeffrey A. Singer & Spencer Pratt, *infra* note 58.
[15] AOA Production – Part 3 – Final, at 134; SJC-AMA-000000001, at 3; NRMP_00002740, at 2740; SJC-AMA-000000001, at 4.
[16] Transcribed Interview of Dr. Aamir Hussain, *supra* note 4, at 128.
[17] Transcribed Interview of Dr. Aamir Hussain, *supra* note 4, at 21-24, 31-33; Transcribed Interview of Dr. Jason Melehani, *supra* note 4, at 83-85, 87-106, 119-122.
[18] Transcribed Interview of Dr. Aamir Hussain, *supra* note 4, at 17.
[19] *Id.* at 97.

Employment terms and positions "are offered essentially on a take it, or take it, basis,"[20] as applicants who reject their pairing can be labeled "as a Match violator" and barred "from subsequent NRMP Matches for one-to-three years, or permanently."[21] For this reason, [i]t's an effective blacklisting to back out" of the Match.[22]

- The Match even controls the process for hiring "unmatched" applicants, known as the Supplemental Offer and Acceptance Program (SOAP).[23] Evidence shows that the SOAP, too, distorts the medical residency market and causes real harms to residents. In an email to the American Osteopathic Association (AOA) shortly after the 2021 Match, an individual who "endured" the process for seeking a position as an unmatched applicant vividly described the system's harms, writing that the SOAP was "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."[24] The applicant described the "emotional toll" that Match week has on aspiring residents and the "[f]eelings of hopelessness and inadequacy" felt by applicants "that were 'stuck' in the SOAP."[25]

- The Committee and Subcommittee received direct evidence of the anticompetitive harms from the Match system, including low and stagnant salaries of medical residents.[26] While physicians made an average salary of $374,000 in 2024, residents only made $66,712 on average.[27] According to one doctor, while "the actual day to day work [was] . . . roughly the same" during his last year of residency and first year as a fully licensed physician, his salary was approximately "five times higher" as a physician.[28] Resident salaries are also substantially lower than other healthcare providers that did not attend medical school but were hired through more traditional employment negotiations undistorted by the Match, such as nurse practitioners, who make a median wage of $132,050, or physician assistants, who make a median wage of $133,260.[29]

- Additional direct evidence of the anticompetitive harms includes the abnormal uniformity of resident salaries across different hospitals, specialties, and even geographic regions, which strongly suggests that programs are suppressing resident wages by fixing them at a specific level. The data show only a $9,000 difference between the twenty-fifth percentile and the seventy-fifth percentile of first-year resident wages and virtually no variance

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[20] *The MATCH Monopoly: Evaluating the Medical Residency Antitrust Exemption*, *Hearing Before the Subcomm. on the Administrative State, Regulatory Reform, and Antitrust of the H. Comm. on the Judiciary*, 119th Cong. (2025) (submitted written statement of Thomas Miller) [hereinafter "Miller Written Statement"].
[21] NRMP_00002743, at 2748.
[22] *Id.*; Transcribed Interview of Dr. Jason Melehani, *supra* note 4, at 104-05.
[23] Applicant Agreement, *infra* note 154, at 16-19; Program Agreement, *infra* note 154, at 16-19.
[24] AOA Production – Part 3 – Final, at 109.
[25] *Id.* at 110.
[26] DUHS-HJC000001, at 16-17; Mayeux, *infra* note 65, at 128; Transcribed Interview of Dr. Jason Melehani, *supra* note 4, at 8.
[27] *Id.*; Jon McKenna, *Medscape Physician Compensation Report 2025*, MEDSCAPE (July 8, 2025).
[28] Transcribed Interview of Dr. Aamir Hussain, *supra* note 4, at 90-91.
[29] DUHS-HJC000001, at 16; *Occupational Employment and Wage Statistics (OEWS) Profiles*, BLS (May 2024).

between different geographic regions apart from cost-of-living adjustments.[30] Over 95 percent of hospitals pay every single resident the same starting salary, regardless of their qualifications or specialty.[31] The American Medical Association (AMA) even acknowledged that resident wages "correlate with training year rather than specialty," and that "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."[32] The Match, according to one doctor, is "a main contributor . . . [to] the suppression of [resident] salaries because it enforces a single offer on everyone participating in the marketplace."[33]

- The Match's monopoly power compels residents to endure long hours and poor working conditions without a meaningful opportunity to obtain new employment.[34] Residency programs do not always comply with the "mandatory" maximum of 80 hours a week required by the Accreditation Council for Graduate Medical Education (ACGME),[35] and it is "fairly common" for residents to "work more than the official cap number of hours that a resident[] [is] allowed to work."[36] In fact, "almost half of all residents report working more than allowed by the ACGME and falsifying duty hour reports,"[37] and residency programs often "pressure residents to report compliance with 80 hour workweek rules established by ACGME, hiding the dangerous work environment these violations foster."[38]

- The Match's monopoly power requires residents to remain in their job placements, even though incidents of "physical, sexual, and emotional abuse are common and gender and racial discrimination are rampant."[39] Medical residents are nearly three and a half times more likely to experience depression than the average American,[40] and "suicide rates are the highest amongst all professions due to the lack of control or negotiation of fair salary and working conditions."[41] As a result of the "low pay, long hours, and a lack of mobility due to the Match and structural impediments to transfer, residents are increasingly turning to collective bargaining to address workplace conditions."[42]

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[30] DUHS-HJC000001, at 15; Transcribed Interview of Dr. Jason Melehani, *supra* note 4, at 18-21, 105; Transcribed Interview of Dr. Aamir Hussain, *supra* note 4, at 22-23.
[31] DUHS-HJC000001, at 11; Transcribed Interview of Dr. Jason Melehani, *supra* note 4, at 18-21, 105; Transcribed Interview of Dr. Aamir Hussain, *supra* note 4, at 22-23.
[32] SJC-AMA-000000626, at 627.
[33] Transcribed Interview of Dr. Jason Melehani, *supra* note 4, at 104.
[34] *See* Park, *infra* note 323.
[35] Transcribed Interview of Dr. Jason Melehani, *supra* note 4, at 7-8, 22-24, 64-69; Transcribed Interview of Dr. Aamir Hussain, *supra* note 4, at 23, 131-32; Park, *infra* note 323.
[36] Transcribed Interview of Dr. Aamir Hussain, *supra* note 4, at 23; *see also* Transcribed Interview of Dr. Jason Melehani, *supra* note 4, at 7-8, 64-69.
[37] Mayeux, *infra* note 65, at 128.
[38] Transcribed Interview of Dr. Jason Melehani, *supra* note 4, at 7.
[39] *Id.*
[40] Mata et al., *infra* note 74, at 2373-74.
[41] NRMP_0004595, at 96.
[42] Marek Written Statement, *supra* note 5.

- The suppression of resident salaries and imposition of uniform wages "creates enormous economic distortions" and "leads to a shortage of physicians in general."[43] By facilitating this suppression, the Match discourages qualified students from pursuing a career in medicine, jeopardizing both the quantity and quality of America's physician workforce.[44] The Match also results in thousands of "unmatched" residents every year, creating an additional barrier that prevents aspiring doctors from entering the physician workforce.[45]

In a normal market, the Match's monopolistic power and anticompetitive conduct would be subject to scrutiny under Section 1 of the Sherman Act.[46] However, in 2004, Congress granted the Match an antitrust exemption that immunized its anticompetitive conduct and barred the use of Match-related evidence in antitrust proceedings.[47] According to Sherman Marek, a health law expert who has challenged the Match's anticompetitive conduct in court, this antitrust "exemption protects market distortions, undermines free market principles, limits personal freedom and choice, prevents normal employment negotiations, shields wage suppression, and contributes to the nationwide physician shortage."[48] The documents and testimony received by the Committee and Subcommittee bear this reality out. In over twenty years of real-world experience since this antitrust exemption, it is clear that the medical residency market would benefit from traditional market forces. Because it created this exemption, Congress has the power to repeal it and help restore competition in America's medical residency market. The Committee will continue to conduct its oversight to inform these potential legislative reforms.

[43] Transcribed Interview of Dr. Jason Melehani, *supra* note 4, at 111.
[44] Madison, *infra* note 123, at 811.
[45] *Results and Data: 2025 Main Residency Match*, NRMP (May 2025), at ix, 23.
[46] *See Brown v. Pro Football, Inc.*, 518 U.S. 231, 252 (1996); *Anderson v. Shipowners' Ass'n of Pac. Coast*, 272 U.S. 359, 361-65 (1926); *Arrington v. Burger King Worldwide, Inc.*, 47 F.4th 1247, 1256 (11th Cir. 2022); *Am. Needle, Inc. v. Nat'l Football League*, 560 U.S. 183, 190 (2010).
[47] Weinmeyer, *infra* note 426, at 149-50; 15 U.S.C. § 37b; Pension Funding Equity Act, Pub. L. No. 108–218, § 207, 118 Stat. 596 (2004).
[48] Marek Written Statement, *supra* note 5.

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I. AMERICA'S MEDICAL RESIDENCY MARKET "IS IN CRISIS"

Medical residency plays a crucial role in the American healthcare system. In medical school, aspiring physicians spend four years "develop[ing] a strong theoretical framework in medicine and the basic sciences."[49] After graduation, these early-career doctors transition into residency and put their education into practice, caring for patients under the supervision of more experienced physicians.[50] Medical residency is "primarily a clinical experience where residents take care of patients in a specific specialty," allowing recent graduates to refine their skills and develop expertise in a given area.[51] While "residents are initially closely supervised[,] . . . [t]he goal of residency is to gradually provide the physician with increasing responsibility to allow them to progress to the point of practicing without supervision."[52] Depending on their specialty, physicians spend between three to seven years in a residency program.[53] In addition, "many physicians pursue additional training to become subspecialists (referred to as a fellowship)."[54] Participating in a medical fellowship typically "adds one to three years of subspecialty training after the core residency program."[55]

For physicians, residency is a "time of great personal and professional growth."[56] Importantly, it is also a legal requirement to receive a state license to practice medicine in the United States.[57] In order to be "eligible for a license to practice" or to become a board-certified physician, doctors must first participate in a medical residency program.[58] For hospitals, residency provides "a vital group of inexpensive yet highly skilled professionals available to treat patients."[59] Residents also help hospitals train medical students, with "[s]tudents rat[ing] resident teaching higher than that of attending physicians."[60] For patients, residency serves as a source of life-saving medical service, as "residents provide most of the patient care in teaching hospitals."[61] In fact, studies show that "[t]he presence of residents at an institution improves patient care, provides increased access to care for underserved populations, enhances the teaching of medical students, and improves the scholarly output of teaching hospitals and

[49] AOA Production – Part 3 – Final, at 295.
[50] *Id.*
[51] *Id.*
[52] *Id.*
[53] *Id.*
[54] *Id.* at 329.
[55] *Id.* at 295; Letter from David J. Skorton, President and CEO, AAMC, to Rep. Scott Fitzgerald, Chairman, Subcomm. on the Admin. State, Regul. Reform, and Antitrust (Mar. 28, 2025).
[56] AOA Production – Part 3 – Final, at 295. While medical residency does include certain educational components, residents are primarily "workers that also study rather than students that also work." Transcribed Interview of Dr. Aamir Hussain, *supra* note 4, at 35; *see also* Boston Med. Ctr. Corp., 330 NLRB 152 (1999); *Mayo Found. for Med. Educ. & Rsch. v. United States*, 562 U.S. 44, 58-60 (2011); *Field v. Comm'r*, 680 F.2d 510, 513-14 (7th Cir. 1982); *Cooney v United States*, 630 F.2d 438, 442 (6th Cir. 1980).
[57] AOA Production – Part 3 – Final, at 295.
[58] *Id.*; Jeffrey A. Singer & Spencer Pratt, *Expand Access to Primary Care: Remove Barriers to Assistant Physicians,* CATO (Apr. 24, 2023); *Licensing and board certification: What residents need to know,* AMA (May 22, 2019).
[59] Melinda Creasman, *Resuscitating the National Resident Matching Program: Improving Medical Resident Placement Through Binding Dual Matching*, 56 VAND. L. REV. 1439, 1443 (2003).
[60] Krystal L. Tomei et al., *Beyond Training the Next Generation of Physicians: The Unmeasured Value Added by Residents to Teaching Hospitals and Communities*, 97 ACAD. MED. 1592, 1594 (Nov. 2022).
[61] Creasman, *supra* note 59, at 1443.

residency programs."[62] As the next generation of doctors, the 167,083 medical graduates in America's 13,762 residency and fellowship programs will determine the quality of the United States' physician workforce for decades to come.[63]

Unfortunately, as experts have explained, "medical residency training is in crisis."[64] In spite of the vital role that residents play in America's healthcare system, resident salaries are strikingly low and have remained stagnant for decades.[65] Real resident wages were higher in 1971 than they were in 2024.[66] On average, residents make significantly less than their fully licensed physician counterparts even though their job duties are nearly identical,[67] and half as much as both nurse practitioners and physician assistants, despite holding more advanced degrees.[68] Even more, residents are regularly expected to work grueling hours, often exceeding the "mandatory" limit of eighty hours a week imposed by the Accreditation Council for Graduate Medical Education (ACGME).[69] In fact, "almost half of all residents report working more than allowed by the ACGME and falsifying duty hour reports."[70]

Additionally, incidents of "physical, sexual, and emotional abuse are common and gender and racial discrimination are rampant," but residents effectively cannot switch jobs because of the Match's rules.[71] Residents often underreport these problems, because "challeng[ing] the status quo, especially through formal complaints . . . risks retaliation with the potential to impact future career opportunities."[72] As a result, many "residents keep[] their head down to get through while their wellbeing and patient safety suffer."[73] Notably, medical residents are nearly three and a half times more likely to experience depression than the average American, which is even more concerning given the fact that "resident depression has been linked to poor-quality patient care and increased medical errors."[74] All of this has "created an environment that fosters harsh, oftentimes unsafe, working conditions,"[75] where "[w]orkplace protections are minimal, fear of retaliation is common, and frustration with the lack of improvement is widespread."[76]

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[62] Tomei et al., *supra* note 60, at 1595.
[63] *About the ACGME: Overview*, ACGME (last visited Oct. 8, 2025).
[64] Transcribed Interview of Dr. Jason Melehani, *supra* note 4, at 7.
[65] DUHS-HJC000001, at 16-17; Melissa Mayeux, *A Match Made in Antitrust Heaven? A Liberalistic Exploration of the Medical Match's Antitrust Exemption*, 13 WASH. U. JURISPRUDENCE REV. 121, 128-29 (2020); Transcribed Interview of Dr. Jason Melehani, *supra* note 4, at 8.
[66] DUHS-HJC000001, at 16-17; *see also* Mayeux, *supra* note 65, at 129.
[67] DUHS-HJC000001, at 16; Jon McKenna, *Medscape Physician Compensation Report 2025*, MEDSCAPE (July 8, 2025); Transcribed Interview of Dr. Aamir Hussain, *supra* note 4, at 90-91.
[68] DUHS-HJC000001, at 16; BLS, OCCUPATIONAL EMPLOYMENT AND WAGE STATISTICS (OEWS) PROFILES (May 2024).
[69] Transcribed Interview of Dr. Jason Melehani, *supra* note 4, at 7-8.
[70] Mayeux, *supra* note 65, at 128.
[71] Transcribed Interview of Dr. Jason Melehani, *supra* note 4, at 7.
[72] *Id.* at 8.
[73] *Id.*
[74] Douglas A. Mata et al., *Prevalence of Depression and Depressive Symptoms Among Resident Physicians*, 314 JAMA 2373, 2373-74 (2015).
[75] Mayeux, *supra* note 65, at 122.
[76] Transcribed Interview of Dr. Jason Melehani, *supra* note 4, at 8.

At the same time, teaching hospitals and residency programs are not producing enough physicians to meet the growing demand for care created by America's aging population.[77] By 2038, the United States is expected to have a shortage of as many as 141,160 physicians.[78] Yet, every year, the number of medical graduates applying to residency programs dramatically exceeds the number of available positions.[79] In 2025, there were over 7,000 more active applicants than available residency positions.[80] The system "creates a bottleneck in residency positions" that "affects the production of new licensed physicians and limits patients' access to care."[81] Worse yet, "[t]he resulting shortages strain hospitals, delay treatment, increase provider burnout, and compromise patient outcomes."[82]

A. The Medical Residency Market Is Controlled by a Monopolistic Placement System Known as the "Match"

The crisis facing America's medical residency system is not the result of normal market forces, but an entrenched monopoly shielded from scrutiny by government protectionism.[83] In the United States, the process for hiring medical residents is controlled by a monopolistic, centrally planned placement regime operated by the National Resident Matching Program (NRMP), commonly referred to as the "Match."[84] Because medical resident candidates are forced to use the Match, this regime effectively prevents medical residents from operating in a competitive labor market.[85]

The Match's monopoly over the placement of residents restricts their freedom of choice, suppresses their wages, limits their ability to negotiate for better employment terms, incentivizes unionization, and stifles the growth of the medical residency market as a whole.[86] Medical institutions created the Match specifically so that residency programs would not "have to compete as hard . . . as they otherwise would have in a free market."[87] By design, "the Match severely constrains competition, resulting in feeble wage growth, and inflat[ing] expenses for medical residents."[88] It "forc[es] students into a one-size-fits-all system" that requires residency applicants to "follow [the] exact same pathway."[89] By artificially constraining the market for medical residents, experts explain how the Match "exacerbate[s] 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."[90]

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[77] HRSA, PHYSICIAN WORKFORCE: PROJECTIONS, 2023-2038 (Dec. 2025); *see also The Complexities of Physician Supply and Demand: Projections From 2021 to 2036*, AAMC (Mar. 2024).
[78] *Id.*
[79] *Results and Data: 2025 Main Residency Match*, NRMP (May 2025), at 29.
[80] *Id.*
[81] Singer Written Statement, *supra* note 5.
[82] Marek Written Statement, *supra* note 5.
[83] *Id.*
[84] *See* Jeffrey A. Singer & Spencer Pratt, *supra* note 58.
[85] Marek Written Statement, *supra* note 5.
[86] *See generally* Transcribed Interview of Dr. Aamir Hussain, *supra* note 4; Transcribed Interview of Dr. Jason Melehani, *supra* note 4.
[87] Transcribed Interview of Dr. Aamir Hussain, *supra* note 4, at 35.
[88] Transcribed Interview of Dr. Jason Melehani, *supra* note 4, at 9.
[89] Transcribed Interview of Dr. Aamir Hussain, *supra* note 4, at 32.
[90] Transcribed Interview of Dr. Jason Melehani, *supra* note 4, at 11-12.

1. Medical Institutions Created the Match to Limit Competition in the Residency Hiring Market

Initially established as the National Intern Matching Program in 1952, "the NRMP is a private nonprofit corporation that matches United States residency and fellowship applicants to participating programs."[91] The "vast majority" of medical residency and fellowship positions in the United States are filled through the NRMP's placement process, known as the Match.[92] In 2025, 52,498 applicants registered for the Match, and 40,764 residency positions were ultimately filled through the Match.[93] Every year, medical students participate in the Match by applying for residency positions, interviewing with various residency programs, and "submit[ting] a confidential list ranking" the programs where they would be willing to work.[94] At the same time, residency programs across the country submit their own confidential lists ranking potential applicants.[95] The Match then uses an algorithm to assign applicants to specific residency programs based on these rankings.[96]

The Match has controlled the placement of medical residents for over seventy years.[97] Supporters of the Match argue that it was created "to tame an increasingly chaotic system" and protect medical graduates from "competition and absence of structure" in the medical residency hiring market.[98] In the early 1900s, hospitals began to formally hire medical school graduates as residents to give them "post-graduation experience and training under the guidance of senior physicians," having the graduates work and reside on the hospital's premises.[99] By the 1930s, however, the number of positions "began to outnumber the students available."[100] To avoid losing top applicants to their competitors, "hospitals raced to sign medical students," with some "hospitals extend[ing] offers to students (via telegram and, more urgently, by telephone) as early as their second year in medical school."[101] The Match contends that this "competition and absence of structure bred unfairness, inequality, and unwarranted pressure."[102]

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[91] Creasman, *supra* note 59, at 1443; Edwin Williamson et al., *The US Residency Match at 70: What Was, What Is, and What Could Be*, 14 J. GRADUATE MED. EDUC. 519 (2022).
[92] *See* Transcribed Interview of Dr. Aamir Hussain, supra note 4, at 13-14, 130-31; Jeffrey A. Singer & Spencer Pratt, *supra* note 58. There are a few smaller matching systems focused on addressing the needs of a specific group of programs or applicants, including the San Francisco Match (SF Match), the Military Match, and the Urology Residency Match. AOA Production – Part 3 – Final, at 294; SJC-AMA-000000001, at 5.
[93] *Results and Data: 2025 Main Residency Match*, NRMP (May 2025), at v, ix.
[94] Creasman, *supra* note 59, at 1445.
[95] *Id.*
[96] *The National Resident Matching Program's Supplemental Statement on Congress's Confirmation of Antitrust Status of Graduate Medical Resident Matching Programs*, NATIONAL RESIDENT MATCHING PROGRAM (June 30, 2025), at 5 [hereinafter "NRMP Statement"].
[97] Historically, medical institutions often referred to first-year residents as interns, and to single-year post-graduate medical positions as internships. SJC-AMA-000000001, at 2-3; SJC-AMA-000000324, at 328.
[98] STANFORD-119HJC-0000075, at 76; NRMP Statement, *supra* note 96, at 3.
[99] Kara Gavin, *Doctors in the house: History of medical interns and residents at U-M hospitals*, UNIVERSITY OF MICHIGAN (July 2, 2020); *see also* SJC-AMA-000000324, at 326-27.
[100] SJC-AMA-000000001, at 2.
[101] SJC-AMA-000000324, at 326.
[102] NRMP Statement, *supra* note 96, at 3.

Medical institutions reformed the process for hiring interns and residents in two different ways prior to the creation of the Match in an effort to address this alleged issue.[103] In 1945, the Association of American Medical Colleges (AAMC) and other medical organizations voted to establish the "Cooperative Plan," the first successful attempt "to generate national adoption of a streamlined process for effecting the transition to [residency] training."[104] The Cooperative Plan established a "uniform 'acceptance date' before which students should not be offered" residency positions as well as a "uniform release" of medical student records.[105] Within a year, the Cooperative Plan "proved to be an effective remedy for the problem it was intended to solve," successfully preventing hospitals from demanding employment commitments from medical students early in their studies.[106] As the NRMP acknowledged to the Committee and Subcommittee, "the Cooperative Plan was an improvement on the process of transitioning students" to residency.[107]

Soon after, however, medical institutions accused hospitals of pressuring students through the use of "exploding offers,"[108] giving students "very short deadlines, compelling them to accept or reject offers without knowing what other offers might be forthcoming."[109] To address this concern, in 1949, the AAMC proposed the "Uniform Intern Placement Plan," which would have required hospitals to keep residency employment offers open for at least twelve hours.[110] However, the American Hospital Association (AHA) argued that this twelve-hour waiting period was "too long" and only voted in favor of the proposal after adding language clarifying that "no specified waiting period . . . is obligatory."[111]

In 1950, after hospitals refused to voluntarily comply with a ban on "exploding offers," the first "centralized clearinghouse for internship placement was proposed by the National Interassociation Committee on Internships (NICI)," a predecessor to the Match comprised of medical establishment organizations including the AAMC and the American Medical Association (AMA).[112] Originally, "the NICI had endorsed the . . . Cooperative Plan," believing that its "uniform school and acceptance dates were an improvement on the process of transitioning students into internships."[113] However, Dr. Francis Joseph Mullin, the dean of students at the University of Chicago School of Medicine and the architect behind the initial proposal for the Match, convinced the NICI that "a centralized clearinghouse would improve on the Cooperative Plan by allowing students and internship programs to submit rank lists of preferences that an algorithm would process."[114]

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[103] *Id.*
[104] SJC-AMA-000000324, at 327.
[105] NRMP Statement, *supra* note 96, at 3.
[106] Alvin E. Roth, *The Evolution of the Labor Market for Medical Interns and Residents: A Case Study in Game Theory*, 92 J. POL. ECON. 991, 994 (1984); *see also* SJC-AMA-000000324, at 327.
[107] NRMP Statement, *supra* note 96, at 3.
[108] Creasman, *supra* note 59, at 1444-45.
[109] SJC-AMA-000000001, at 2; Roth, *supra* note 106, at 994-95.
[110] Roth, *supra* note 106, at 995.
[111] *Id.*
[112] SJC-AMA-000000324, at 327.
[113] *Id.*
[114] *Id.*

In 1951, Dr. Mullin also created the first proposed algorithm for this central clearinghouse with Stanford University academic John Marshall Stalnaker.[115] As medical journalist Ben Stanley had noted, the NICI moved forward with the algorithm "[d]espite the obvious problem" that it was "fundamentally flawed," as the design of the algorithm "penalized students" who ambitiously listed a higher ranked school as their first choice and "incentivized potential residents and hospitals to make deals outside the system."[116] When medical students raised these concerns, the creators of the Match dismissed them out of hand. The then-dean of Harvard Medical School and president of the AAMC, Dr. George Berry, reportedly told the students that "they had spent $100,000 of money from the Association of American Medical Colleges in working out the details of this plan, and he didn't give a damn if any [medical students] got an internship."[117]

However, medical students were so upset by Dr. Mullin's plan that they developed their own proposal that they called the "Boston Pool Plan," which was designed so "students tentatively matched to hospitals 'until or unless' they matched at one of their higher picks."[118] The Boston Pool Plan addressed the problems inherent in Dr. Mullin's plan by ensuring that students were not punished for being ambitious in their rankings or incentivized "to make deals outside the system," and the students "voted 'en masse' not to use the Mullin-Stalnaker approach."[119] As a result, "the NICI caved in" and agreed to implement the Boston Pool Plan the following year.[120] Using the students' proposed algorithm, in 1952, the NICI conducted the very first Match, with "10,400 internship positions . . . available for 6,000 graduating U.S. medical school seniors."[121]

While proponents of the Match argue that it was created to promote stability in the resident hiring process, it also served as a way to limit competition among hospitals and prevent residents from demanding higher wages.[122] Before the creation of the Match, hospitals aggressively competed with each other to recruit the most qualified applicants and avoid having their residency positions go unfilled.[123] According to Dr. Kenneth Ludmerer, the Mabel Dorn Reeder Distinguished Professor in the History of Medicine at the Washington University School of Medicine in St. Louis:

> Salary became a weapon in the efforts of teaching hospitals to recruit the best house officers, particularly when they were competing

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[115] Ben Stanley, *The Wild True Story of the First Match Day, And Its Hero: A Maverick Ex-Carrier Pilot From New Orleans*, ONLINE MEDED (Mar. 19, 2021); Don K. Nakayama & W. Hardy Hendren, III, *The 1951 Harvard student uprising against the intern match*, 161 SURGERY 1728, 1729-30 (2017); Bryan Carmody, *The Match, Part 2: Getting Under the Hood – How Does the Match Work?*, SHERIFF OF SODIUM (Feb. 3, 2020).
[116] *Id.*
[117] *Oral History Project: W. Hardy Hendren III, MD*, PEDIATRIC HIST. CTR. (June 16, 2006); *see also* Nakayama, *supra* note 115, at 1730.
[118] Stanley, *supra* note 115; *see also* Nakayama, *supra* note 115, at 1730.
[119] Stanley, *supra* note 115; *see also* Nakayama, *supra* note 115, at 1730.
[120] Stanley, *supra* note 115.
[121] AOA Production – Part 1 – Final, at 158.
[122] Roth, *supra* note 106, at 994; Complaint, *Jung v. Ass'n of Am. Med. Colls.*, 300 F. Supp. 2d 119 (D.D.C. 2004) [hereinafter "*Jung* Complaint"].
[123] Kristin Madison, *The Residency Match: Competitive Restraints in an Imperfect World*, 42 HOUS. L. REV. 759, 771 (2005).

> against hospitals in the same city or geographical region. . . . Jefferson Medical College, for instance, repeatedly raised its house staff pay scale in response to competition from the other Philadelphia teaching programs. Students and house officers reveled in this competition. . . . [T]hey made their desire for higher incomes known, and leaders of even the most prestigious programs had to listen.[124]

In a 2004 lawsuit challenging the Match, discussed below, residents noted how "hospitals and other entities employing resident physicians determined that the continuation of free competition in recruiting, hiring, employing and compensating resident physicians . . . would 'bid up' compensation and other terms of employment by which employers commonly compete to attract employees."[125] According to Dr. Kristin Madison, Professor of Law and Health Sciences at Northeastern University, the fact that there were nearly twice as many available residency positions as aspiring residents "would have placed upward pressure on the compensation offered to applicants."[126] In their lawsuit, the residents correctly noted that by controlling the process for hiring residents and preventing applicants from negotiating the terms of their employment, the Match "enabled employers to obtain resident physicians without such a bidding war, thereby artificially fixing, depressing, standardizing and stabilizing compensation and other terms of employment below competitive levels."[127] In the words of one scholar, "[t]he Match has stripped medical residents of any semblance of bargaining power and . . . artificially depressed wages."[128]

2. The Match Consolidated Control over the Medical Residency Hiring Market

In 1966, the AMA commissioned a report that "examined the length and quality of graduate medical education and argued for a broader move from stand-alone internships to integrated residency training."[129] This development "threatened" the Match's market power, as "[t]he Match had been built exclusively to place students into internships," or first-year residency positions, not multiyear programs.[130] With the "influx of integrated residency training options (not required to be placed in the Match)," more residency positions were increasingly filled outside of the Match process.[131]

To reflect this development, in 1968, the National Intern Matching Program changed its name to "the National Intern and Resident Matching Program (NIRMP) in recognition of the broadening landscape of graduate medical education."[132] Four years later, in 1972, the NIRMP "revised its participation requirement[s]" to "include all [Post-Graduate Year]-1 positions

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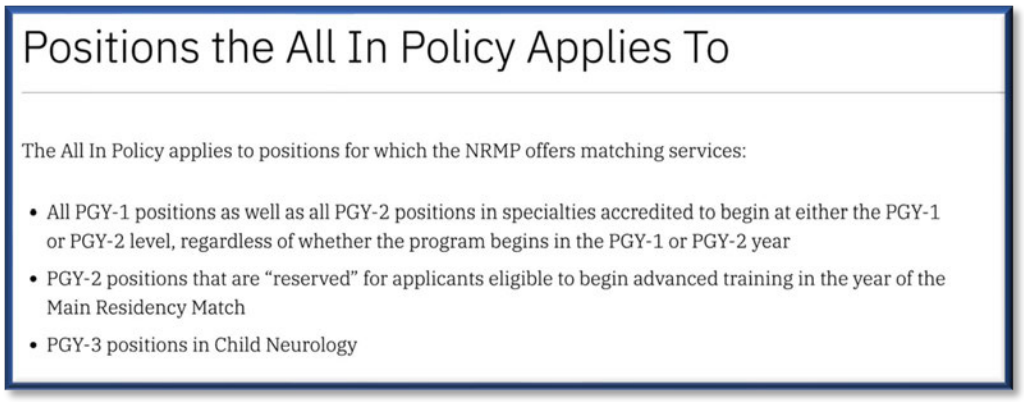
[124] KENNETH M. LUDMERE, TIME TO HEAL: AMERICAN MEDICAL EDUCATION FROM THE TURN OF THE CENTURY TO THE ERA OF MANAGED CARE 193 (1999).
[125] Madison, *supra* note 123, at 771 (quoting *Jung* Complaint, *supra* note 122).
[126] *Id.* at 771.
[127] *Jung* Complaint, *supra* note 122, at ¶ 84.
[128] Mayeux, *supra* note 65, at 122.
[129] SJC-AMA-000000324, at 328.
[130] *Id.*
[131] *Id.*
[132] *Id.*

(internship or integrated programs)"[133] and "require[] all institutions participating in the Match to select U.S. senior students in allopathic medical schools *only* through the Match."[134] In other words, if a hospital wanted access to the pool of medical school graduates participating in the Match, it had to use the Match to fill both its single-year internships and multi-year residency positions, though it could still hire specific applicants outside of any matching system on a case-by-case basis. By 1975, the market for stand-alone single-year internships was "abandoned," causing the NIRMP to change its name again to its current form: the National Residency Matching Program (NRMP).[135]

By 2002, hospitals offered more than 80 percent of all first-year residency positions exclusively through the Match.[136] However, in 2009, the NRMP Board of Directors ordered a study of residency positions offered outside of the Match and found that "more than one-third of residency programs in Match-participating specialties offered non-Match positions and that 1 in 7 residents obtained positions outside the Match."[137] In response, in 2011, the NRMP announced a new requirement called the "All In Policy," forcing Match-participating residency programs to "register and attempt to fill all positions through the Match or another national matching plan."[138] The All In Policy specified that "[p]rograms planning to participate in [t]he Match cannot offer positions outside [t]he Match."[139] The NRMP officially implemented the All In Policy in 2013 over the opposition of thirty-five percent of internal medicine program directors.[140]



The "All In" Policy forces residency programs to fill all positions through the Match.[141]

[133] *Id.*
[134] *Id.* (emphasis added).
[135] *Id.*
[136] Frances H. Miller & Thomas L. Greaney, *The National Resident Matching Program and Antitrust Law*, 289 JAMA 913, 914 (2003).
[137] Zaid I. Almarzooq et al., *The Single Match: Reflections on the National Resident Matching Program's Sustained Partnership With Learners*, 96 ACAD. MED. 1116, 1117-18 (2021).
[138] NRMP_00002740, at 2740; SJC-AMA-000000001, at 4.
[139] SJC-AMA-000000001, at 4.
[140] Michael Adams et al., *Changes in the National Residency Matching Program Policy: Are Internal Medicine Program Directors "All-In"?*, 4 J. GRADUATE MED. EDUC. 148, 149 (2012).
[141] NRMP_00002740, at 2740.

The Match's All In Policy "operates as [a] type of exclusivity agreement," limiting the choice of both residency applicants and programs.[142] According to Dr. Hussain, 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."[143] Likewise, Match-participating residency programs agree not to fill any of their positions outside of the Match or "bypass the NRMP to recruit talent directly."[144] Because most residency programs cannot risk losing access to the pool of applicants participating in the Match, residency programs are effectively required to participate in the Match.[145] Within two years of implementing the All In Policy, "the number of positions in the Match had grown by more than 2,800, or nearly 11 percent," a significant increase that further solidified the NRMP's control over the medical residency hiring market.[146]

More recently, the Match expanded its control over residency hiring by merging with the National Matching Services (NMS), a competing matching service offered by the American Osteopathic Association (AOA), and integrating nearly all osteopathic medical students into its matching program.[147] Before this shift, osteopathic medical students applied to AOA-accredited programs through the NMS, as only ACGME-accredited residency programs were authorized to participate in the Match.[148] Over time, the fact that applicants had to participate in the Match if they wanted to apply for a position with an ACGME-accredited program increasingly forced more osteopathic residency applicants into the Match.[149] By 2014, over half of all osteopathic applicants applied to residency positions through the Match.[150]

In 2015, the AOA started the process of merging its accreditation authority with the ACGME, resulting in the creation of the Single Accreditation System (SAS).[151] As a result of this merger, "the AOA and NRMP match programs" also merged, leading to the "transition of osteopathic seniors from the AOA match to a single match under the NRMP."[152] As of 2020, the Match serves as the gatekeeper for virtually all residency programs, positions, and applicants in the United States.[153]

3. The Match Controls the Residency Hiring Process from Beginning to End

Throughout the residency hiring process, the Match imposes strict rules on how applicants and programs conduct interviews, communicate with each other, rank their

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[142] Transcribed Interview of Dr. Aamir Hussain, *supra* note 4, at 129.
[143] *Id.* at 128.
[144] *Id.*
[145] *Id.* at 130-131.
[146] *PROGRESS REPORT: 2010-2014*, NRMP (2015), at 19.
[147] AOA Production – Part 3 – Final, at 134; SJC-AMA-000000001, at 3.
[148] AOA Production – Part 3 – Final, at 134; SJC-AMA-000000001, at 3.
[149] AOA Production – Part 3 – Final, at 134.
[150] *Id.*
[151] SJC-AMA-000000001, at 3.
[152] SJC-AMA-000000476, at 477.
[153] Transcribed Interview of Dr. Aamir Hussain, supra note 4, at 13-14, 130-31; Jeffrey A. Singer & Spencer Pratt, *supra* note 58.

preferences, and ultimately secure employment commitments.[154] Unlike in a traditional hiring market where employers and employees freely negotiate over terms, the NRMP imposes severe restrictions on communication between applicants and programs, including salary negotiations.[155] The NRMP then requires residency applicants and programs to accept any pairing given to them by the Match, even if either party, or both parties, would prefer to reject it.[156] The NRMP even exercises authority over the market for residency applicants who fail to place with a program through the Match through its Supplemental Offer and Acceptance Program.[157]

i. The Match Prevents Residents from Negotiating Employment Terms

Even before applicants submit their rank-ordered lists of preferred residency programs, the Match imposes strict rules that govern what aspiring residents are allowed to say to their prospective employers.[158] In the summer before their fourth year of medical school, medical students begin the transition to residency by "applying to and interviewing with [residency] training programs."[159] To submit residency applications, the vast majority of applicants use the AAMC's Electronic Residency Application Service (ERAS), a "centralized online application service [that] delivers applications and supporting documents to residency programs."[160] After reviewing their applications, "programs [then] select which applicants they wish to interview."[161] Following the interview period, both applicants and programs must submit their rank-order preferences in the Match's Registration, Ranking, and Results (R3) system.[162]

Although the Match does not specifically prohibit applicants from negotiating the terms of their employment during the interview period, the way the Match works effectively prevents applicants from negotiating with residency programs.[163] Applicants and programs are allowed to "communicate their interest" to each other during interviews, but the Match explicitly prohibits them from "solicit[ing] verbal or written statements" that "impl[y] a commitment to rank" each other.[164] Because applicants and programs are prohibited from committing to rank each other, doctors have explained that negotiations on employment terms would be futile and could not be used to obtain an offer, secure better employment terms, or strengthen an applicant's position

[154] Match Participation Agreement for Applicants, NATIONAL RESIDENT MATCHING PROGRAM (2026) [hereinafter "Applicant Agreement"]; Match Participation Agreement for Programs, NATIONAL RESIDENT MATCHING PROGRAM (2026) [hereinafter "Program Agreement"].
[155] Applicant Agreement, *supra* note 154, at 10; Program Agreement, *supra* note 154, at 11.
[156] Applicant Agreement, *supra* note 154, at 19; Program Agreement, *supra* note 154, at 19.
[157] Applicant Agreement, *supra* note 154, at 16-19; Program Agreement, *supra* note 154, at 16-19; Transcribed Interview of Dr. Aamir Hussain, *supra* note 4, at 17-30.
[158] Applicant Agreement, *supra* note 154, at 10.
[159] SJC-AMA-000000001, at 3.
[160] *Id.*
[161] Letter from David J. Skorton, President and CEO, AAMC, to Rep. Scott Fitzgerald, Chairman, Subcomm. on the Admin. State, Regul. Reform, and Antitrust (Mar. 28, 2025).
[162] SJC-AMA-000000001, at 3; Letter from David J. Skorton, President and CEO, AAMC, to Rep. Scott Fitzgerald, Chairman, Subcomm. on the Admin. State, Regul. Reform, and Antitrust (Mar. 28, 2025).
[163] Transcribed Interview of Dr. Aamir Hussain, *supra* note 4, at 17-19, 21-24, 31-33.
[164] Applicant Agreement, *supra* note 154, at 10; Program Agreement, *supra* note 154, at 11.

with other residency programs.[165] One doctor told the Committee and Subcommittee that due to the Match's rule against discussing employment commitments, an applicant "can't go to a program with the strength of a competing offer in hand and ask for a salary increase."[166] If aspiring residents were allowed to obtain employment commitments, they could leverage those commitments with other residency programs to secure better employment terms, including higher salaries.[167] However, because of the Match's rules, residency applicants are unable to do so.[168]

The NRMP's rule against employment commitments has real consequences for doctors' careers. Dr. Aamir Hussain, a former dermatology resident and member of the residency admissions committee at Georgetown University, explained that if he had been able to secure "a commitment from . . . a lower ranked program," he would have been able to take that offer to a "higher ranked program and . . . negotiate an increase."[169] Similarly, Dr. Jason Melehani, a former resident and fellow at Stanford University, testified that if he had been allowed to "receiv[e] offers for other employment opportunities at other institutions . . . and negotiate those offers all in parallel," he would have been able to secure a higher salary from Stanford.[170] Both Dr. Hussain and Dr. Melehani testified that the NRMP's restriction on employment commitments hindered their ability to negotiate effectively with residency programs in a way that negatively affected the employment terms they ultimately received.[171]

ii. The Match Creates Uncertainty and Inefficiency that Harms Residents and Programs

In testimony to the Committee and Subcommittee, doctors explained how the Match's ban on employment commitments harms applicants by "creat[ing] a lot of ambiguity in the [hiring] process."[172] This ambiguity makes it difficult for applicants to know which residency programs would consider them competitive and, accordingly, which programs they should apply to, interview with, and ultimately rank.[173] Under the Match's rules, residency applicants and programs are effectively prohibited from asking what they "need to do in order to get a commitment."[174] According to Dr. Hussain, this restriction prevents applicants from obtaining the information they need to determine which programs they should rank and "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."[175] As a result, residents apply to more positions than they otherwise would and residency programs provide only general information on the types of candidates they are looking to recruit while struggling to identify which applicants are genuinely

[165] Transcribed Interview of Dr. Aamir Hussain, *supra* note 4, at 21-24, 31-33; Transcribed Interview of Dr. Jason Melehani, *supra* note 4, at 83-85, 87-106, 119-122; *see also* Heather S. Crall, *Unreasonable Restraints: Antitrust Law and the National Residency Matching Program*, 82 WASH. U. L.Q. 245, 269-270 (2004).
[166] Transcribed Interview of Dr. Aamir Hussain, *supra* note 4, at 18.
[167] *Id.* at 91-92.
[168] *Id.* at 92.
[169] *Id.* at 18.
[170] Transcribed Interview of Dr. Jason Melehani, *supra* note 4, at 83-85.
[171] *Id.*; Transcribed Interview of Dr. Aamir Hussain, *supra* note 4, at 18, 91-92.
[172] Transcribed Interview of Dr. Aamir Hussain, *supra* note 4, at 17.
[173] *Id.* at 17-19, 95-97.
[174] *Id.* at 95.
[175] *Id.* at 19.

interested in participating in their program.[176] Both residents and programs are incentivized to signal more interest in the other than they may actually have to avoid a situation in which they do not receive a match.[177]

For example, Dr. Hussain explained that the Match's rules prevented him from determining the requirements for him to be accepted by his preferred residency program, which leads to inefficiency in the hiring process.[178] As a result, Dr. Hussain applied to and ranked every single dermatology program in the United States, approximately one hundred programs, because he had been advised that "applying to more programs would increase [his] chance of getting a match position."[179] Instead of leaving any dermatology programs off his list, Dr. Hussain "just ranked them lower," as he was "worried that [he] wasn't going to get a position."[180]

Every year, residency applicants apply to a large number of programs in order to minimize the risk of going unmatched.[181] In 2025, medical students who matched with a residency program submitted a median of 37 applications.[182] Doctor of Osteopathic Medicine (DO) programs graduates who matched with a position "applied to more programs, with a median of 49."[183] The application rate for applicants who were unable to secure a position was even higher, with unmatched Medical Doctor (MD) and DO students submitting a median of 50 and 62 applications, respectively.[184] In competitive specialties, such as dermatology, "applicants commonly apply to 70–80 programs to secure a small number of interviews."[185]

Many residency applicants rank programs in specialties they would otherwise prefer not to work in just to avoid going unmatched.[186] As Dr. Hussain explained, in a normal market, "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."[187] However, it is "quite common" for medical students "applying to a competitive specialty" to also "include[e] less

[176] *Id.* at 16-19, 39-40, 67-74, 95-97.
[177] *Id.*
[178] *Id.* at 17-19, 95-97.
[179] *Id.* at 14-15, 68-69.
[180] *Id.* at 68-69.
[181] *Id.* at 39-40.
[182] SJC-AMA-000000708, at 710.
[183] *Id.*
[184] *Id.*
[185] Transcribed Interview of Dr. Aamir Hussain, *supra* note 4 (Exhibit 1). The high number of applications to, and rankings of, residency programs is expensive for medical students. The AAMC's Electronic Residency Application Service (ERAS) charges applicants $11 per application for their first thirty applications and $30 for each additional application. *Fees for ERAS Residency Applications*, AAMC (last visited Oct. 22, 2025). Additionally, the NRMP requires applicants to pay $70 for their first twenty rankings and $30 per program for any additional rankings. *Match Fees*, NATIONAL RESIDENT MATCHING PROGRAM (last visited Oct. 22, 2025). Accordingly, the median U.S. senior, with 37 applications and 14 ranked programs, pays $610 in application and ranking fees, and medical students applying to competitive specialties pay "[t]he cumulative direct cost of . . . [over] $800 per applicant." Transcribed Interview of Dr. Aamir Hussain, *supra* note 4 (Exhibit 1). In fact, "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," while "NRMP Match fees contribute the majority of that organization's $6–8 million budget." Transcribed Interview of Dr. Aamir Hussain, *supra* note 4 (Exhibit 1).
[186] Transcribed Interview of Dr. Aamir Hussain, *supra* note 4, at 16, 67.
[187] *Id.* at 68-69.

competitive specialties in the rank order list."[188] These applicants split their rank-ordered list between programs in their preferred specialty and programs in less competitive specialties.[189] Even though these programs are not "necessarily their preference," applicants choose to rank them in order to "hedge their bets" and "ensure that they don't go unmatched all together."[190]

Because of the Match, residency programs provide less information about the types of applicants they are looking to recruit so as to increase the number of applications they receive and avoid having their positions go unfilled.[191] Dr. Hussain explained that without the Match's restrictions, "you would be able to have more clarity on your competitiveness as an applicant," as programs would be able to clearly communicate "certain requirements that are unique to [the] program" and signal that "if you meet those requirements, you have a decent chance of getting into that program."[192] Instead, he explained, the Match's "structure directly incentivize[s] programs to provide less information about what they'd like in an applicant."[193] Because of the Match process, residency programs only "get one bite at the apple" to secure residents.[194] If "programs fail to recruit the right number of students, they suffer by having fewer residents."[195] As a result, residency programs are incentivized to "put out as wide of a net as possible to make sure they get the largest pool of applicants."[196] For that reason, instead of detailing "specific attributes they're looking for that would make someone more competitive," Dr. Hussain explained that residency programs provide "very generic" descriptions of the type of residents they hope to recruit, such as "doctors that care about their patients or that are interested in service."[197] He noted how programs "often set their baseline standards a little bit lower . . . to get more applicants and more applicants ranking them on their rank ordered list," even though this makes it difficult for an applicant to know whether they would actually be competitive for the position.[198]

The Match also hinders the ability of residency programs to determine which applicants they should recruit. Because of the Match's prohibition on "employment commitments," it is "extremely challenging" for programs to gauge whether an applicant's interest in their program is genuine.[199] Residency programs struggle to determine "which students were committing to attend the program or which ones had . . . simply selected all and applied to every single program."[200] The Match makes it "very difficult for programs to identify which applicants are likely to rank them and fill their positions."[201] As a result, "programs often . . . cut more highly qualified applicants out of fear that they may not rank them on their rank ordered list."[202]

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[188] *Id.* at 16.
[189] *Id.* at 16, 67.
[190] *Id.* at 16-17.
[191] *Id.* at 72-74, 95-97.
[192] *Id.* at 72.
[193] *Id.* at 97.
[194] *Id.* at 96-97.
[195] *Id.* at 97.
[196] *Id.* at 96-97.
[197] *Id.* at 73-74.
[198] *Id.* at 95-96.
[199] *Id.* at 19.
[200] *Id.* at 96.
[201] *Id.*
[202] *Id.*

iii. The Match "Binds" Residents and Programs to its Decisions

The Match forces residency applicants and programs to accept any pairing assigned to them by the NRMP.[203] After the Match creates a pairing, aspiring residents "[a]re in a binding commitment with the program and must accept an appointment as matched or offered," and residency programs "[a]re in a binding commitment with the applicant and must offer an appointment as matched or offered."[204] "A waiver or deferral of the binding commitment may be requested only from the NRMP" after "demonstrating an unanticipated serious and extreme hardship," and "[t]he NRMP has sole discretion to grant or deny a requested waiver or deferral."[205] Following the Match process, "there is no flexibility—neither the hiring program nor the applicant can release the other from the match commitment."[206] Once an applicant has been paired with a program, "[t]hey're not able to seek additional offers," as "if they try to use [their] offer to seek a different one, they'll have violated [the Match] agreement."[207] This is true even if the applicant is paired with a program that was their last choice, not in their preferred specialty, or hundreds of miles from where they plan to live or practice.[208] Residency positions, and the terms of those positions, "are offered essentially on a take it, or take it, basis."[209]

When the NRMP finds that a residency applicant has violated one of these rules, or any other rule in the Match agreement, it has the power to apply harsh sanctions.[210] The NRMP may withdraw an applicant "[a]t any time before the Match results are released . . . without first affording an opportunity for a hearing" if it believes that an "applicant has violated the terms of [the Match] Agreement" in a way that jeopardizes "the integrity of the Match."[211] If the NRMP finds that an applicant has violated the Match agreement, it can designate the applicant "as a Match violator" and bar the applicant "from subsequent NRMP Matches for one-to-three years, or permanently."[212] In addition, the Match's "disciplinary action includes notification of all professional medical societies in the country . . . includ[ing] the boards that provide the eligibility and certification under medical specialties, the AAMC, the ACGME, the medical schools themselves."[213] As Dr. Melehani described to the Committee and Subcommittee, "[i]t's an effective blacklisting to back out" of the Match or otherwise violate the terms of the Match agreement.[214]

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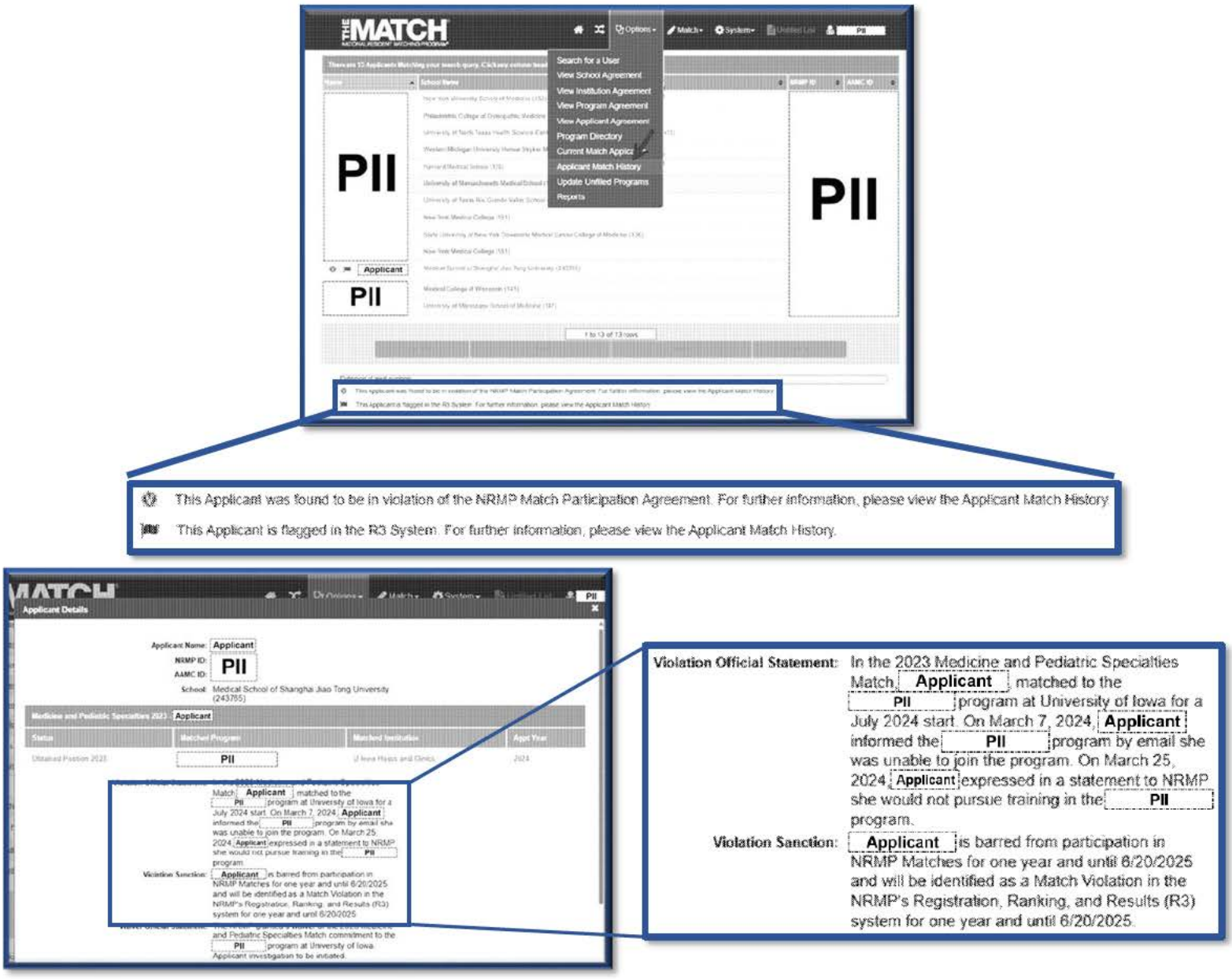
[203] Applicant Agreement, *supra* note 154, at 6-7; Program Agreement, *supra* note 154, at 7.
[204] Applicant Agreement, *supra* note 154, at 19; Program Agreement, *supra* note 154, at 19.
[205] Applicant Agreement, *supra* note 154, at 20; Program Agreement, *supra* note 154, at 20.
[206] Mayeux, *supra* note 65, at 127.
[207] Transcribed Interview of Dr. Aamir Hussain, *supra* note 4, at 26-27.
[208] Applicant Agreement, *supra* note 154, at 20.
[209] Miller Written Statement, *supra* note 20.
[210] Applicant Agreement, *supra* note 154, at 21-22.
[211] *Id.* at 22.
[212] NRMP_00002743, at 2748.
[213] Transcribed Interview of Dr. Jason Melehani, *supra* note 4, at 104-05; NRMP_00002743, at 2747-48.
[214] *Id.*



How residency applicants flagged as "Match violators" appear in the NRMP's R3 database.[215]

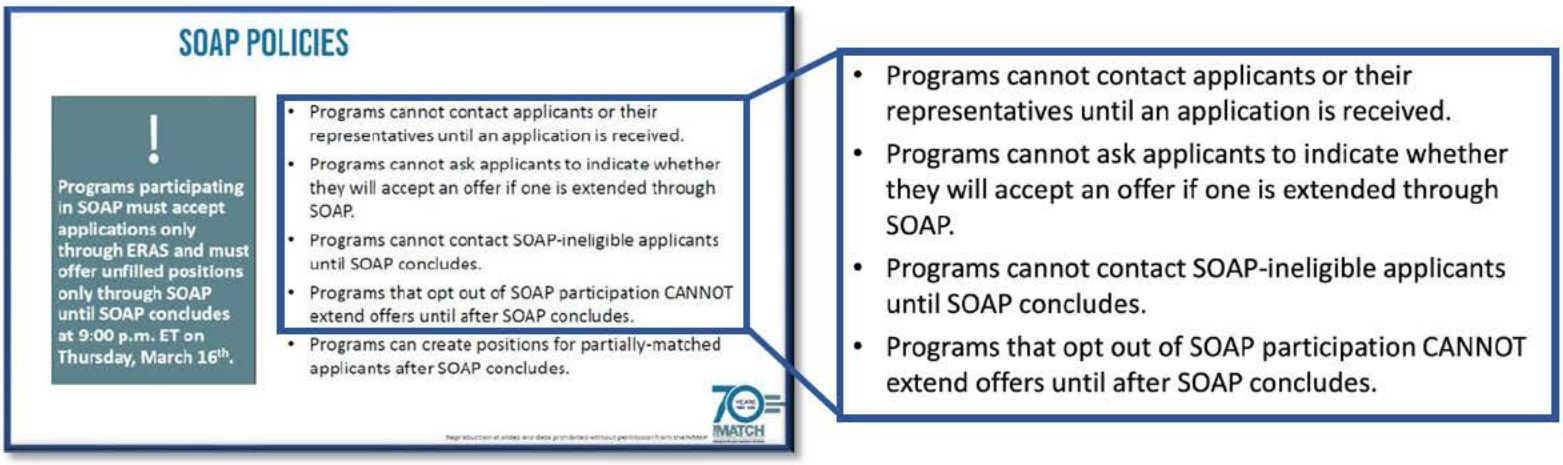
iv. The Match Also Regulates the Hiring Process for "Unmatched" Applicants

Even after initial residency pairings have been made, the NRMP places strict rules on how residency programs are allowed to hire the remaining "unmatched" applicants.[216] Every year, thousands of applicants fail to secure a residency position through the Match.[217] Before 2012, "unmatched" applicants would attempt to secure unfilled residency positions during a

[215] NRMP_00004565; NRMP_00004566.
[216] Applicant Agreement, *supra* note 154, at 16-19; Program Agreement, *supra* note 154, at 16-19.
[217] *Results and Data: 2025 Main Residency Match*, NRMP (May 2025), at 29.

three-day period in which applicants and programs negotiated with each other to fill the remaining spots without much intervention from the NRMP.[218] In an effort to exercise more control over this process, in 2012, the Match created the Supplemental Offer and Acceptance Program (SOAP).[219]

The SOAP is a four-day period starting on "Match Day" where unmatched applicants attempt to secure "positions that were not filled when the matching algorithm was initially processed."[220] The SOAP is divided into four consecutive "Offer Rounds," in which "applicants have two hours to accept or reject offers" and "[o]ffers not accepted or rejected expire automatically."[221] Similar to the Match itself, communication between SOAP-participating applicants and programs is heavily restricted during this process.[222] Residency programs participating in the SOAP "cannot contact applicants or their representatives until an application is received," "cannot ask applicants to indicate whether they will accept an offer if one is extended through SOAP," and "cannot contact SOAP-ineligible applicants until the SOAP concludes."[223] In addition, "SOAP-eligible applicants can only apply to SOAP-participating programs" and "[p]rograms that opt out of SOAP participation CANNOT extend offers until after SOAP concludes."[224] Like placements through the Match, residency pairings made through the SOAP "constitute a binding commitment under the Match Participation Agreement."[225]



The NRMP closely regulates the market for "unmatched" applicants through the SOAP.[226]

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[218] Stephanie Detterline & Robert Ferguson, *In the SOAP: the Supplemental Offer and Acceptance Program (SOAP) from the perspective of a Community Hospital Residency*, J. COMMUNITY HOSPITAL INTERNAL MEDICINE PERSPECTIVES (July 16, 2012).
[219] Detterline & Ferguson, *supra* note 218.
[220] SJC-AMA-000000749, at 749-50.
[221] *Id.* at 750.
[222] AAMC Exhibit 52, at 4-5.
[223] *Id.* at 4.
[224] AAMC Exhibit 62; AAMC Exhibit 52, at 4-5.
[225] AAMC Exhibit 52, at 3.
[226] *Id.* at 4.

There are substantially more SOAP-eligible applicants than there are open residency positions in the SOAP.[227] In 2025, there were 13,670 SOAP-eligible applicants, but only 2,521 available positions in the SOAP.[228] Less than 17 percent of eligible applicants were able to secure a position through the SOAP.[229] During the SOAP process, "the resident . . . is in a position where if they don't find something, anything, they are not going to have a job for the next year."[230] According to Dr. Hussain, the SOAP process "tak[es] advantage of the most vulnerable students at their most vulnerable period."[231]

In addition, it is exceedingly difficult for SOAP-participating applicants to secure a residency position in their preferred specialty.[232] A large number of Match-participating specialties do not offer any positions at all through the SOAP.[233] Out of the 47 specialties that offered first-year positions through the Match in 2025, only 27 offered positions through the SOAP.[234] For specialties that do participate in the SOAP, the number of positions they offer is incredibly limited.[235] For example, in 2025, first-year residents in the SOAP were forced to compete for three dermatology positions, two neurological surgery positions, and only one otolaryngology position.[236]

Documents produced to the Committee and Subcommittee highlight just how much the Match and the SOAP have distorted the market for residents and diminished the quality of the product.[237] In an email to the AOA on March 23, 2021, a week after the 2021 Match, a recent applicant "who endured the SOAP" described the situation that aspiring residents are forced to contend with in detail.[238] The applicant explained that while the transition to residency "is supposed to be one of the most exciting, important, and joyous times that person will experience in their entire career as a physician," for many applicants, "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."[239] According to the applicant, "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."[240] The applicant detailed her own personal experience with the Match:

> When it came time [to] apply[] 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. . . I applied to 154 programs, and

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[227] *Results and Data: 2025 Main Residency Match*, NRMP (May 2025), at 81.
[228] *Id.* at 80-81.
[229] *Id.* at 81.
[230] Transcribed Interview of Dr. Jason Melehani, *supra* note 4, at 122-23.
[231] Transcribed Interview of Dr. Aamir Hussain, *supra* note 4, at 42.
[232] *Results and Data: 2025 Main Residency Match*, NRMP (May 2025), at 81.
[233] *Id.* at 45, 81.
[234] *Id.*
[235] *Id.*
[236] *Id.* at 81.
[237] AOA Production – Part 3 – Final, at 109.
[238] *Id.*
[239] *Id.*
[240] *Id.*

> 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. . . And guess what? I didn't match.[241]

As a result, the applicant "ended up needing to [enter the] SOAP during Match Week."[242] Unfortunately, the SOAP process proved just as difficult for the applicant:

> 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.[243]

The applicant highlighted "the emotional toll last week took" on aspiring residents and the "[f]eelings of hopelessness and inadequacy [that] rang through most of us last week that were 'stuck' in the SOAP."[244] How the applicant's "mom didn't get to see me jump for joy or smile with all the excitement in the world," and how "[i]nstead, 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 [Graduate Medical Education]."[245] This applicant's experience not only underscores the emotional toll of the Match process, but also provides direct evidence of how this monopoly has reduced resident choice and diminished the quality of service.

B. The Match Suppresses Resident Wages, Increases Working Hours, and Restricts Freedom of Choice

With few exceptions, aspiring physicians must participate in the Match to secure a residency position in the United States.[246] By giving teaching hospitals and residency programs a captive pool of applicants, the Match actively suppresses resident salaries, increases their working hours, and constrains their freedom of choice. Because of the Match's prohibition on securing employment commitments, residency applicants cannot meaningfully negotiate the terms of their employment, removing one of the most important incentives for programs to provide better employment terms and creating "the conditions for a price fixing scheme."[247]

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[241] *Id.* at 110.
[242] *Id.*
[243] *Id.*
[244] *Id.*
[245] *Id.* at 113-14.
[246] *See* Section I.A.
[247] Transcribed Interview of Dr. Jason Melehani, *supra* note 4, at 98-99.

Even more, by artificially constraining the residency hiring market, the Match is also fueling America's growing doctor shortage.

1. The Match Suppresses Resident Wages by Restricting Negotiations

Resident salaries are remarkably low and have remained stagnant for decades.[248] In 2024, first-year residents earned an average salary of $66,712.[249] Adjusted for inflation, resident wages were higher in 1971 than they were in 2024.[250] Residents often work 80 hours or more a week and "provide most of the patient care in teaching hospitals" while "allow[ing] attending physicians to manage and bill for services to more patients more efficiently."[251] Research has indicated that the "value of the work each resident performs annually is $232,726."[252] In fact, in 2013, a comprehensive study found that the value of adding an additional internal medicine resident could be as high as $253,910, while the value of adding an additional cardiology resident could reach $340,199.[253] Even still, Dr. Melehani explained that, for example, "[t]he total annual salary for someone at In N Out or Panda Express is higher than" the salary of many residents.[254]

On average, residents make five and a half times less than their fully licensed physician counterparts.[255] While residents made an average salary of $66,712 in 2024, physicians made $374,000 on average.[256] Even under more conservative estimates, the average physician salary is still three and a half times greater than the average resident salary.[257] The disparity is especially striking for soon-to-be physicians in their fifth and final year of residency, who earn between $160,030 and $294,830 less than fully licensed physicians, despite the fact that they are only a year away from being fully licensed themselves.[258] Dr. Hussain testified that while "the actual day to day work [was] . . . roughly the same" during his last year of residency and first year as a fully licensed physician, his salary was approximately "five times higher."[259]

Even more, resident salaries are substantially lower than other healthcare providers who did not go to medical school but were hired through more traditional employment negotiations undistorted by the Match and its restrictions, like nurse practitioners and physician assistants.[260] In 2024, nurse practitioners made a median wage of $132,050, while physician assistants made a median wage of $133,260, almost twice as much as the average resident's salary despite the fact

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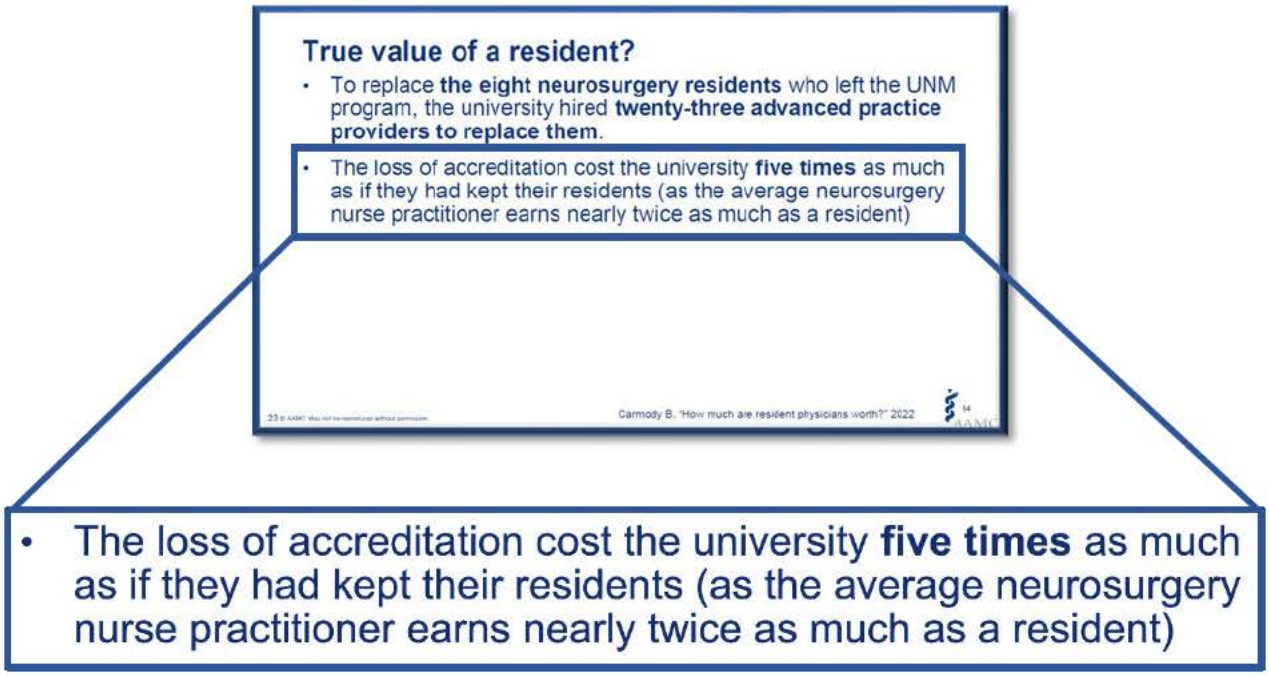
[248] DUHS-HJC000001, at 16-17; Mayeux, *supra* note 65, at 128; Transcribed Interview of Dr. Jason Melehani, *supra* note 4, at 8.
[249] DUHS-HJC000001, at 16-17.
[250] *Id.*; *see also* Mayeux, *supra* note 65, at 129.
[251] Creasman, *supra* note 59, at 1443; Singer Written Statement, *supra* note 5.
[252] ELISABETH ROSENTHAL, AN AMERICAN SICKNESS: HOW HEALTHCARE BECAME BIG BUSINESS AND HOW YOU CAN TAKE IT BACK 43 (2017).
[253] Barbara O. Wynn et al., *Does It Cost More to Train Residents or to Replace Them? A Look at the Costs and Benefits of Operating Graduate Medical Education Programs*, RAND CORPORATION (2013).
[254] Transcribed Interview of Dr. Jason Melehani, *supra* note 4, at 102-03.
[255] DUHS-HJC000001, at 16; McKenna, *supra* note 27.
[256] *Id.*
[257] DUHS-HJC000001, at 16; *Occupational Outlook Handbook: Physicians and Surgeons*, BLS (Aug. 28, 2025).
[258] *Id.*; McKenna, *supra* note 27.
[259] Transcribed Interview of Dr. Aamir Hussain, *supra* note 4, at 90-91.
[260] DUHS-HJC000001, at 16; *Occupational Employment and Wage Statistics (OEWS) Profiles*, BLS (May 2024).

that residents hold more advanced degrees.[261] According to the Health Resources and Services Administration, an agency within the U.S. Department of Health and Human Services tasked with improving access to health care, if hospitals no longer employed residents, the medical services they provide would have to be done by "higher paid, fully certified physician(s), or, at a minimum, a nurse practitioner or physician assistant."[262] But, "[i]n either case, the hospital would bear a replacement cost in excess of employing the resident."[263]

For example, in 2019, the ACGME withdrew accreditation from the University of New Mexico School of Medicine's neurosurgery residency program.[264] As a result, the University of New Mexico Hospital lost its eight neurosurgery residents.[265] In order "to handle the workload of the departing residents," the hospital was forced to "hire[] 23 advanced practice providers," such as nurse practitioners and physician assistants.[266] According to documents produced to the Committee and Subcommittee, the loss of these residents "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)."[267]



The University of New Mexico Hospital had to hire 23 APPs to replace 8 residents.[268]

[261] *Id.*
[262] *Graduate Medical Education and Public Policy: A Primer,* HRSA (Dec. 2000), at 6.
[263] *Id.*
[264] Ryan Beotel, *Residents complained before loss of accreditation, UNM says*, ALBUQUERQUEJOURNAL (Dec. 15, 2019).
[265] *Id.*
[266] *Id.*
[267] AAMC Exhibit 78, at 23.
[268] *Id.*

Resident compensation is "far below not only the value of services they provide on behalf of the hospital to patients, but also far below what Medicare pays the hospital to train that resident."[269] In 2023, the federal government provided $29 billion to residency programs for graduate medical education, which averages out to roughly $178,303 per resident or fellow,[270] well over twice as much as the average resident salary.[271]

One of the main reasons for this salary discrepancy is that teaching hospitals are not required to spend Graduate Medical Education (GME) funds on residents or even the residency programs more generally.[272] In most cases, "hospitals distribute GME payments through a general revenue fund with no restriction that these payments must support only GME."[273] Notably, according to documents produced to the Committee and Subcommittee,"[h]ospitals fund the bulk (often over 70%) of [residency] training programs *out of patient care revenues*" that "are generated by [residents] *acting* as employees."[274] This means that residency programs use the revenue they receive from resident labor to fund the vast majority of resident training, allowing hospitals to use an even greater amount of the GME subsidies they receive from the federal government for other purposes.[275]

Resident salaries are also abnormally uniform across different hospitals, specialties, and even geographic regions, which suggests they are not set by normal market dynamics. Across the United States, there is only a $9,000 difference between the twenty-fifth percentile and the seventy-fifth percentile of first-year resident wages, with virtually no variance between different geographic regions apart from cost-of-living adjustments.[276] By comparison, according to the Bureau of Labor Statistics, there is a difference of over $39,000 between the twenty-fifth percentile and the seventy-fifth percentile of nurse practitioners, and a difference of over $46,000 when it comes to physician assistants.[277] In addition, over 95 percent of hospitals pay every single resident the same starting salary, regardless of their qualifications, specialty, the difficulty of the work they will be performing, the number of hours they will be working, or the amount of value they are likely to create for the hospital.[278] In documents produced to the Committee and Subcommittee, the AMA acknowledges that resident wages "correlate with training year rather than specialty," and that "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."[279]

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[269] Marek Written Statement, *supra* note 5.
[270] $29 billion divided by the 162,644 residents and fellows that were active in 2023. *See* Marco A. Villagrana, *Medicare Graduate Medical Education, 2025*, CONG. RESEARCH. SERV. (Aug. 20, 2025); *ACGME Releases 2023-2024 Statistics on Graduate Medical Education Programs and Resident Physicians*, ACGME (Oct. 3, 2024).
[271] Marek Written Statement, *supra* note 5.
[272] Thomas M. Henderson, *How Accountable to the Public Is Funding for Graduate Medical Education? The Case for State Medicaid GME Payments*, 111 AM. J. PUB. HEALTH 1216, 1218 (2021).
[273] *Id.*
[274] AAMC Exhibit 78, at 18 (emphasis in original).
[275] *Id.*
[276] DUHS-HJC000001, at 15; Transcribed Interview of Dr. Jason Melehani, *supra* note 4, at 18-21, 105; Transcribed Interview of Dr. Aamir Hussain, *supra* note 4, at 22-23.
[277] *Occupational Employment and Wage Statistics (OEWS) Profiles*, BLS (May 2024).
[278] DUHS-HJC000001, at 11; Transcribed Interview of Dr. Jason Melehani, *supra* note 4, at 18-21, 105; Transcribed Interview of Dr. Aamir Hussain, *supra* note 4, at 22-23.
[279] SJC-AMA-000000626, at 627.

The uniformity in resident salaries is especially striking given the fact that the workload, complexity, and expected time commitment differ dramatically between different specialties and subspecialties.[280] For example, surgical residents often work more than eighty hours per week and "spend most of their training in . . . operating rooms, and caring for patients in that setting."[281] On the other hand, family medicine residents "spend a lot of their time in clinics . . . [that] operate during normal business hours."[282] While family medicine residents certainly perform important work, "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" given the nature of the work they are providing and the costs associated with those procedures.[283] In spite of this, nearly all hospitals pay first-year surgical and family residents the same salary.[284] In contrast, for fully licensed physicians, the salary difference between specialties varies by "orders of magnitude," and "the difference in some cases is hundreds of thousands of dollars."[285]Similarly, the average salary of physicians differs drastically between different geographic regions, with a difference of over $200,000 between the highest and lowest paying states.[286]

According to Dr. Melehani, the Match is "a main contributor . . . [to] the suppression of [resident] salaries because it enforces a single offer on everyone participating in the marketplace."[287] In a normal market, an employee can "leverage[] one offer against another offer."[288] However, because of the Match's restrictions on employment commitments, residents are unable to secure offers, much less leverage them in salary negotiations.[289] This problem is compounded by the fact that "after the match, [residents] have to accept the position they're given with no ability to change positions or leverage [their] offer to get a different position" or a higher salary.[290] As a result, "the Match and its rules against employment negotiations lead to lower salaries for residents" and "result in more wage uniformity between residents."[291] As Dr. Hussain explained:

> 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

[280] Transcribed Interview of Dr. Jason Melehani, *supra* note 4, at 20-22; *see also* Transcribed Interview of Dr. Aamir Hussain, *supra* note 4, at 22-23.
[281] Transcribed Interview of Dr. Jason Melehani, *supra* note 4, at 21.
[282] *Id.*
[283] *Id.* at 21-22.
[284] DUHS-HJC000001, at 11; Transcribed Interview of Dr. Jason Melehani, *supra* note 4, at 18-21, 105; Transcribed Interview of Dr. Aamir Hussain, *supra* note 4, at 22-23.
[285] Transcribed Interview of Dr. Jason Melehani, *supra* note 4, at 105.
[286] *Occupational Employment and Wage Statistics (OEWS) Maps*, BLS (May 2024).
[287] Transcribed Interview of Dr. Jason Melehani, *supra* note 4, at 104-05.
[288] Transcribed Interview of Dr. Aamir Hussain, *supra* note 4, at 93.
[289] *Id.*
[290] *Id.*
[291] *Id.* at 22.

> offering, they essentially will not become a physician and be unable to practice[.][292]

Dr. Hussain testified that this serves as "a huge barrier" for residents, such that "they'll essentially take [the] lower offer" to avoid jeopardizing their ability to obtain a license or board certification.[293] By removing the ability of applicants to engage in meaningful salary negotiations, the Match's "placement processes make it easier for residency programs to coordinate on things like salary decisions."[294]

Economic research of placement systems like the Match confirms how these systems distort salaries. In 2006, two economists found that "[w]ages fall relative to any competitive equilibrium while profits rise almost as much."[295] Because they do not have to compete in order to obtain residents, "the top hospitals gain the most" while "the residents whose salaries are most reduced are the very best ones."[296] The distortionary effect created by systems like the Match also "accounts for the compression in the wage distribution" of residents.[297] In fact, "the compression of salaries within programs, within specialties, and across fields is remarkable, compared to the variation in pay among more senior doctors."[298]

Dr. Melehani's experience at Stanford University is instructive in highlighting the ways in which teaching hospitals and training programs work in conjunction with the Match to prevent salary negotiations and suppress resident and fellow wages.[299] Through the Match, Dr. Melehani was paired with an internal medicine residency position at Stanford.[300] After completing his residency, Dr. Melehani "pursued further training in fellowship while at Stanford in rheumatology and pulmonary medicine."[301] As part of this fellowship, Dr. Melehani "received approval from [his] 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 [his] training."[302] Over the next several months, Stanford remained "quite supportive" of Dr. Melehani's efforts to partner with Gilead in order to complete his training.[303]

It was not until Dr. Melehani reached out to request a reduction in his Stanford salary to account for the decrease in time he would spend working as a fellow that Stanford raised any concerns about his work with Gilead.[304] In the conversations that followed, Stanford "recognized and acknowledged that the salary from [Gilead] was substantially greater than the salary they

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[292] *Id.* at 92.
[293] *Id.*
[294] Transcribed Interview of Dr. Jason Melehani, *supra* note 4, at 97-98.
[295] Jeremy Bulow & Jonathan Levin, *Matching and Price Competition*, 96 AM. ECON. REV. 652 (2006).
[296] *Id.* at 653.
[297] *Id.*
[298] *Id.* at 652.
[299] Transcribed Interview of Dr. Jason Melehani, *supra* note 4.
[300] *Id.* at 6.
[301] *Id.*
[302] *Id.* at 28.
[303] Transcribed Interview of Dr. Jason Melehani, *supra* note 4, at 29.
[304] *Id.*

were paying" Dr. Melehani.[305] Even still, Stanford told Dr. Melehani that he had to be paid at the same level as every other fellow.[306] When asked "if there were any policies" that led to this decision, Dr. Melehani testified that Stanford's Associate Dean of Graduate Medical Education, Dr. Laurence Katznelson simply told him, "This is how we do things here."[307]

In emphasizing Stanford's insistence on uniform salaries for residents and fellows, Dr. Katznelson "brought up an example where the Department of Orthopaedic Surgery . . . wanted to recruit a resident who they thought was a stellar candidate."[308] To do so, "the Department of Orthopaedic Surgery made a request [to] [Stanford] to make a better offer than what the [resident salary] scale offered."[309] However, Stanford denied the request on the grounds that it "could not deviate from the set scale that everybody had to be paid."[310] Stanford made it clear that it does "not allow programs to offer better salaries in order to recruit candidates . . . based on their qualifications or to improve the standing of employees based on their performance on the job."[311] Because the Match and ACGME make it exceedingly difficult for residents and fellows to obtain a position with a different program, Stanford was—and still is—able to impose this restriction without a meaningful risk of losing these employees to competing institutions.[312]

Over the next several months, Dr. Melehani made several attempts to work with Stanford to find a path forward.[313] Throughout these discussions, Stanford continually emphasized to Dr. Melehani that "everyone has to be paid the same."[314] Dr. Melehani quickly realized that Stanford's insistence on the need for uniformity in resident and fellow salaries was "in the interest of . . . maintaining control of the residents."[315] The former director of Stanford's internal medicine residency program explicitly told Dr. Melehani that Stanford was likely worried that allowing him to make more money could "set a precedent where other[s] . . . are going to want to do this as well."[316] The former program director explained that "residents represent a very low expense, high-quality workforce for the hospital and for the research labs," and that "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."[317]

Dr. Melehani testified to the Committee and Subcommittee that he believes that his "additional source of income through [his] position at Gilead threatened Stanford's participation in its price fixing scheme," and that "Stanford feared setting a precedent" in which residents and

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[305] Notably, "over a 3 year training period," the wages from Gilead represented "a difference of nearly a million dollars in salary." *Id.* at 34.
[306] *Id.*
[307] *Id.*
[308] *Id.*
[309] *Id.*
[310] *Id.* at 34-35.
[311] *Id.* at 56-57.
[312] Applicant Agreement, *supra* note 154, at 19; Program Agreement, *supra* note 154, at 19; Marek Written Statement, *supra* note 5.
[313] Transcribed Interview of Dr. Jason Melehani, *supra* note 4, at 36-40.
[314] *Id.* at 38-39.
[315] *Id.* at 39-40.
[316] *Id.*
[317] *Id.*

fellows would be "able to dramatically increase [their] salary."[318] According to Dr. Melehani, "Stanford really benefits from this price control" over resident and fellow salaries, as "price fixing allows it to hire and employ more qualified healthcare professionals and pay them less," while at the same time "get[ting] more from them in terms of the time worked."[319] From Dr. Melehani's perspective, Stanford's repeated assertions that it "needed to pay residents all the same . . . were clear expressions of the motivation and effect of what they were aiming to achieve with this price fixing scheme."[320] This understanding was reinforced by the fact that "Stanford prevented one of its programs from actively negotiating with residents to attract more qualified residents . . . to maintain uniformity in salaries."[321]

As Dr. Melehani noted in his testimony to the Committee and Subcommittee, the Match and its restrictions "make it easier for residency programs to coordinate on things like salary decisions" by "allow[ing] 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."[322] By preventing salary negotiations, the Match empowers hospitals and residency programs to suppress wages and fix the salaries of residents and fellows at a uniformly low level.

2. The Match Forces Residents to Accept Long Hours and Poor Conditions

In addition to suppressing resident salaries, the Match compels residents and fellows to endure long hours and poor working conditions.[323] In a normal hiring market, workers have "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."[324] However, by limiting residents' ability to negotiate and requiring them to accept whatever position they are given, the Match forces residents into a system where they are compelled to tolerate such conditions.[325]

Residents and fellows infamously work exceedingly long hours that raise concerns about patient safety.[326] For nearly a century after hospitals first started hiring residents, "it was common for residents to work extremely long hours, including shifts that lasted over 24 consecutive hours or more."[327] During this period, "[o]n-duty hours of first-year residents exceeded a mean of 80 hours per week (e.g., neurosurgery residents reported averaging 110 hours per week)."[328] These "[e]xcessive work hours . . . 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," and "[s]everal research studies conducted in the late 1980s and early 2000s shed light on the adverse effects of long work hours and sleep deprivation on

[318] *Id.* at 98-99.
[319] *Id.* at 96-97.
[320] *Id.* at 99-100.
[321] *Id.*
[322] *Id.* at 97-99.
[323] *See* Ryan Park, *Why So Many Young Doctors Work Such Awful Hours*, THE ATLANTIC, (Feb. 21, 2017).
[324] Transcribed Interview of Dr. Jason Melehani, *supra* note 4, at 12.
[325] *See* Section I.A.3.
[326] Park, *supra* note 323.
[327] SJC-AMA-000000073, at 75.
[328] *Id.*

resident physicians."[329] In "[o]ne high-profile case," a patient "died while under the care of fatigued and overworked residents at New York Hospital."[330]

In 2003, following "mounting concerns about resident well-being, patient safety, and the need for standardized guidelines," the ACGME adopted a set of reforms aimed at addressing this issue.[331] Among other things, these reforms included a limit on working more than 80 hours per week, mandatory time off, and "a maximum shift length of 24 consecutive hours, with an additional six hours permitted for specific patient care activities and transitions."[332] Notably, the reforms also included restrictions on "Moonlighting," which "refer[s] to engaging in additional paid work outside of the residency program."[333]

While the ACGME's adoption of these reforms helped alleviate some of the burden on residents, the hours they work are still inordinately long. As Dr. Melehani explained, there are "about 144 hours in a week, so 80 hours is more than half of the entirety of the week, even . . . giving consideration for sleep."[334] Dr. Melehani testified that "when [he] was at Stanford, the longest period of time that [he] would work continuously was 30 hours straight."[335] During these shifts, Dr. Melehani was "responsible for the care of patients in the ICU at the county hospital, which could include up to 25 or 30 beds."[336] This extreme workload is unique, even among medical personnel. Dr. Hussain testified that unlike residents, "physician assistants are not going to work 80 hours a week, . . . 28 hour shifts nonstop," as "no sane person would do that unless they were forced to."[337] Even when residency programs comply with the ACGME's 80-hour limit, residents are still working shifts that virtually no one else would willingly agree to work.[338]

Unfortunately, residency programs do not always comply with the "mandatory" maximum of 80 hours a week.[339] It is "fairly common throughout the market" for residents to "work more than the official cap number of hours that a resident[] [is] allowed to work."[340] In fact, "almost half of all residents report working more than allowed by the ACGME and falsifying duty hour reports."[341] Dr. Melehani testified that while residency programs know "about the tendency of residents and fellows to exceed the maximum number of working hours allowed by the ACGME,"[342] they often "pressure residents to report compliance with 80 hour workweek rules established by ACGME, hiding the dangerous work environment these

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[329] *Id.*
[330] *Id.*
[331] *Id.* at 76.
[332] *Id.*
[333] *Id.*
[334] Transcribed Interview of Dr. Jason Melehani, *supra* note 4, at 63-64.
[335] *Id.*
[336] *Id.*
[337] Transcribed Interview of Dr. Aamir Hussain, *supra* note 4, at 131-32.
[338] *Id.*; *see also* Transcribed Interview of Dr. Jason Melehani, *supra* note 4, at 64-69.
[339] Transcribed Interview of Dr. Jason Melehani, *supra* note 4, at 7-8, 22-24, 64-69; Transcribed Interview of Dr. Aamir Hussain, *supra* note 4, at 23, 131-32; Park, *supra* note 323.
[340] Transcribed Interview of Dr. Aamir Hussain, *supra* note 4, at 23; *see also* Transcribed Interview of Dr. Jason Melehani, *supra* note 4, at 7-8, 64-69.
[341] Mayeux, *supra* note 65, at 128.
[342] Transcribed Interview of Dr. Jason Melehani, *supra* note 4, at 22.

violations foster."[343] He explained that there are many "situations where residency programs . . . encourag[e] residents to either break these hours or to say that they are in compliance with ACGME requirements on things like surveys."[344] In an anonymous survey conducted by the UT Southwestern Medical Center GME Task Force, 43.8 percent of residents reported witnessing or experiencing pressure to exceed or underreport their duty hours.[345]

Worse yet, incidents of "physical, sexual, and emotional abuse are common and gender and racial discrimination are rampant."[346] According to the 2019 UT Southwestern survey, 55 percent of residents reported workplace misconduct, including physical threats and sexual harassment.[347] In a majority of these cases, the source of the misconduct was the faculty of the residency program.[348] In 2019, a cross-sectional national survey of general surgery residents found that 49.9 percent experienced mistreatment, 38.4 percent experienced discrimination, and 30.3 percent experienced abuse.[349] In addition, a 2024 study found that nearly 50 percent of female surgical residents delayed having children because of residency, which "[g]iven the length of procedural training and declining fecundity in the fourth decade of life . . . is likely to increase the risk of future infertility, with significant future health and financial consequences."[350] Even more, 58 percent of female surgical residents who did have children reported experiencing mistreatment as a direct result of it, and "[s]uicidal ideation among surgical residents who had experienced pregnancy was more than twice as common as in the general population."[351]

Notably, medical residents are nearly three and a half times more likely to experience depression than the average American.[352] According to documents produced to the Committee and Subcommittee, "numerous residents suffer from depression and [] suicide rates are the highest amongst all professions due to the lack of control or negotiation of fair salary and working conditions."[353] This is not just a problem for residents, as resident depression has been shown to result in lower quality patient care and increased number of medical errors.[354]

The true scope of this problem is likely even greater than the evidence suggests, as residents regularly under-report these problems because "challeng[ing] the status quo, especially through formal complaints . . . risks retaliation with the potential to impact future career

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[343] *Id.* at 7.
[344] *Id.* at 22-23.
[345] *Summary Task Force Report on UT Southwestern GME Trainees' Ability to Raise Concerns Without Fear*, UT SW. MED. CTR. (Mar. 2020), at 37.
[346] Transcribed Interview of Dr. Jason Melehani, *supra* note 4, at 7.
[347] *Summary Task Force Report on UT Southwestern GME Trainees' Ability to Raise Concerns Without Fear*, UT SW. MED. CTR. (Mar. 2020), at 37.
[348] *Id.* at 38.
[349] Yue-Yung Hu et al., *Discrimination, Abuse, Harassment, and Burnout in Surgical Residency Training*, 381 NEW ENGLAND J. MED. 1741, 1745 (2019).
[350] Ruojia Debbie Li et al., *Pregnancy and Parenthood Among US Surgical Residents*, 159 JAMA SURGERY 1127, 1134 (2024).
[351] *Id.*
[352] Mata et al., *supra* note 74, at 2373-74.
[353] NRMP_0004595, at 96.
[354] Mata et al., *supra* note 74, at 2373-74.

opportunities."[355] Because of this fear of retaliation, many "residents keep[] their head down to get through while their wellbeing and patient safety suffer."[356] The result is a system where residents have "no incentive . . . to raise any concerns."[357] In testimony to the Committee and Subcommittee, Dr. Melehani explained:

> 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.[358]

Residents cannot obtain multiple offers and negotiate for better schedules or more humane working conditions through the Match.[359] Once the Match places a resident with a specific program, the resident is in a "binding" commitment with the program and is required to accept the employment agreement on the program's terms.[360] These restrictions eliminate competition among teaching hospitals and residency programs, as the hospitals know that residents cannot "leverage[] one offer against another offer" or demand better employment terms.[361] Even more, once residents are placed with a program, they are unlikely to report such issues due to "an overriding fear of retaliation."[362] All of this has "created an environment that fosters harsh, oftentimes unsafe, working conditions,"[363] where "[w]orkplace protections are minimal, fear of retaliation is common, and frustration with the lack of improvement is widespread."[364] According to Dr. Melehani:

> [W]e get into this job because we want to help people. And then we spend 3 to 8 years of our life in indentured servitude . . . And in some instances[,] . . . 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. . . . [N]o one should have to commit suicide because they can't leave their employer.

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[355] Transcribed Interview of Dr. Jason Melehani, *supra* note 4, at 8.
[356] *Id.*
[357] Transcribed Interview of Dr. Aamir Hussain, *supra* note 4, at 125.
[358] Transcribed Interview of Dr. Jason Melehani, *supra* note 4, at 22-23.
[359] *See* Section I.A.3.i.
[360] *See* Section I.A.3.iii.
[361] Transcribed Interview of Dr. Aamir Hussain, *supra* note 4, at 93.
[362] Transcribed Interview of Dr. Jason Melehani, *supra* note 4, at 116-17.
[363] Mayeux, *supra* note 65, at 122.
[364] Transcribed Interview of Dr. Jason Melehani, *supra* note 4, at 8.

> 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 burnt out, who provide poor care, . . . 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.[365]

3. The Match Pushes Residents to Unionize to Remedy Workplace Shortcomings

By suppressing wages and preventing residents from negotiating for better working conditions, the Match has pushed residents to unionize and turn to collective bargaining to address their concerns. In 2019, only 10 percent of the resident workforce was represented by a union.[366] By 2023, that number had risen to 20 percent,[367] and by 2025, 27 percent of residents reported that they belonged to a union.[368] This stark increase in the number of unionized residents "reflect[s] the extremely rapid pace of the movement of residents to unionize."[369]

As a result of "low pay, long hours, and a lack of mobility due to the Match and structural impediments to transfer, residents are increasingly turning to collective bargaining to address workplace conditions."[370] The push towards unionization "reflects a growing desire for representation and recourse in a system where residents have little power to negotiate independently."[371] In 2023, the AMA's House of Delegates passed a resolution highlighting the Match's anticompetitive effects and noting 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."[372] Notably, in a study of resident unionization efforts, "[p]ay was the most commonly cited factor in considering unionization," while "[w]ork hours were the second most frequently cited factor."[373] Even more, "the least financially secure resident physicians were more than 4 times as likely to vote for unionization."[374] According to documents produced to the Committee, "[r]esidents may **resort to their own advocacy** when they feel **abandoned** by the institutions to which they commit much of their lives."[375]

Because the Match does not allow residents to advocate for themselves through individualized negotiations, residents are increasingly turning to unions to "negotiate for improvements in work conditions, duty hours, supervision, workload, and other aspects that

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[365] *Id.* at 121.
[366] Adam E. Mikolajczyk & Colin Goodman, *Resident Labor Unions—Learning as We Go*, 7 JAMA 1, 1 (July 17, 2024).
[367] Laura K. Barger et al., *Resident Physician Intentions Regarding Unionization*, 8 JAMA 1, 6 (Apr. 3, 2025).
[368] Jon McKenna, *An 'Imperative' to Organize?: Medscape Residents and Unions Report 2025*, MEDSCAPE (Nov. 4, 2025).
[369] *Id.*
[370] Marek Written Statement, *supra* note 5.
[371] *Id.*
[372] NRMP_0004595, at 95.
[373] Barger et al., *supra* note 367, at 5.
[374] *Id.* at 6.
[375] AAMC Exhibit 78, at 73 (emphasis in original).

affect resident physicians' work and safety environment and well-being."[376] However, "a union cannot guarantee that residents' future employability would not be jeopardized by their activism," and is limited in its ability "to provide its members protection from retribution by employers."[377] As such, by depriving residents of the ability to negotiate for better working conditions, the Match is pushing residents to unionize and engage in collective bargaining, even though these activities may result in "retribution by employers" and are largely unable to fix the problems created by the Match.[378]

4. The Match Contributes to America's Growing Doctor Shortage

By artificially constraining the medical residency hiring market, the Match is fueling America's growing doctor shortage. The Health Resources and Services Administration within the U.S. Department of Health and Human Services projects that by 2037, the United States will have a shortage of as many as 187,130 physicians.[379] Even now, American patients struggle with access to medical care.[380] In 2023, a study by the National Association of Community Health Centers found that "[o]ver 100 million Americans—nearly one third of the nation—do not have access to a usual source of primary care due to a shortage of providers in their local community."[381] Additionally, it now takes an average of 31 days to book an appointment with a physician, an increase of 19 percent since 2022 and 48 percent since 2004.[382]

While the growing physician shortage affects all American patients, the "shortage is especially pronounced in rural areas and communities serving marginalized populations."[383] According to the Health Resources and Services Administration, 91 million Americans live in designated areas with a shortage of primary care physicians.[384] Given the escalating need for additional physicians, residency programs serve as a vital source of life-saving care, especially for rural America.[385] When residents work in rural communities, "there is a higher probability that anyone who completes training is going to stay in that same area," caring for local patients for years to come.[386] On the other hand, when a rural community does not have a residency program, "there's even less likelihood that someone from outside that [area] would end up wanting to move there."[387] For this reason, "one of the biggest predictors of practicing in a rural setting is . . . training" in that setting.[388]

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[376] SJC-AMA-000000073, at 82.
[377] *Id.* at 83.
[378] *Id.*
[379] HRSA, PHYSICIAN WORKFORCE: PROJECTIONS, 2022-2037 (Nov. 2024); *see also The Complexities of Physician Supply and Demand: Projections From 2021 to 2036*, AAMC (Mar. 2024).
[380] *Closing the Primary Care Gap: How Community Health Centers Can Address the Nation's Primary Care Crisis*, NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS (Feb. 2023).
[381] *Id.* at 3.
[382] Lambeth Hochwald, *Wait Times to See Physicians Continue to Climb*, MEDSCAPE (June 19, 2025).
[383] Transcribed Interview of Dr. Aamir Hussain, *supra* note 4, at 112; HRSA, HEALTH WORKFORCE SHORTAGE AREAS (last visited Oct. 30, 2025).
[384] HRSA, HEALTH WORKFORCE SHORTAGE AREAS (last visited Oct. 30, 2025).
[385] Tomei et al., *supra* note 60, at 1595; Transcribed Interview of Dr. Aamir Hussain, *supra* note 4, at 6, 34-35, 111-113.
[386] Transcribed Interview of Dr. Aamir Hussain, *supra* note 4, at 111.
[387] *Id.*
[388] *Id.*

The Match contributes to America's growing physician shortage by suppressing resident wages and creating a bottleneck between medical school and the physician workforce. Even before residency, the path to becoming a licensed physician in the United States is long and expensive.[389] For students in medical school, "[t]he average total cost of attendance for four years, including living expenses, is $244,000 for public schools and $323,000 for private schools."[390] As a result, "[a]pproximately 75% of all graduating medical students have an average of $190,000 in student loan debt."[391] In addition, because "[t]he transition to residency can be costly, particularly for those moving long distances," some medical graduates take out "[r]esidency-relocation loans . . . aimed at helping cover the cost of interviewing for and relocating to a residency program."[392] In a document produced to the Committee and Subcommittee, the AMA even warns medical students that "[i]t takes years to realize your earning potential."[393] In a 2023 survey of medical students, "69 percent said they were concerned about their income, 63 percent expressed concerns about experiencing burnout[,] and 60 percent were worried about how clinician shortages would affect them."[394]

The suppression of resident salaries and imposition of uniform wages between different specialties and geographic areas "creates enormous economic distortions" and "leads to a shortage of physicians in general."[395] By facilitating this suppression, the Match discourages qualified students from pursuing a career in medicine, jeopardizing both the quantity and quality of America's physician workforce.[396] As Professor of Law and Health Sciences at Northeastern University, Kristin M. Madison, explains:

> Talented and productive college graduates facing lucrative alternative career paths may choose to pursue those opportunities rather than enrolling in medical school because the bargaining power of the residency programs depresses wages just enough to make a difference. These potential applicants' medical school positions, and later, residency positions, may be taken over by lower-quality applicants. If medical schools apply an absolute quality screen to applicants so that they refuse to admit applicants of lower quality, lower wages may be associated with fewer U.S. residents; if medical schools apply a relative quality screen to applicants so that they have a set number of positions available and will fill them with lower-quality applicants if necessary, lower wages will be associated with lower-quality residents.[397]

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[389] AOA Production – Part 3 – Final, at 294.
[390] *Id.*
[391] *Id.*
[392] SJC-AMA-000000785, at 785-86.
[393] SJC-AMA-000000626, at 627.
[394] Joseph Choi, *1 in 4 US medical students consider quitting, most don't plan to treat patients: report*, THE HILL, (Oct. 30, 2023).
[395] Transcribed Interview of Dr. Jason Melehani, *supra* note 4, at 110-11.
[396] Madison, *supra* note 123, at 811.
[397] *Id.*

Either way, "[l]ow compensation levels send the wrong signals," as "[a] prospective medical student might choose another profession; a teaching hospital, an inefficient mix of employees; a prospective resident, the wrong residency program."[398] In all three scenarios, "resources are wasted."[399]

The Match also results in thousands of "unmatched" residents every year, creating an additional barrier that prevents aspiring doctors from entering the physician workforce.[400] In 2025, a total of 52,498 applicants registered in the MATCH to compete for 43,237 available residency positions.[401] After "Match Day," at least 11,734 applicants, 22.6% of those who registered, remained unmatched.[402] During the SOAP, an additional 2,308 applicants secured a position, leaving a minimum of 9,426 applicants, or 17.9 percent, without a position.[403] Additionally, the percentage of unmatched residency applicants is disproportionately greater for certain competitive specialties.[404] For example, 22.7 percent of MD seniors and 57.1 percent of DO seniors who applied solely to dermatology positions, and 27.1 percent of MD seniors and 66.7 percent of DO seniors who applied solely to neurological surgery, remained unmatched.[405] Dr. Hussain testified to the Committee and Subcommittee that "if an applicant fails to match, that doesn't mean that they are an unqualified person to be a doctor" and "the fact that they don't match is not itself indicative of their quality as a[n] applicant."[406]

Unlike in other markets, unmatched applicants are not simply denied a specific position when they do not receive an offer, they are effectively denied any position until the following year.[407] Dr. Hussain explained:

> [I]n 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 . . . go through this one unified pathway, so they have to either switch to a different career . . . or they essentially have to waste a year of their time and . . . then reapply for the following year.[408]

Even more, for many applicants, becoming an "unmatched" doctor also reduces the likelihood of securing a residency position in subsequent application cycles.[409] Unmatched doctors "may have an even lower chance of matching the subsequent year because of . . . [the]

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[398] *Id.* at 814.
[399] *Id.*
[400] *Results and Data: 2025 Main Residency Match*, NRMP (May 2025), at ix, 23.
[401] *Id.* at ix, 19, 23.
[402] *Id.* at 23, 35. Because the Match did not release the total number of applicants that matched with a residency position, the figure above is based on the total number of matches. However, some applicants match with multiple positions, so the total number of unique unmatched applicants may be even higher.
[403] *Id.* at ix, 19, 23, 81.
[404] *Id.* at 69.
[405] *Id.*
[406] Transcribed Interview of Dr. Aamir Hussain, *supra* note 4, at 45.
[407] *Id.* at 118.
[408] *Id.*
[409] *Id.*

stigma of not matching the previous cycle."[410] In fact, "most teaching hospitals view the failure to match as a black mark in subsequent match hiring processes."[411] This gives teaching hospitals even more power over applicants in the SOAP, as "they know that they have all the leverage" and "can take advantage of these" applicants.[412]

By denying aspiring residents the ability to enter the physician workforce, the Match "contribute[s] significantly to the nationwide physician shortage, locking many partially-trained residents out of the system and preventing them from ever becoming board-certified."[413] Every year, thousands of residency applicants are deprived of the opportunity "to train and practice medicine in the United States— not because [they] lack[] the qualifications, but because of a structural bottleneck in our graduate medical education (GME) system."[414] Even more, "[a] significant number of them were prepared — and in many cases highly motivated — to serve in rural or underserved areas," but because these applicants went unmatched, "they were not afforded the opportunity to do so."[415]

II. THE MATCH IS PROTECTED BY A SPECIAL-INTEREST ANTITRUST EXEMPTION

The Match functions as a centralized hiring monopoly that limits competition, suppresses resident wages, and reduces the output of medical residents into the physician workforce.[416] Because of the Match's ban on employment commitments, residents are, "in practice, barred from negotiating employment terms such as salary and benefits."[417] This "deprive[s] workers of fair competitive pay and of the ability to bargain for better working conditions,"[418] resulting in "the stagnation and even a regression in resident salaries across decades."[419] Restoring competition in the medical residency hiring market would help to address the stagnation of resident wages while improving residency programs more generally, as "all elements of a bargain—quality, service, safety, and durability—and not just the immediate cost, are favorably affected by the free opportunity to select among alternative offers."[420]

In a normal market, the Match's monopolistic power and anticompetitive restraints would trigger antitrust scrutiny and likely violate Section 1 of the Sherman Act.[421] Under U.S. antitrust law, employers are generally prohibited from conspiring, either directly or through a centralized coordinating body, to control job placements, prevent employment negotiations, fix wages, limit

[410] *Id.*
[411] *Id.* at 30.
[412] *Id.* at 43.
[413] Marek Written Statement, *supra* note 5.
[414] *The MATCH Monopoly: Evaluating the Medical Residency Antitrust Exemption*, *Hearing Before the Subcomm. on the Administrative State, Regulatory Reform, and Antitrust of the H. Comm. on the Judiciary*, 119th Cong. (2025) (submitted written statement of Caleb Atkins).
[415] *Id.*
[416] *See* Section I.A.
[417] Transcribed Interview of Dr. Aamir Hussain, *supra* note 4, at 18.
[418] U.S. DEP'T OF JUST. & F.T.C., ANTITRUST GUIDELINES FOR BUSINESS ACTIVITIES AFFECTING WORKERS (2025).
[419] Transcribed Interview of Dr. Jason Melehani, *supra* note 4, at 106-08.
[420] *Nat'l Soc. of Pro. Eng'rs*, 435 U.S. at 695.
[421] *See Brown v. Pro Football, Inc.*, 518 U.S. 231, 252 (1996); *Anderson v. Shipowners' Ass'n of Pac. Coast*, 272 U.S. 359, 361-65 (1926); *Arrington v. Burger King Worldwide, Inc.*, 47 F.4th 1247, 1256 (11th Cir. 2022); *Am. Needle, Inc. v. Nat'l Football League*, 560 U.S. 183, 190 (2010).

transfers, or otherwise restrict competition in the hiring market.[422] Even more, "an agreement that 'interfere[s] with the setting of price by free market forces' is illegal on its face."[423] This is true even when these efforts are implemented through a "legally single entity" that is "controlled by a group of competitors and serve[s], in essence, as a vehicle for ongoing concerted activity."[424] Such restrictions "deprive[] the marketplace of independent centers of decision-making that competition assumes and demands."[425]

However, in 2004, Congress attached a last-minute rider to an unrelated bill that provided the Match with an antitrust exemption, granting it immunity for its anticompetitive conduct and barring the use of Match-related evidence in antitrust proceedings.[426] This exemption was the product of an aggressive lobbying campaign by the NRMP and other medical organizations after residents filed a class-action lawsuit arguing that the Match violated Section 1 of the Sherman Act.[427] Since its enactment, this carve-out has insulated the Match from scrutiny under U.S. antitrust law, allowing it to suppress wages, entrench substandard working conditions, and artificially restrict the supply of medical residents without oversight or accountability.[428]

A. Residents Sued the Match for Violating Federal Antitrust Law

On May 7, 2002, before Congress created the Match's antitrust exemption, a group of medical residents filed a class-action lawsuit challenging the Match under U.S. antitrust law.[429] The lawsuit argued that the NRMP had colluded with other nonprofit organizations, residency programs, and teaching hospitals to restrict competition in the medical residency market with "the purpose and effect of depressing, standardizing and stabilizing compensation and other terms of employment."[430] It alleged that the Match, by its very design, "eliminates a free and competitive [hiring] market and substitutes a centralized, anticompetitive allocation system assigning prospective resident physicians ('applicants') to a single, specific and mandatory residency position."[431] Even more, it alleged that the Match had "adopt[ed] policies forcing the vast majority of prospective resident physicians to use the matching program" and "ensuring that the centralized and exclusive matching process is irrevocably substituted for all aspects of competitive, individual negotiations."[432]

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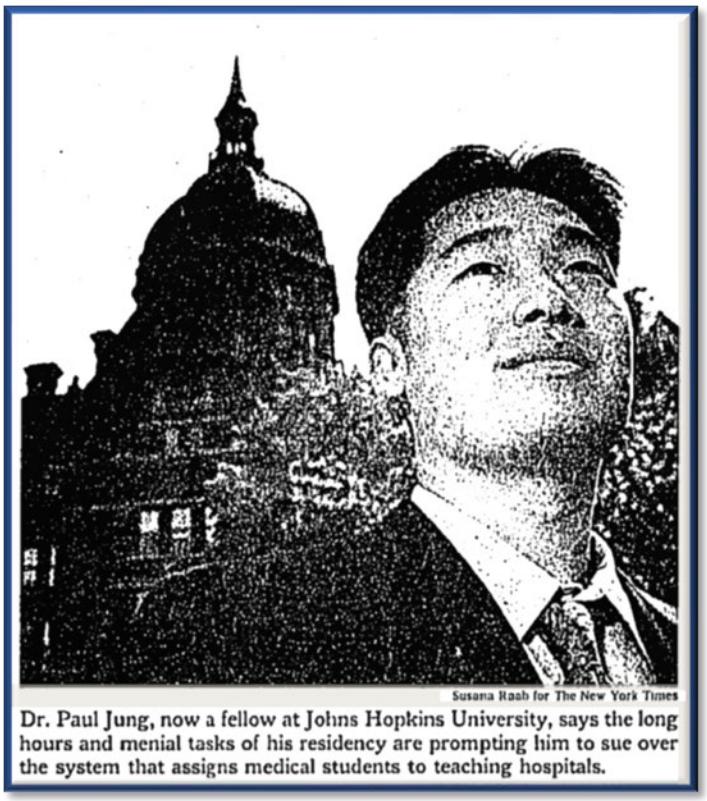
[422] *Id.*; *National Collegiate Athletic Association v. Alston*, 594 U.S. 69 (2021)
[423] *Nat'l Soc. of Pro. Eng'rs*, 435 U.S. at 692 (quoting *United States v. Container Corp.*, 393 U.S. 333, 337 (1969)).
[424] *Am. Needle, Inc.*, 560 U.S. at 191.
[425] *Am. Needle, Inc.*, 560 U.S. at 190 (quoting *Copperweld Corp. v. Indep. Tube Corp.*, 467 U.S. 752, 768-69 (1984)).
[426] *See* Richard Weinmeyer, *Challenging the Medical Residency Matching System through Antitrust Litigation*, 17 AMA J. ETHICS 147, 149-50 (2015); 15 U.S.C. § 37b; Pension Funding Equity Act, Pub. L. No. 108–218, § 207, 118 Stat. 596 (2004).
[427] Neil A. Lewis, *Medical Establishment Turns to Powerful Allies to Thwart Residents' Lawsuit*, N.Y. TIMES (Aug. 18, 2003); Mayeux, *supra* note 65, at 122-23; *Jung*, 300 F. Supp. 2d at 119.
[428] Mayeux, *supra* note 65, at 122-24; Marek Written Statement, *supra* note 5.
[429] *Jung* Complaint, *supra* note 122; Adam Liptak, *Medical Students Sue Over Residency System*, N.Y. TIMES (May 7, 2002).
[430] *Jung* Complaint, *supra* note 122, at ¶ 73.
[431] *Id*, at ¶ 83.
[432] *Id*, at ¶ 86a.


Susana Raab for The New York Times

Dr. Paul Jung, now a fellow at Johns Hopkins University, says the long hours and menial tasks of his residency are prompting him to sue over the system that assigns medical students to teaching hospitals.

A picture of Dr. Jung in a New York Times article from 2002 discussing the lawsuit.[433]

The lawsuit provided empirical support to demonstrate the anticompetitive effects that the Match has on the medical residency market.[434] It noted that "first-year residents earned an average salary of about $35,700 during the 2000-2001 employment year, equating to about $10 per hour," while "[r]esidents in their second and later years of employment were paid only slightly more, with lock-step increases based on the year of employment."[435] The lawsuit also highlighted the fact that, as discussed, "[r]esidents generally earn less, on both an annualized and hourly basis, than other hospital employees such as nurse practitioners and physician assistants," and that resident wages have been stagnant since the 1970s.[436] In addition to being abnormally low, the lawsuit pointed out that residents wages are strikingly uniform, "regardless of such factors as program prestige, medical specialty, geographic location, resident merit and year of employment."[437]

On February 11, 2004, the United States District Court for the District of Columbia denied a motion by the NRMP and several of its codefendants to dismiss the residents'

[433] Liptak, *supra* note 429.
[434] *Jung* Complaint, *supra* note 122, at ¶ 93.
[435] *Id.*
[436] *Id.*
[437] *Id.*, at ¶ 94.

lawsuit.[438] The court held "that plaintiffs adequately have alleged a common agreement to displace competition in the recruitment, hiring, employment and compensation of resident physicians and to impose a scheme of restraints, which have the purpose and effect of fixing, artificially depressing, standardizing and stabilizing resident physician compensation and other terms of employment."[439] As such, the court allowed the residents' lawsuit to proceed.[440]

B. The Match Lobbied for a Special-Interest Antitrust Exemption

In response to the lawsuit, the Match and several other medical organizations launched a full-scale "public relations campaign to 'save the match.'"[441] The goal of the campaign was "to make the suit not about whether the Match was *illegal* – but whether it was *good*."[442] Through this campaign, the NRMP and its supporters worked to defend the Match legislatively in an effort to circumvent the court's decision allowing the case to proceed.[443] According to one journalist, these organizations were "clearly troubled by the possibility the suit could upend the decades-old system of medical residents' selection and deployment around the country."[444] Their concern was not unfounded, as "the damages claimed [would] be monumental—far more than any defendant [could] afford to pay."[445] By one estimate, the damages from the residents' class actions lawsuit could have been as high as $9 billion, and that is before even considering the fact that "under the antitrust laws, prevailing plaintiffs are entitled to have the defendants pay their costs and attorneys fees, which in this case will be well into seven figures."[446]

The Match and its supporters were "so worried" about the resident lawsuit that they "asked their allies in the Senate to enact legislation that would derail the suit, inoculating them from damages that might otherwise run into the hundreds of millions of dollars."[447] In April 2004, just two months after the district court allowed the residents' case to proceed against the NRMP and most of its codefendants, the Match secured its antitrust exemption.[448] The exemption was attached as a last-minute rider to an otherwise unrelated bill, the Pension Funding Equity Act of 2004, which was "designed to update the interest rate for calculating employee pension contributions."[449] The sweeping language contained in the rider not only insulated the Match from antitrust liability, but prevented all Match-related evidence from being used in any

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[438] The court did grant the motion to dismiss as to certain defendants, including the AHA, the AMA, the Council of Medical Specialty Societies, and the American Board of Medical Specialties, and the Washington University Medical Center, but the court denied the motion as to the NRMP, the ACGME, the AAMC, and several teaching hospitals. *Jung*, 300 F. Supp. at 173-74.
[439] *Id.* at 162.
[440] *Id.* at 173-74.
[441] Jeffrey A. Singer, *In An Ironic Twist, the AMA Seeks Alternatives to the Residency Matching Program*, CATO (June 14, 2023).
[442] Bryan Carmody, *The Match, Part 5: The Lawsuit*, SHERIFF OF SODIUM (Mar. 3, 2021).
[443] Lewis, *supra* note 427.
[444] *Id.*
[445] Jack R. Bierig, *Jung v. Association of American Medical Colleges: The Lawsuit Challenging Our System of Graduate Medical Education*, 1 J. AM. COLL. RADIOLOGY 40, 42 (2004).
[446] *Id.*
[447] Lewis, *supra* note 427.
[448] Mayeux, *supra* note 65, at 132.
[449] Weinmeyer, *supra* note 426, at 149.

antitrust proceeding, both prospectively and retroactively.[450] The rider's findings praised the Match and defended its necessity, asserting that "[a]ntitrust 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."[451]

With the new antitrust exemption in hand, the Match and its codefendants filed a motion "for judgment on the pleadings on the ground that the action must be dismissed in light of this new legislation which creates or confirms an antitrust exemption for graduate medical education residency matching programs."[452] Because the Match was the "centerpiece" of the lawsuit, on August 12, 2004, the United States District Court for the District of Columbia dismissed the case in its entirety.[453] However, the court did go out of its way to acknowledge the difficult situation imposed on the residents by the creation of this new antitrust exemption.[454] The court opined:

> Plaintiffs understandably are frustrated. They won a significant victory in court; Congress now has snatched it away. As a result, they have spent a significant portion of their brief discussing the 'highly peculiar' legislative path Section 207 took before its passage. They point out that there were no hearings, no testimony, no significant debate, and vigorous opposition from those few Senators and Representatives who cared enough or were importuned enough to focus on the Match legislation. 'By furtively attaching the Match Legislation as a rider to an unrelated bill on the eve of imminent passage rather than introducing legislation through normal procedures, defendants were able to avoid public and Congressional awareness and avoid opposition to their scheme.' As Bismarck suggested, 'the making of laws, like the making of sausage, is something from which the fastidious person would often be well advised to avert his or her gaze.' . . . [H]owever, the responsibility of the courts is to interpret and apply the statute, not to second-guess.[455]

By codifying the Match's antitrust exemption, Congress "has practically ended all organized criticism of the system."[456] The exemption not only "terminated the [*Jung*] litigation," it "has shielded the Match and associated entities from antitrust scrutiny ever since."[457] As a result, as the attorney representing the residents in the *Jung* litigation explained, "the exemption has extended what was already 50 years of judicial avoidance into 75 years of complete immunity."[458]

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[450] 15 U.S.C. § 37b.
[451] 15 U.S.C. § 37b(a)(1)(E).
[452] *Jung v. Ass'n of Am. Med. Colleges*, 339 F. Supp. 2d 26, 31 (D.D.C. 2004).
[453] *Id.* at 36-39.
[454] *Jung*, 339 F. Supp. 2d at 40.
[455] *Id.*
[456] Mayeux, *supra* note 65, at 123.
[457] Marek Written Statement, *supra* note 5.
[458] *Id.*

C. Congress Should Consider Repealing the Match's Antitrust Exemption

Congress has the ability to help restore competition in America's medical residency market. Included as a last-minute rider in an unrelated bill, the Match's antitrust "exemption protects market distortions, undermines free market principles, limits personal freedom and choice, prevents normal employment negotiations, shields wage suppression, and contributes to the nationwide physician shortage."[459] As Dr. Melehani testified to the Committee and Subcommittee, the "removal of the Match's antitrust exemption would likely lead to more choice, higher salaries, and . . . greater workforce participation within the medical field."[460]

On April 24, 2025, Representative Victoria Spartz reintroduced a bill that would repeal the Match's antitrust exemption.[461] The Restoring Rights of Medical Residents Act would strike Section 207 of the Pension Funding Equity Act of 2004, removing the Match's statutorily granted antitrust immunity.[462] Notably, this "would not dismantle the Match or decide its legal merits, it would simply restore the authority of courts to examine those merits fully and fairly."[463] It would reaffirm "the courts' ability to evaluate the facts and legal claims through established judicial procedures and apply more than 130 years of precedent under the Sherman Act."[464] The Match and its defenders would still have the opportunity to "present their justifications in court and attempt to prove them."[465] Repealing the Match's antitrust exemption would "represent a return to consistency in federal law and a reaffirmation of sound legal and economic policy."[466]

On May 14, 2025, the Subcommittee held a hearing to evaluate the Match's antitrust exemption and whether it should be repealed.[467] During the hearing, one of the Subcommittee's expert witnesses testified that "the exemption protects market distortions, undermines free market principles, limits personal freedom and choice, prevents normal employment negotiations, shields wage suppression, and contributes to the nationwide physician shortage."[468] Another expert witness testified that "Congress should seriously consider ways to limit, if not repeal, the current antitrust exemption," as it results in "vastly unequal bargaining power, . . . wage suppression and compression, and onerous working conditions for residents that the program's interrelated rules and practices sustain."[469]

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[459] *Id.*
[460] Transcribed Interview of Dr. Jason Melehani, *supra* note 4, at 120-21.
[461] Restoring Rights of Medical Residents Act, H.R. 3018, 119th Cong. (2025).
[462] *Id.*
[463] Marek Written Statement, *supra* note 5.
[464] *Id.*
[465] *Id.*
[466] *Id.*
[467] *The MATCH Monopoly: Evaluating the Medical Residency Antitrust Exemption*, *Hearing Before the Subcomm. on the Administrative State, Regulatory Reform, and Antitrust of the H. Comm. on the Judiciary*, 119th Cong. (2025).
[468] *Id.*
[469] *Id.*

III. CONCLUSION

The Match is a centralized hiring monopoly that has consolidated control over America's medical residency market through anticompetitive conduct and burdensome restraints. Created to limit the effects of competition between teaching hospitals and residency programs, the Match prevents residents from negotiating the terms of their employment, creates uncertainty for programs and applicants, "binds" both sides to its decisions, and even regulates the hiring process for "unmatched" applicants. This results in the suppression of resident salaries, uniformity in wages across geographic regions and specialties, long hours and poor working conditions, restricted mobility and freedom of choice, and a bottleneck that contributes to America's growing doctor shortage.

While this monopolistic placement system and the anticompetitive restraints it imposes on the medical residency market would typically raise concerns under U.S. antitrust law, the Match is protected by a special-interest exemption. In response to ongoing litigation, the Match partnered with other medical institutions to lobby Congress for antitrust immunity. Included as a last-minute rider to an unrelated bill, the Match's antitrust exemption insulates it from judicial scrutiny and bars the use of Match-related evidence in antitrust proceedings. This carve-out undermines the competitive process, locks applicants and programs into a one-size-fits-all placement regime, and artificially constrains the pathway from medical school to the physician workforce to the detriment of residents, patients, and the American public.

The Committee on the Judiciary is entrusted with the "[p]rotection of trade and commerce against unlawful restraints and monopolies."[470] This report documents how the Match's monopolistic placement system, shielded by statutory immunity, harms residents, impedes patients' access to care, and constrains the growth of America's physician workforce. The Committee will continue its oversight to inform legislative reforms that could help restore competition in the medical residency market.

[470] Rules of the House of Representatives R. X (2025).