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Resuscitating the National Resident Matching Program: Improving Medical Resident Placement Through Binding Dual Matching

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NOTES

Resuscitating the National Resident Matching Program: Improving Medical Resident Placement Through Binding Dual Matching

I. INTRODUCTION

People outside the medical profession have likely heard of the long hours that doctors keep, but are probably unaware of the low salaries and nonnegotiable contracts that medical school graduates must accept upon entering a residency program. In fact, young doctors are among the few professionals who do not find postgraduate employment in the open job market. Currently, fourth-year medical students seeking postgraduate residency training participate in a process that matches them to a single residency program.[1] This match dictates where the new doctor will spend the next three to seven years of her career.[2] Upon receiving a match, the doctor must enter the particular program.[3] This system has been in place for over fifty years without any significant challenges. But, does the matching process actually work well, or have residents simply failed to consider whether they had any other choice?

In May of 2002, a group of former medical residents filed a class action lawsuit alleging that the National Resident Matching Program (NRMP or the Match) illegally prevents residents from enjoying competitive compensation and employment terms.[4] The case, *Jung v. Association of American Medical Colleges*, which has been consolidated as *In re Resident Physicians Antitrust Litigation*,[5]

1. *See infra* Part II.B.2.
2. *See infra* Part II.
3. *See infra* Part II.B.3.
4. Nat'l Resident Matching Program, NRMP Statement on Litigation, *at* http://www.nrmp.org/memo_litigations.html (last modified May 30, 2002).
5. Complaint, Jung v. Ass'n of Am. Med. Colls. (D.D.C. filed May 7, 2002) [hereinafter Complaint], http://www.aamc.org/newsroom/jungcomplaint/jung-nrmp.pdf. On September 2,

spotlights the heated issue of how medical residents are treated on the job and how the medical community should be treated under the law. The outcome of the case has far-reaching implications both for all United States medical residency programs and for United States graduate medical education. Much has been written about resident working hours, leading to recent notable reforms.[6] For the first time, however, *Jung* opens the door to discussion about resident remuneration and the legality of a binding employment process unique to the medical profession. This controversial case has polarized members of the medical community. In part, the controversy represents a power struggle between the medical establishment and young doctors-in-training.[7]

The central issue in *Jung* is whether the current system violates antitrust laws by depressing medical resident wages below fair market value.[8] This Note contends that it does and advocates facilitating competition by providing a limited number of matches from which residents may choose. With the proposed reforms, the resident placement process will not only better serve the needs of both residents and programs but will comply with antitrust laws.

This Note examines where medical resident placement has been, where it is now, and where it should go. Part II explains the mechanics of graduate medical education and then discusses the NRMP and how it facilitates student placement. Part III documents the chronological development of residents' efforts to improve their working conditions. Part IV analyzes the relevant antitrust principles governing the *Jung* case.

Part V concludes that the *Jung* plaintiffs have a meritorious antitrust claim. It then considers resident placement options in a post-*Jung* era by examining the consequences of both a legislative

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2002, the NRMP filed a motion to dismiss and to compel arbitration. Nat'l Resident Matching Program, Save the Match, FAQ, What's Happening in the Lawsuit?, *at* http://www.savethematch.org/faq/all.aspx (last visited Nov. 11, 2003). Seven other defendants (one medical school and six medical organizations) each filed motions to dismiss for failure to state a claim upon which relief can be granted. *Id.* Eighteen of the defendants (two medical organizations and sixteen teaching hospitals) filed motions to dismiss based on lack of jurisdiction due to insufficient contacts with the District of Columbia. *Id.* The court heard arguments on these motions on February 26, 2003. *Id.* No rulings had been issued by the time of publication. Association of American Medical Colleges, Reporter, *Court Hears Arguments in NRMP Suit Hearing*, http://www.aamc.org/newsroom/reporter/april03/nrmp.htm (discussing the various outstanding motions and their grounds) (last visited Nov. 11, 2003). For simplicity, this Note will reference the case as *Jung*.

6. *See infra* Part III.A-B.

7. *See* Stephen L. Cohen, *Doctors-in-Training: Our Last Indentured Servants*, L.A. TIMES, Dec. 31, 2000, at M2, 2000 WL 25931824.

8. *See infra* Part IV.

exemption to preserve the NRMP as well as its possible abolition of the NRMP in favor of an unfettered labor market. Part V also discusses the similarities and differences between these two approaches and proposes combining the Match and free market systems under a revised program that includes binding dual matching. Finally, Part VI demonstrates how this proposal harmonizes the competing interests of students, hospitals, and the government.

II. ANATOMY OF THE RESIDENCY: GRADUATE MEDICAL EDUCATION AND THE NATIONAL RESIDENT MATCHING PROGRAM

Medical education in the United States consists of two distinct phases, both of which are required to gain a license to practice medicine.[9] Medical school, the first phase, takes four years and includes classroom, laboratory, and clinical experiences provided by the school and its affiliated hospitals.[10] Students who successfully complete medical school receive an M.D. degree.[11] During residency, the second phase, novice physicians work in teaching hospitals where they gain in-depth training under the supervision of senior residents and attending physicians.[12] While many states require only one year of residency for licensure, the American Board of Medical Specialties requires additional varying numbers of years for certification as a specialist.[13] The Accreditation Council on Graduate Medical Education (Accreditation Council) oversees the nation's residency system and is responsible for authorizing all of the nation's approximately 7,800 residency programs.[14]

State and federal governments are the primary financiers of graduate medical education, with individual hospitals subsidizing the remainder of program costs.[15] Medicare, the largest sponsor,

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9. Nat'l Resident Matching Program, Why the Match? 1 (Jan. 3, 2003), *at* http://www.aamc.org/newsroom/jungcomplaint/whythematch.pdf.

10. *Id.*

11. *Id.*

12. *Id.*

13. *Id.* The ABMS certifies a physician as a specialist. *Id.*; *see* Am. Bd. of Med. Specialties, About ABMS, *at* http://www.abms.org/about.asp (last visited Sept. 1, 2003).

14. Michael Romano, *Preserving Quality of Education: Accreditation Council Limits Residents' Work Week*, MODERN HEALTHCARE, June 17, 2002, at 17, *available at* 2002 WL 9525097; *see* Katherine Huang, Note, *Graduate Medical Education: The Federal Government's Opportunity to Shape the Nation's Physician Workforce*, 16 YALE J. ON REG. 175, 185 (1999).

15. Am. Med. Assoc., *Graduate Medical Education Funding*, *at* http://www.ama-assn.org/ama/pub/category/2391.html (last updated Sept. 4, 2003); *see also* AM. MED. ASSOC., REPORT G(A-99): MEDICARE FUNDING OF GME 1-2, *at* http://www.ama-assn.org/ama/upload/mm/ 16/repga99.doc (last visited Sept. 1, 2003). *See generally* Mahdi Bsha et al., *Graduate Medical*

contributed $2.2 billion in 1999 to cover the direct costs of graduate medical education, including resident salaries, supervisory costs, and related overhead.[16] To compensate for higher operating costs associated with managing a residency program, teaching hospitals received an additional $3.7 billion from Medicare in 1999.[17]

A. Residency as a Prerequisite for Licensure

Residency is the period of clinical training required of all medical school graduates before they can independently practice medicine.[18] Teaching hospitals and academic health centers provide this necessary training.[19] Residencies serve as the sole entry point into the physician workforce for both domestic and foreign medical school graduates.[20] Although the primary purpose of a residency is to educate the residents, residents provide most of the patient care in teaching hospitals.[21] As a result, residents are a vital group of inexpensive yet highly skilled professionals available to treat patients.[22]

B. NRMP as the Vehicle for Obtaining a Residency

Formed in 1952, the NRMP[23] is a private nonprofit corporation that matches United States residency and fellowship applicants to participating programs.[24] The NRMP's corporate charter states that it is "organized exclusively for matching the preferences of applicants for residencies with the hospitals' choices of their applicants, in order to assist medical students and others in obtaining, to the extent possible,

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Education Primer, (discussing the current and proposed sources of GME funding), *at* http://www.amsa.org/hp/gmeprimer.cfm (last visited Nov. 13, 2003).

16. Am. Med. Assoc., *Graduate Medical Education Funding*, *supra* note 15.

17. *Id.* Higher costs are due to more complicated cases, additional tests ordered by residents as part of the learning process, and reduced patient care productivity by all staff members. *Id.*

18. Huang, *supra* note 14, at 176.

19. *Id.*

20. *Id.*

21. *Id.*

22. *Id.*

23. The NRMP is managed by the Association of American Medical Colleges and is sponsored by the American Medical Association, the Association of American Medical Colleges, the American Hospital Association, the Council of Medical Specialty Societies, and the American Board of Medical Specialties. Nat'l Resident Matching Program, *at* http://www.nrmp.org (last modified Aug. 13, 2002).

24. Marcia Coyle, *Resident Physicians Ask Court for Relief*, NAT'L L.J., May 20-27, 2002, at A1, WL 5/20/02 NLJ A1; Nat'l Resident Matching Program, *supra* note 22.

their choices of residencies."[25] The NRMP operates sixteen residency matching programs in addition to the Specialties Matching Service, which provides fellowship positions for training beyond the initial residency.[26] Each year, roughly 30,000 graduates of U.S. and foreign medical schools enter the NRMP, vying for approximately 20,000 entry-level residency positions in accredited programs.[27] On average, more than 92% of U.S. medical school seniors obtain their first-year residency positions through the Match.[28]

1. History of the Match

The NRMP was originally created after World War II when the number of residency positions greatly exceeded the number of residents.[29] Due to a recurring surplus of positions, hospitals sought to employ the best candidates as early as possible.[30] Medical students were often forced to settle for positions before they could explore their full range of options.[31] These so-called "exploding offers" required an

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25. Nat'l Resident Matching Program, Save the Match, FAQ, What is the Purpose of the NRMP?, *at* http://www.savethematch.org/faq/all.aspx (last visited Nov. 11, 2003). Entry-level residency matching includes positions for postgraduate year 1 (PGY-1) and postgraduate year 2 (PGY-2). Nat'l Resident Matching Program, Save the Match, FAQ, How Many Matching Programs Does the NRMP Operate?, at http://www.savethematch.org/faq/all.aspx (last visited Nov. 11, 2003). In 2003, the Match included 20,908 PGY-1 positions offered by programs in twenty-four specialty areas, as well as 2,457 PGY-2 positions in fifteen disciplines. *Id.* Simultaneous matching for PGY-1 and PGY-2 positions allows applicants who wish to obtain a one-year position in a general medicine program to obtain a position for subsequent training in a related specialty area at the same time. *Id.*

26. The NRMP operates fifteen matching programs for thirty-one types of advanced residency, or fellowship, positions through the Specialties Matching Service. Nat'l Resident Matching Program, Save the Match , FAQ, How Many Matching Programs Does the NRMP Operate?, *at*, http://www.savethematch.org/faq/all.aspx (last visited Nov. 11, 2003). Each year, between thirty and one thousand applicants participate in the various specialty matches. *Id.*

27. *See* Nat'l Resident Matching Program, *supra* note 9, at 1-2; Coyle, *supra* note 24, at A1. In 2003, the NRMP enrolled 3,719 programs in the Match, which altogether offered 23,365 positions. Nat'l Resident Matching Program, About the NRMP, *at* http://www.nrmp.org/about_nrmp/index.html (last modified Aug. 13, 2003). A total of 31,004 applicants participated in the Match. *Id.*

28. Nat'l Resident Matching Program, *supra* note 9, at 5; *see also* Complaint, *supra* note 5, ¶ 71 (stating that "[i]n 2000, more than 80% of all first-year residency positions were offered exclusively through the Matching Program").

29. Coyle, *supra* note 24. In 1950, there were 5,553 U.S. medical school graduates and 9,398 available first-year residency positions. Nat'l Resident Matching Program, *supra* note 9, at 2.

30. Gordon Schnell, *An Antitrust Challenge to the National Resident Matching Program*, N.Y. L.J., Aug. 1, 2002, at 4, WL 8/1/2002 N.Y.L.J. 4. "Even the most prestigious institutions got sucked into the frenzy for fear of losing choice candidates to earlier offers from competing hospitals." *Id.*

31. *Id.*

applicant to accept an offer within a very short period of time, usually twenty-four to forty-eight hours, or risk having the offer rescinded.[32]

According to the American Medical Association, the lack of a formal system during the pre-NRMP era fostered an "old-boy's network."[33] Students with connections to the medical community had an advantage over other applicants for the most coveted positions.[34] The NRMP resolves these two problems by ensuring that no student and hospital can be matched unless both mutually prefer to be matched.[35] Further, the NRMP was designed to alleviate the pressure to make premature decisions by prohibiting students and programs from making a commitment as to how each will be ranked.[36]

2. Match Selection Process

On a specified date every February, fourth-year medical students submit a confidential list ranking their desired residency programs to the NRMP.[37] On the same date, residency program directors submit a confidential list ranking the students they prefer.[38] The NRMP then uses the lists to electronically generate a single assignment for each student.[39] The computer first attempts to place an applicant into her top choice program.[40] If the applicant cannot be matched to this program, due to the hospital's indicated preference for other candidates, the computer then attempts to place the applicant into her second choice program.[41] This process continues until the

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32. Nat'l Resident Matching Program, Save the Match, FAQ, Why was the Match Established?, *at* http://www.savethematch.org/faq/all.aspx (last visited Nov. 11, 2003).

33. Nat'l Resident Matching Program, *supra* note 9, at 2.

34. *Id.* Side-deals were commonplace, stifling merit-driven competition. *Id.*

35. *See* Schnell, *supra* note 30.

36. Nat'l Resident Matching Program, How the NRMP Process Works, *at* http://www.nrmp.org/about_nrmp/how.html (last modified Aug. 13, 2003).

37. Nat'l Resident Matching Program, *supra* note 9, at 3-4.

38. *Id.*

39. *Id.*; Coyle, *supra* note 24; *see also* Gordon Schnell, *Iffy Prognosis for Intern Suit*, NAT'L L.J., June 24-July 1, 2002, at A12 (likening the Match to an "annual computerized mating dance"), WL 6/24/02 NLJ A12. The results of the Match are then announced nationwide during the third week in March. Nat'l Resident Matching Program, *supra* note 27.

40. Nat'l Resident Matching Program, How the Matching Algorithm Works?, *at* http://www.nrmp.org/res_match/about_res/algorithms.html (last modified Aug. 13, 2003).

41. *Id.* The NRMP's algorithm is based on the premise that each applicant should be matched to the program that she most prefers and that is willing to accept her. Nat'l Resident Matching Program, Save the Match, How the Match Works, *at* http://www.savethematch.org/history/howworks.aspx (last visited Nov. 11, 2003). A match can be achieved when a program has vacant positions that have not yet been filled with other applicants who desire the same program and whom the program prefers. *Id.*

applicant obtains a match or until all of her choices are exhausted.[42] Applicants who fail to receive an assignment participate in a post-Match "scramble" for unfilled positions.[43]

3. Binding Nature of the NRMP

The NRMP requires that all parties agree in advance to accept its results without negotiating employment terms.[44] Prior to entering the Match, students and programs sign a Match Participation Agreement that stipulates that a match is a binding commitment.[45] The only way to evade a match is through an NRMP waiver based on a "serious hardship."[46] Failure to honor a match triggers strict penalties, including program and applicant disqualification from subsequent matches and applicant classification as a "match violator" for up to three years.[47]

III. EVOLUTION OF THE MEDICAL RESIDENT LABOR RIGHTS MOVEMENT:

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42. Nat'l Resident Matching Program, How the Matching Algorithm Works, *at* http://www.nrmp.org/res_match/about_res/algorithms.html (last modified Aug. 13, 2003).

43. Unmatched applicants are notified of their status three days prior to the general release of the Match results. Nat'l Resident Matching Program, Save the Match, How the Match Works, *at* http://www.savethematch.org/history/howworks.aspx (last visited Nov. 11, 2003). During this scramble period, unmatched applicants work individually to find programs that have unfilled positions. *Id.* These applicants generally accept the first offer they receive rather than risk not receiving an offer from a more preferred program. *Id.*

44. Complaint, *supra* note 5, ¶ 86.2; Mayer, Brown, Rowe & Maw, *Jung v. Association of American Medical Colleges*, ANTITRUST, Q4 2002, at 20-21, http://www.mayerbrown.com/antitrust/pdf/AntitrustQuarterly2002Q4.pdf; Coyle, *supra* note 24.

45. Nat'l Resident Matching Program, Match Participation Agreement Among Applicants, the NRMP, and Participating Programs, § 1.0, *at* http://www.nrmp.org/res_match/policies/map_main.html, (last modified Aug. 13, 2003.

46. *Id.* § 2.5; *see* Nat'l Resident Matching Program, The Integrity of the NRMP Match, *at* http://www.nrmp.org/res_match/about_res/ensuring.html (last modified Aug. 13, 2003). The NRMP states the following policy:

> "Serious hardship" refers to the occurrence of a highly unusual, unexpected, and unpredictable situation or circumstance that renders the fulfillment of the Match obligation impossible or would result in irreparable harm to any one of the committed Match participants. Examples of "serious hardship" include an applicant who failed to graduate on time; the closing of a program or institution; the death or serious illness of a family member that requires the applicant to alter the choice of residency location; or the loss of accreditation by a program or institution. "Serious hardship" does not include taking advantage of a more "desirable" choice of a program or applicant after rank order lists are submitted.

Id.

47. Nat'l Resident Matching Program, *supra* note 45, § 7.2.1. The NRMP reports violations to the applicant's medical school, the programs included in the applicant's rank list, the NRMP Executive Committee, and the American Board of Medical Specialties, among others. *Id.*; *see* Complaint, *supra* note 5, ¶¶ 85, 86.3.

THE STRUGGLE FOR MORE HUMANE WORKING CONDITIONS

To fully understand *Jung*'s impact on residents and on the medical community, one must understand the context in which the case arises. Prior to *Jung*, residents focused primarily on decreasing their work hours.[48] On the heels of the Accreditation Council's recent enactment of hours limitations, residents have now turned their efforts towards fighting binding matches and low salaries.

For decades, the medical community has extolled the virtues of this training system, which relies on residents as an abundant source of cheap labor.[49] Observers outside the medical community refer to residents as the "last indentured servants of the modern age."[50] Some medical residents find these work conditions oppressive and demand a change in the status quo. In a survey conducted by the Journal of the American Medical Association designed to examine the residency experience, researchers found that 93% of residents surveyed experienced at least one incident of perceived mistreatment, with 53% reporting being belittled or humiliated by more senior physicians.[51] In the same study, 70% of residents reported witnessing colleagues working in an impaired condition, most often due to lack of sleep.[52] Residents and the medical establishment now find themselves engaged in a heated power struggle implicating Congress, the Occupational Safety and Health Administration (OSHA), and, most recently, the federal court system.

A. The Regulatory Initiative: Fighting for the Right to Unionize

In an attempt to improve their working conditions through negotiations, residents sought unionization rights from OSHA. Under the 1935 National Labor Relations Act (NLRA),[53] a group of employees

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48. *See generally* Dori Page Antonetti, Note, *A Dose of Their Own Medicine: Why the Federal Government Must Ensure Healthy Working Conditions for Medical Residents and How Reform Should Be Accomplished*, 51 CATH. U. L. REV. 875 (2002) (advocating work-hour limitations for medical residents); Coyle, *supra* note 24.

49. Cohen, *supra* note 7.

50. *Id.* Until recently, residency programs have routinely required up to one hundred hours of work per week, including thirty-six and forty-eight hour uninterrupted on-call shifts. Antonetti, *supra* note 48, at 876; Coyle, *supra* note 24..

51. Steven R. Daugherty et al., *Learning, Satisfaction, and Mistreatment During Medical Internship: A National Survey of Working Conditions*, 279 JAMA 1194, 1196 (Apr. 15, 1998).

52. *Id.* at 1197.

53. 29 U.S.C. §§ 151-69 (2000). Section 151 states the following policy:

> It is hereby declared to he the policy of the United States to eliminate the causes of certain substantial obstructions to the free flow of commerce and to mitigate and eliminate these obstructions when they have occurred by

can form a bargaining unit only after formal recognition from the National Labor Relations Board (NLRB).[54] Presumably, forming a union would provide residents with the necessary leverage to prompt workplace reforms.[55] After rejecting two attempts to gain such recognition,[56] the NLRB, in 1999, finally acknowledged residents' right to unionize.[57] In doing so, the NLRB uniquely classified residents as both students and employees.[58] Granting the right to unionize spurred a move toward a more humane approach for training residents and a move away from the notion that residency is a form of professional hazing.[59] Indeed, the NLRB acknowledged that, "[a]lthough essential to the training of a physician, an internship,

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> encouraging the practice and procedure of collective bargaining and by protecting the exercise by workers of full freedom of association, self-organization, and designation of representatives of their own choosing, for the purpose of negotiating the terms and conditions of their employment or other mutual aid or protection.

§ 151.

54. *See* Eva M. Panchyshyn, Comment, *Medical Resident Unionization: Collective Bargaining by Non-Employees for Better Patient Care*, 9 ALB. L.J. SCI. & TECH. 111, 115 (1998). To organize under the NLRA, the union that represents the group of employees files a petition for an election with one of the Board's regional offices. *Id.* (citing 29 U.S.C. § 159). The regional director then investigates the petition to determine whether the group of employees is an appropriate "unit." *Id.* The factors considered in making this determination include a community of interests among the employees in the proposed unit, the hargaining history in the business, and the relationship between the employer's business and the proposed unit. *Id.*

55. In 1976, medical interns, residents, and clinical fellows at Cedars-Sinai Medical Center led the unionization movement by filing a petition under section 9(c) of the National Labor Relations Act, asking that residents be recognized as a labor unit. *Id.*

56. *Id.* at 116-17 (citing Cedars-Sinai Medical Center, 223 N.L.R.B. 251 (1976) and St. Clare's Hosp. and Health Ctr., 229 N.L.R.B. 1000 (1977)). In *Cedars-Sinai Medical Center*, the NLRB ruled that medical residents were not "employees" within the meaning of the NLRA because "although they possess certain employee characteristics, [they] are primarily students." *Id.* at 117 (citing *Cedars-Sinai Medical Center* 223 N.L.R.B. at 251 (denying medical residents certification as a labor organization)).

57. *See* Jack E. Karns, Note, *The National Labor Relations Board Defines "Medical Employee" Under the Wagner Act Regarding Residents and Interns Thereby Opening the Door to Unionization and Collective Bargaining Demands*, 77 N.D. L. REV. 53, 55-56 (2001) (citing Boston Med. Ctr. Corp., 330 N.L.R.B. 152, 152 (1999)). "In *Boston Medical Center Corp.*, the majority held that the petitioner house staff were employees within the context of the NLRA and entitled to its protection." *Id.* at 55 n.27.

58. In *Boston Medical Center Corp.*, in a 3-2 decision, the NLRB reversed its previous decisions that denied residents unionization rights, declaring that residents are employees as well as students. *See Prof'l Students*, 158 N.J. L.J. 958, 958 (1999). Thus, residents at both public and private hospitals are now authorized to form labor unions to collectively bargain for wages, hours and working conditions. *Id.*

59. *See* Karns, *supra* note 57, at 57-58 (noting that the *Boston Medical Center Corp.* ruling is not just a legal decision but also has severe social policy overtones). Karns points out that the mere fact that residents have been mistreated for twenty years, pursuant to NLRB precedent, underscores the legal and humane need to change the law. *Id.* at 69.

residency or fellowship is not just an academic exercise."[60] This ruling reflects a more realistic assessment of the important role that residents play in the administration of patient care.[61]

B. The Legislative Initiative: Limiting Resident Work Hours

While a notable victory, unionization proved to be largely symbolic as it failed to produce limits on the infamous hundred-hour work week.[62] In 2001, the American Medical Student Association and the Committee of Interns and Residents filed a petition with OSHA requesting restrictions on resident work hours.[63] When OSHA denied the petition in 2002, medical professionals enlisted the help of legislators to reform the structure of residency programs.[64] Driven by growing public awareness and concern over resident working hours and conditions,[65] a congressional movement to regulate hours gained significant support in the House of Representatives.[66]

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60. *Boston Med. Ctr. Corp.*, 330 N.L.R.B. at 164.

61. *Prof'l Students*, 158 N.J. L.J. at 958.

62. Unionization is not widespread, despite the fact that the ruling affected an estimated 90,000 resident physicians. Coyle, *supra* note 24. One of the greatest reasons that residents may be reluctant to organize is the power that chiefs of residency programs exert over residents' future careers. *Id.* Residents who wish to pursue a fellowship for further training need a recommendation from their program chief, who would almost undoubtedly frown upon a squeaky wheel resident. *Id.* So, although unionization was an important symbolic victory, it has not proven to be a comprehensive solution to the problem. *Id.*

63. Residents filed the petition on April 30, 2001, based on data linking long work hours to depression, adverse pregnancy outcomes, and motor vehicle crashes. Press Release, Public Citizen, *OSHA Denies Petition to Reduce Work Hours for Doctors-in-Training* (Oct. 10, 2002), *at* http://www.citizen.org/pressroom/release.cfm?ID=1239. The petition recommended that no physician be permitted to work more than eighty hours per week or more than twenty-four consecutive hours in one shift. *Id.* Noting a dangerous incentive to work employees around the clock, which jeopardizes their safety as well as that of the public, the petition analogized the need for federal regulation of the medical workplace to the need for federal regulation of railroads, airlines, motor carriers, and maritime crews. Antonetti, *supra* note 48, at 906. The petition also included more stringent restrictions for residents working in busy emergency medicine units and requested that OSHA investigate whether more restrictive standards should be implemented. *Id.* To enforce the proposed restrictions, the petition requested that OSHA require hospitals to keep public records of resident work schedules, conduct unannounced and recurrent inspections, and to impose fines substantial enough to deter future violations. *Id.*

64. Antonetti, *supra* note 48, at 878.

65. In recent years, the mass media has begun to highlight the negative aspects of harsh working conditions both on resident health and patient safety. *See id.* at 878 n.9 (citing various TV shows).

66. In an effort to improve the working conditions of medical residents, Representative John Conyers (D-Mich.) drafted the Patient and Physician Safety and Protection Act (PPSPA) containing hours-of-service limitations identical to those requested in Public Citizen's Petition to OSHA. The proposed bill would amend title XVIII of the Social Security Act to ensure the safety of patients and resident-physicians. H.R. 3236, 107th Cong. § 2(a) (2001); *see* Antonetti, *supra* note 48, at 907; American College of Surgeons, ACS Views on Legislative, Regulatory, and other

Prompted by the threat of onerous congressional regulation, the Accreditation Council finally adopted limits on work schedules for medical residents in June 2002.[67] The new guidelines, which took effect in 2003, limit residents to an eighty-hour work week, allow residents to be on call for only twenty-four hour periods, and require hospitals to provide residents with at least ten hours of rest between the times that each resident is on call.[68] The Accreditation Council's acknowledgment that work hours must be limited is a step in the right direction but more reforms are needed.

C. The Legal Initiative: Landmark Challenge to the NRMP

Medical residents continue to lack the competitive employment terms that a free labor market offers. As a result, on May 7, 2002, three former residents filed a class action complaint in the United States District Court for the District of Columbia alleging that the NRMP violates antitrust laws.[69] According to Dr. Paul Jung, a lead plaintiff, the suit was filed to ensure that "every student in the country has a say in their residency program, in their salaries and working conditions."[70] Dr. Jung calls it a "fairness issue" in that one can apply to different employers but there is not choice at all for

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Issues, Resident Work Hours, *at* http://www.facs.org/ahp/views/gme.html (last updated Nov. 12, 2002). The bill establishes guidelines for resident supervision and includes enforcement mechanisms with significant fines for violators. *Id.* As of November 2002, seventy-one members of the House of Representatives had cosponsored the legislation. *Id.* Companion legislation, Sentate Bill 2614, was then introduced in the Senate by Senator Jon Corzine (D-N.J.). *Id.* Officials with the American Medical Student Association have said that the rumblings on Capital Hill forced the Accreditation Council to act on an issue that has received "scant attention" for decades. Romano, *supra* note 14. Commentators view the PPSPA more favorably than the unsuccessful OSHA petition because the bill is aimed at safeguarding patients, with resident protections as an ancillary bonus. Antonetti, *supra* note 48, at 913-14. Thus, they believe that the proposed legislation has a greater chance of acceptance by the medical community since doctors are trained to do what is best for their patients. *Id.* at 914.

67. Romano, *supra* note 14. The Accreditation Council cites its primary purpose as "residents' medical education" but is quick to point out that "[w]e are also very sensitive to patient safety." *Id.* (quoting David Leach, M.D., executive director of the Chicago-based Accreditation Council).

68. *Id.* Violating hospitals will be stripped of their accreditation, a penalty that could result in the withdrawal of federal funding, or as much as $100 million per year in the case of a major academic medical center. *Id.*; *see also* Katherine S. Mangan, *Facing Loss of Accreditation, Yale Reduces Workweek of Surgery Residents*, CHRON. HIGHER EDUC., May 6, 2002 (discussing the case of Yale University Medical Center, whose violations of work hour limitations threatened its program's accreditation), *quoted in* Am. Med. Ass'n, Report F (I-02): Resident/Fellow Work and Learning Environment app. C, *at* http://www.ama-assn.org/ama1/pub/upload/mm/16/repfi02.doc (last visited Sept. 1, 2003).

69. Complaint, *supra* note 5; *see also* Schnell, *supra* note 39; Coyle, *supra* note 24.

70. AAIM, *Residents File Lawsuit Against NRMP* (May 10, 2002), *at* http://www.im.org/AAIM/PublicPolicy/MerlinArchive/May2002.htm.

residency programs.[71] The following part will discuss the legal issues surrounding this controversial case, analyze the arguments on both sides, and reach a conclusion as to the expected outcome.

IV. *JUNG* MAY TAKE SCALPEL TO THE NRMP

The suit alleges that the NRMP, by its nature, eliminates a "free and competitive [job] market," which makes the NRMP anticompetitive and illegal under antitrust law.[72] Although plaintiffs allege three separate antitrust violations,[73] this Note will focus only on the challenge to the NRMP. With regard to the NRMP, the suit charges that defendants violate section one of the Sherman Antitrust Act (Sherman Act) by "illegally contracting, combining, and conspiring to eliminate competition in the recruitment, hiring, employment, and compensation of student physicians."[74] The complaint states that the alleged restraints "fix, artificially depress, standardize and stabilize resident compensation and terms of employment."[75] Specifically, plaintiffs claim that the NRMP has the anticompetitive purpose[76] and effect[77] of restricting residents' job search attempts and eliminating individual employment negotiations.[78] This inability to negotiate allegedly forces incoming residents to accept less compensation than they would receive in a competitive job market.[79]

There are three named plaintiffs in the case, each of whom obtained his or her residency position through the NRMP.[80] The

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71. Id.

72. Complaint, *supra* note 5, ¶ 83.

73. Plaintiffs allege that defendants' illegal combination and conspiracy has restrained competition in the employment of residents by 1) stabilizing wages below competitive levels through the exchange of information regarding resident compensation and terms of employment, 2) eliminating competition in the recruitment and employment of residents by assigning residents' positions through the Matching Program and 3) establishing and complying with anticompetitive accreditation standards of the Accreditation Council (ACGME). *Id* ¶ 3.

74. *Id.* ¶¶ 2, 83, 98-99; *see also* 15 U.S.C. § 1 (2000).

75. Complaint, *supra* note 5, ¶ 2.

76. *Id.* ¶ 84.

77. *Id.* ¶ 85.

78. *Id.* ¶ 86.1-.2.

79. *See id.* ¶¶ 83, 84.

80. The three named plaintiffs are Paul Jung, M.D., Luis Llerena, M.D., and Denise Greene, M.D. Memorandum from Jordan J. Cohen, M.D., of the Association of American Medical Colleges 1 (Aug. 15, 2002), *at* http://www.aamc.org/newsroom/jungcomplaint/memo02-26.pdf. Dr. Paul Jung completed a three-year residency program in 2000 at Metro Health Medical Center in Cleveland, Ohio. *Id.* At the time the complaint was filed, he was a Robert Wood Johnson Clinical Scholar at the Johns Hopkins University. *Id.* At the time the complaint was filed, Dr. Luis Llerena was a sixth-year resident working in a two-year fellowship program at Orlando Regional Medical Center. *Id.* Previously, he completed a five-year residency program at Cooper

defendants are divided into two categories: "organization defendants" and "institution defendants."[81] The "organization defendants" include the Association of American Medical Colleges (AAMC), the NRMP, the Accreditation Council, the American Hospital Association (AHA), the American Medical Association (AMA), the American Board of Medical Specialties (ABMS), and the Council of Medical Specialty Societies (CMSS).[82] The "institution defendants" include twenty-nine hospitals[83] that sponsor medical residency programs.[84]

A. Fundamentals of an Antitrust Inquiry

Section one of the Sherman Antitrust Act prohibits "[e]very contract, combination . . . or conspiracy, in restraint of trade."[85] Thus, an antitrust plaintiff must show that the defendants entered into a collective agreement that unreasonably restrains trade.[86] The agreement need not be formal or express but can be satisfied merely by showing a meeting of the minds to engage in anticompetitive

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Hospital in Camden, New Jersey, after spending three years in a residency program at MCP Hahnemann Hospital in Philadelphia. *Id.* At the time the complaint was filed, Dr. Denise Greene was in her fourth year of a five-year residency program at the University of California-Davis. *Id.*

81. *Id.* at 2.

82. *Id.* These "organization defendants" either manage (AAMC) or sponsor (ACGME, AHA, AMA, ABMS, CMSS) the NRMP. *Id.* at 3.

83. The twenty-nine hospitals named as defendants are as follows: Medstar-Georgetown Hospital Medical Center, Inc.; George Washington University; Medstar Health, Inc.; Administrators of the Tulane Educational Fund; Barnes-Jewish Hospital; Baylor College of Medicine; Beth Israel Deaconess Medical Center, Inc.; Beth Israel Medical Center; Boston Medical Center Corp.; Cedars-Sinai Medical Center; The Cleveland Clinic Foundation; Duke University Health System, Inc.; Emory University; Henry Ford Health System; The Massachusetts General Hospital; The McGaw Medical Center of Northwestern University; The Mount Sinai School of Medicine of the City University of New York; The New York and Presbyterian Hospital; Rhode Island Hospital; Rush-Presbyterian-St. Luke's Medical Center; St. Louis University; Stanford Hospital and Clinics; Strong Memorial Hospital of the University of Rochester; Thomas Jefferson Hospital, Inc.; University Hospitals of Cleveland, Inc.; Washington University Medical Center; William Beaumont Hospital; Yale-New Haven Hospital, Inc.; Yeshiva University. Complaint, *supra* note 5.

84. Memorandum from Jordan J. Cohen, M.D., *supra* note 80, at 2.

85. 15 U.S.C. § 1 (2002).

86. Literally applied, section one would outlaw every contract restraining trade, since every commercial contract restrains trade in some way. 54 AM. JUR. 2D *Monopolies and Restraints of Trade* § 47 (2003) (citing Chicago Board of Trade v. United States, 246 U.S. 231, 238 (1918) and Standard Oil Co. v. United States, 221 U.S. 1, 49 (1911)). Nonetheless, section one has been construed by the Supreme Court to ban only those contracts that constitute unreasonable restraints of competition. *Id.* (citing Business Electronic Corp., v. Sharp Electronics Corp., 485 U.S. 717, 723 (1988), where the Court stated that "[s]ince the earliest decisions of this Court interpreting this provision, we have recognized that it was intended to prohibit only unreasonable restraints of trade).

conduct.[87] Once an agreement is established, whether the agreement unreasonably restrains trade will be analyzed either under the rule of per se invalidity or under the rule of reason.[88]

Restraints whose nature and necessary effect are so plainly anticompetitive that no elaborate study of the relevant industry is required are deemed illegal per se.[89] Since a practice constituting a per se violation is conclusively presumed to be unreasonable, a court facing such a restraint looks only to see whether the defendant actually engaged in the conduct alleged.[90] In determining whether a particular activity justifies per se treatment, the critical question is whether the activity historically and consistently restricts competition, thereby making the market less competitive and less efficient.[91] As a general rule, an activity will be deemed a per se violation only after the courts have had considerable experience with the challenged conduct such that any prior application of the rule of reasons inevitably resulted in a finding of anticompetitive effects.[92]

Traditionally, courts have held that any agreement between competitors to stabilize prices constitutes a per se violation of section one.[93] Horizontal price fixing, as defined by common law, occurs when direct competitors get together to set either maximum[94] or minimum[95]

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87. Absent an express or formal agreement to engage in anticompetitive conduct, a plaintiff may establish an unlawful combination by present circumstantial evidence showing a unity of purpose among the defendants. 54 AM. JUR. 2D *Monopolies and Restraints of Trade* § 40 (2003). A tacit agreement, also called "conscious parallelism," must be accompanied by "plus" factors that indicate the absence of independent action. 54 AM. JUR. 2D *Monopolies and Restraints of Trade* § 41 (2003). The concerted action element of a section one claim also includes proof of an unlawful objective. 54 AM. JUR. 2D *Monopolies and Restraints of Trade* § 32 (2003).

88. *See* James F. Blumstein & Frank Sloan, *Antitrust and Hospital Peer Review*, 51 LAW & CONTEMP. PROBS. 7, 53-54 (1988) (outlining the differences between per se treatment and the rule of reason analysis).

89. Robert H. Jerry, II & Donald E. Knebel, *Antitrust and Employer Restraints in Labor Markets*, 6 INDUS. REL. L.J. 173, 176 (1984); *see* AM. JUR. 2D *Monopolies and Restraints of Trade* § 50 (2003) (outlining the doctrine of per se illegality).

90. *See* 54 AM. JUR. 2D *Monopolies and Restraints of Trade* § 50 (2003).

91. *See* 54 AM. JUR. 2D *Monopolies and Restraints of Trade* § 51 (2003).

92. *Id.* The doctrine of per se illegality applies only to historically anticompetitive conduct where judicial and administrative resources would be wasted by the repetition of a competitive analysis. *Id.* Practices which have been conclusively deemed illegal per se include price fixing arrangements, tying arrangements, agreements among competitors to divide markets or allocate customers, group boycotts, and agreements to limit production. *Id.*

93. *See* United States v. Socony-Vacuum Oil Co., 310 U.S. 150, 223 (194) (holding that "a combination formed for the purpose and with the effect of raising, depressing, fixing, pegging, or stabilizing the price of a commodity in interstate . . . commerce is illegal per se."). *See also* United States v. Trenton Potteries Co., 273 U.S. 392, 397 (1927) (holding that it is no defense that a fixed price is reasonable since the reasonable price fixed today may become unreasonable tomorrow).

94. *See* Arizona v. Maricopa County Med. Soc'y, 457 U.S. 332, 332 (1982) (holding that an agreement between doctors and insurers fixing maximum prices for the doctors' services was

prices for a product or service. An agreement that restricts a competitor's ability to set a price based on his own judgment will constitute a horizontal price fix.[96] For example, the elimination of competitive bidding has historically been deemed illegal per se even where prices were not expressly fixed.[97] Horizontal restraints have the greatest chance of seriously limiting or eliminating competition in the marketplace. As such, antitrust law considers them most egregious.[98]

Per se treatment precludes any defense that the price fixed was reasonable[99] or that adherence to the fixed price was not mandatory.[100] A horizontal price fix may be considered appropriate only when an agreement to fix prices is necessary to make the product available at all.[101]

Restraints that are not illegal per se are evaluated by analyzing the facts peculiar to the business, the history of the restraint, and the reasons why it was imposed so as to determine its anticompetitive effect.[102] Courts apply the rule of reason if the purpose or effect of the allegedly anticompetitive conduct is unclear or if the court is unfamiliar with the agreement at issue.[103] A rule of reason analysis essentially balances the harms of the allegedly

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illegal per se). Even though competitors are free to price at below the maximum, the presence of the ceiling tends to stabilize prices and distort resource allocation. *Id.*

95. *See* Goldfarb v. Va. State Bar, 421 U.S. 773, 773 (1975) (holding that a minimum fee schedule adopted by the bar association violated section one of the Sherman Act).

96. *Id.*

97. *See, e.g.*, Nat'l Soc'y of Prof'l Engineers v. United States, 435 U.S. 679, 693-95 (1978) (holding per se illegal a trade association's canon of ethics that prohibited competitive bidding by its members).

98. *See* 54 AM. JUR. 2D *Monopolies and Restraints of Trade* § 75 (2003) (stating that an agreement among competitors is the "archetypal example of a practice that is so plainly anticompetitive and so often lacking any redeeming virtue that it is conclusively presumed illegal").

99. United States v. Addyston Pipe & Steel Co., 175 U.S. 211, 238 (1899) (holding pipe manufacturers' price schedule illegal per se despite any defense that the prices fixed were reasonable and meant to benefit consumers).

100. United States v. Nat'l Ass'n of Real Estate Bds., 399 U.S. 485, 488-90 (1950) (holding that a real estate board's establishment of a suggested price schedule was per se illegal even where members were not required to adhere to the schedule and where no penalties were imposed for noncompliance).

101. Broad. Music, Inc. v. Columbia Broad. Sys., Inc., 441 U.S. 1, 35-37 (1979) (holding that use of a blanket licensing agreement was not illegal per se because such a license was necessary to make the product available in the first place).

102. Jerry & Knebel, *supra* note 89, at 176.

103. *See Broad. Music, Inc.*, 441 U.S. at 3 (holding that a blanket licensing agreement, which forced a user of ASCAP's copyrighted music to purchase a blanket license for use of all ASCAP's music, required rule of reason treatment because such a horizontal restraint was necessary to make the product available in the first place); 54 AM. JUR. 2D *Monopolies and Restraints of Trade* § 48 (2003) (outlining the rule of reason standard).

anticompetitive conduct against its procompetitive benefits to determine the net effect on competition.[104] Courts will not inquire into whether the impairment of competition may actually be in the best interests of a specific industry. This is because the Sherman Act reflects a legislative judgment that competition is the best method of allocating resources in a free market.[105]

Applying the rule of reason entails a somewhat imprecise assessment of the facts peculiar to the challenged business.[106] While the reasonableness of restraint is necessarily a question of relation and degree, courts analyzing allegedly anticompetitive conduct generally focus on 1) the market conditions before and after the restraint was imposed, 2) the purpose and motivation for the restraint, and 3) the nature and effect of the challenged conduct.[107]

A court considers market conditions to determine whether the parties who have reached an agreement have a sufficient amount of market power to restrain trade in the market at issue.[108] Market power is the ability to independently influence the price of a product by restricting its output. The defendant[s] must have the ability to raise prices without incurring a critical loss of sales.[109] Without this power, the agreement has an insignificant effect on the market and does not provoke governmental concern.[110] Courts consider the motivation of a restraint by inquiring into its history, duration, and stated purpose.[111] To that end, a plaintiff may present evidence of a

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104. Jerry & Knebel, *supra* note 89, at 175-76. "In *Chicago Board of Trade v. United States*, Justice Brandeis observed that the broad language of section one, if applied literally, would invalidate every contract." *Id.* at 175-76. Thus, the Supreme Court historically follows a rule of reason analysis to determine whether the challenged agreement is one that promotes or suppresses competition. *Id.* at 176.

105. Thomas A. Piraino, Jr., Note, *Making Sense of the Rule of Reason: A New Standard for Section 1 of the Sherman Act*, 47 VAND. L. REV. 1753, 1767-68 (1994). The Sherman Act reflects Congress' judgment that "competition is the best method of allocating resources in a free market." Jerry & Knebel, *supra* note 89, at 175 (citing National Society of Professional Engineers v. United States, 435 U.S. at 695). The efficient allocation of resources enhances consumer welfare because competition lowers prices and results in better goods and services. *Id.*

106. 54 AM. JUR. 2D *Monopolies and Restraints of Trade* § 48 (2003).

107. *See, e.g.*, 54 AM. JUR. 2D *Monopolies and Restraints of Trade* § 48 (2003); Blumstein & Sloan, *supra* note 88, at 86-88.

108. 54 AM. JUR. 2D *Monopolies and Restraints of Trade* § 49 (2003)

109. Without market power, consumers can shop around to find a rivaling better deal. *Id.* at n. 87.

110. When a given product has significant substitutes or alternatives readily available, the risk to competition from any one entity taking action is low. Blumstein & Sloan, *supra* note 88, at 87. As alternatives become less accessible, less attractive, or otherwise more costly, the potential adverse impact on competition is higher and the antitrust defendant must justify his actions by showing their procompetitive effects. *Id.*

111. 54 AM. JUR. 2D Monopolies and Restraints of Trade § 48 (2003).

defendant's anticompetitive motivation or bad faith. Behavior that is seemingly consistent with anticompetitive animus will be viewed more harshly if a plaintiff can show there is little likelihood that the conduct was entered into for procompetitive reasons.[112] The essence of a rule of reason inquiry is to identify the true effect of an agreement. To violate the antitrust laws, the agreement at issue must be anticompetitive; it must unreasonably restrain competition.[113]

B. Residents' Burden of Proof

As threshold issues, the plaintiffs must show collective conduct on the part of the defendants and the implication of interstate commerce.[114] The plaintiff residents likely meet both requirements. First, the organization and institution defendants act together to administer the Match. Specifically, the organization defendants engaged in collective conduct by establishing and maintaining the NRMP.[115] The institution defendants then act collectively by using the NRMP as a means to fill their respective residency programs.[116] Second, both the organization and institution defendants meet the low burden required to bring them within federal regulation since both participate in interstate commerce.[117]

The residents allege that defendant hospitals, which compete with each other for residents, set horizontal restraints that circumvent fair compensation. Yet, the Jung court will most likely reject mechanical per se treatment because the restraint at issue is a matter of first impression and the NRMP has redeeming virtues.[118]

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112. *Id.*

113. *Id.*

114. *See id.*

115. *See* Nat'l Resident Matching Program, *supra* note 23 (listing sponsors of the NRMP).

116. *See* Complaint, *supra* note 5, ¶¶ 83-89.

117. The institution defendants participate in interstate commerce by inviting prospective candidates to cross state lines to interview for employment positions, receiving millions of dollars from out-of-state sources, and purchasing goods and services from out-of-state parties. Complaint, *supra* note 5, ¶ 66. Further, both the organization and institution defendants communicate with each other and their professional organizations using interstate communications networks, the Internet, and the United States mail. *Id.* Congress has broad authority to regulate interstate commerce. U.S. CONST. art. I, § 3, cl. 3; *see* 15 AM. JUR. 2D *Commerce* § 18 (2000).

118. *See* Schnell, *supra* note 39. The NRMP's redeeming virtues include the efficiency of a central placement system with one deadline and one Match Day. *See supra* Part II.B. (discussing the reasons for the current NRMP).

Furthermore, most courts will not apply per se treatment to practices involving education or the professions.[119]

Therefore, the *Jung* court will analyze the Match under the rule of reason. To determine whether the NRMP has a net pro- or anticompetitive effect, the court will consider the condition of the resident labor market before and after the NRMP was instituted, the motivation for creating the NRMP, and the nature and effect of the NRMP to determine whether the NRMP has a net pro- or anticompetitive effect.

1. Market Conditions

Before the NRMP, medical students obtained residency positions through the open job market.[120] Some members of the medical community describe the former process, which is akin to the current "scramble," as "chaotic, inefficient and inhumane."[121] Without question, the NRMP's centralized application process has created structural efficiencies in the market for resident services.[122] However, these efficiencies may indirectly thwart interprogram wage competition because the NRMP requires applicants to accept a single binding match without the option to entertain a competing offer.[123]

Moreover, the *Jung* defendants undoubtedly possess significant power within the relevant market,[124] defined as the services of resident physicians in accredited residency programs across the United States.[125] The NRMP is the primary route by which applicants

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119. The Court has been wary of condemning rules adopted by professional associations as unreasonable per se because they observe that certain types of restrictive activities may be pro-competitive in operation. Blumstein & Sloan, *supra* note 88, at 27-28. The primary justification for increased reliance on the rule of reason analysis is the Court's growing sense that some types of superficially restrictive conduct may, overall, have a positive effect on competition. *Id.*

120. Nat'l Resident Matching Program, *supra* note 9, at 2; *see* Part II.B.1.

121. Nat'l Resident Matching Program, Save the Match, Why the NRMP's History is Relevant, *at* http://www.savethematch.org/history/history.aspx (last visited Nov. 11, 2003).

122. *See infra* Part V.B.

123. *See supra* Part II.B.

124. The relevant market consists of two components: the relevant geographic market and the relevant product market. 54 AM. JUR. 2D *Monopolies and Restraints of Trade* § 57 (2003). The relevant geographic market is defined by the area in which the defendant can sell the product or service. *Id.* The relevant product market is determined by consumer preferences and the extent to which the product or service is reasonably interchangeable. *Id.* In this case, the relevant geographic market is the United States. Complaint, *supra* note 5, ¶ 67. The relevant product market consists of the market for services of resident physicians in ACGME-accredited residency programs (including programs combined of ACGME-accredited programs and subspecialty programs commonly referred to as fellowships). *Id.* ¶ 68.

125. Complaint, *supra* note 5, ¶¶ 67-68.

obtain positions in accredited residency programs.[126] The practical effect is that there are no viable substitutes or alternatives to the NRMP. Ultimately, the court must weigh the advantage of the NRMP's efficiencies against the disadvantage of a single entity administering resident job placement.

2. Motivation

The *Jung* plaintiffs likely will not prove that the NRMP was established with bad intentions.[127] The stated purpose of the NRMP was to organize a previously chaotic process.[128] Even so, the residents may be able to argue successfully that despite the program's altruistic beginning, the defendants have, over time, demonstrated bad faith by refining the program to "strengthen and expand its anticompetitive effect . . . ."[129] Establishing withdrawal deadlines for programs and applicants,[130] as well as developing a policing system for match violations,[131] could be viewed as conduct intended to maintain the restrictiveness of the NRMP. If residents can show that these changes to the structure of the matching process were made with anticompetitive motivations, they will certainly strengthen their case against defendants.

Both the organization and institution defendants have a history of conduct that appears to violate antitrust laws.[132] Specifically, the residents point to three incidents in support of this contention.[133] First, in 1996, the United States Department of Justice investigated

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126. *Id.* ¶ 71; *see also supra* Part II.B (stating that on average each year, more than 92% of United States medical school seniors obtain their first-year residency positions through the Match). Furthermore, 100% of residency positions in the United States are subject to the ACGME's accreditation standards. Complaint, *supra* note 5, ¶ 71.

127. *See generally* Nat'l Resident Matching Program, *supra* note 9. The Match was instituted to take pressure off of students and bring organization to a previously chaotic process. *Contra* Complaint, *supra* note 5, ¶ 84 (arguing that "[t]he anticompetitive purpose and effect of the Matching Program is revealed in its genesis").

128. *See generally* Nat'l Resident Matching Program, *supra* note 9. The Match was instituted to take pressure off of students and hring organization to a previously chaotic process. *Contra* Complaint, *supra* note 5, ¶ 84 (arguing that "[t]he anticompetitive purpose and effect of the Matching Program is revealed in its genesis").

129. *See* Complaint, *supra* note 5, ¶ 85.

130. *Id.* ¶ 85. Withdrawal deadlines were changed to more effectively prevent employers from entering into "side-deals" with applicants and then withdrawing corresponding positions from the NRMP before they were filled. *Id.*

131. *Id.* The NRMP developed systems for reporting match violations to the respective specialty certification board that will ultimately decide an applicant's request for certification. *Id.* Additionally, a resident who declines a match and obtains alternative employment may be subject to dismissal if his employer learns of the match violation. *Id.*

132. *Id.* ¶¶ 89-91.

133. *Id.* ¶¶ 89-91.

the Association of Family Practice Residency Directors because the Association allegedly conspired to restrain competition among family practice residency programs by promulgating guidelines that limited recruitment practices and the payment of certain kinds of economic incentives to prospective residents.[134] Under a subsequent consent decree,[135] the Association was required to withdraw the challenged guidelines and prohibited from promulgating similar rules in the future.[136]

Second, plaintiffs note three cases of price fixing involving physicians' fees and nurses' salaries.[137] Finally, the residents cite instances where the medical establishment boycotted the services of competing professions including podiatrists, psychologists, chiropractors, osteopathic physicians, and nurse-midwives.[138] These instances evidence a pattern of anticompetitive conduct within the medical establishment.

3. Nature and Effect of the NRMP

The NRMP consists of agreements between the defendant hospitals and professional associations.[139] The organization defendants provide the NRMP to the institution defendants who agree to use it to fill their first-year resident positions.[140] By its nature, the

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134. *Id.* ¶ 89 (citing United States v. Assoc. of Family Practice Residency Directors, 1996 WL 557841 (W.D. Mo. Aug. 15, 1996)).

135. A consent decree is the antitrust equivalent to a cease and desist order. 54 AM. JUR. 2D *Monopolies and Restraints of Trade* § 572 (1996). A consent decree prohibits the continuation of claimed illegal conduct and circumvents a time-consuming and expensive trial by setting forth an adequate remedy if its terms are violated. *Id.*

136. *Justice Department Moves to Stop Anticompetitive Actions of National Medical Residency Trade Association*, NAT'L ASS'N ATT'YS GEN., May/June 1996, at 22, 23; *see Assoc. of Family Practice Residency Dirs.*, 1996 WL 557841, at *1-2.

137. *See* United States v. Utah Soc'y for Healthcare Human Resources Admin., 1994 WL 729931 (D. Utah Sept. 14, 1994) (fixing nurses' salaries); Mich. State Med. Soc'y, 101 F.T.C. 191 (Feb. 17, 1983) (Final order; fixing physicians' fees); Complaint, *supra* note 5, ¶ 90 (citing Arizona v. Maricopa County Medical Society, 457 U.S. 332 (1982) (fixing physicians' fees).

138. Complaint, *supra* note 5, ¶ 91; *see, e.g.*, Blue Shield of Va. v. McCready, 457 U.S. 465 (1982) (psychologists); Wilk v. Am. Med. Ass'n, 895 F.2d 352 (7th Cir. 1990) (chiropractors); Hahn v. Or. Physician's Serv., 86 F.2d 1022 (9th Cir. 1989) (podiatrists); Weiss v. York Hosp., 745 F.2d 786 (3d Cir. 1984) (osteopathic physicians); Sweeney v. Athens Reg'l Med. Ctr., 709 F. Supp. 1563 (M.D. Ga. 1989) (nurse-midwives).

139. *See generally* Nat'l Resident Mathcing Program, Match Participation Agreement for Institutions (displaying the Match Participation Agreement Between Participating Institutions and the NRMP), *at* http://www.nrmp.org/res_match/policies/map_institution.html (last modified Aug. 13, 2003).

140. *See id.* § 1.0. "Institutions that register any programs in the Matching Program agree to select senior students of U.S. allopathic medical schools for all of their programs only through the Matching Program." *Id.*

current NRMP constitutes an unreasonable restraint of trade because its mandatory participation rule gives competing programs the ability to collectively set resident salaries.[141] So long as each program adheres to the narrow salary range, hospitals can avoid wage bidding and still be assured of gaining their preferred candidates, who must accept the single placement they receive.[142]

Whether or not the NRMP unreasonably restrains trade by its nature, its effect is anticompetitive in at least three ways. First, fourth-year medical students planning to enter a residency essentially must participate in the Match.[143] Second, the NRMP removes an applicant's choice to accept or decline the Match placement.[144] Finally, the NRMP structure effectively eliminates individual negotiations between applicants and programs because students are required to accept the placement they receive.[145] The combined effect of these factors is to suppress interprogram wage competition by giving hospitals a captive group of incoming employees.

C. Justification for the NRMP

If the *Jung* plaintiffs successfully show anticompetitive conduct that suppresses wage competition, the defendants must show that the procompetitive virtues of the NRMP outweigh its anticompetitive effect. The defendants must utilize accepted antitrust defenses to avoid liability. The tendency by courts to view noncommercial conduct with greater leniency under antitrust laws weighs heavily in the defendants' favor.[146] Nevertheless, each relevant defense will likely fail, resulting in a legal victory for the plaintiffs.

As a threshold matter, defendants may argue that the Sherman Act does not apply to employer restraints in labor markets.[147] Some legal scholars suggest that practices in labor markets come under

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141. *See id.*; Complaint, supra note 5 ¶ 83.

142. *See supra* Part II.B.3.

143. Since a student's goal in pursuing a residency is to become an accredited practitioner, she is limited to a position at an accredited program. Over 80% of sucb positions are offered exclusively through the NRMP. Complaint, *supra* note 5, ¶ 71. Student applicants are further compelled to use the Match because residency programs that opt to participate in the NRMP are largely prohibited from choosing candidates outside the Match. *Id.* ¶ 86.1.

144. Pursuant to NRMP rules, both prospective residents and programs agree in advance to be bound by the Match. *See, e.g.*, Coyle, *supra* note 24; Jenny B. Davis, *Disturbing Diagnosis: Physician Residents Sue Their System for Antitrust*, A.B.A. J. E-REPORT, May 10, 2002, at 2, WL 1 No. 18 ABAJERPT 2; AAIM, *supra* note 70; *supra* Part II.B.3.

145. *See, e.g.*, Complaint, *supra* note 5, ¶ 86.2; *see infra* Part V.B. (discussing absence of individual negotiations between candidates and programs).

146. Schnell, *supra* note 39, at A12.

147. *See* Jerry & Knebel, *supra* note 89, at 246.

antitrust scrutiny only if they adversely affect competition in the product market.[148] The plaintiffs' decision to sue under antitrust law will force a court to decide whether the Sherman Act protects competition in labor markets as well as in product markets.[149] Several scholars have argued that section one does not regulate concerted employer conduct that restrains only the labor market, pointing to the legislative history and circumstances surrounding the enactment of the Sherman Act as evidence that employer restraints are illegal only if they have direct or indirect consequences on the product market.[150] Thus, when employees challenge concerted employer conduct in a particular labor market, they must show that the labor market restraint is intended to affect, or actually does affect, a product market.[151] Since employer attempts to restrain labor costs may actually benefit consumers in the form of lower prices, it may be difficult to argue that anticompetitive labor restraints adversely affect the product market.[152]

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148. *See id.* at 174.

149. *See* Jerry & Knebel, *supra* note 89, at 173-74 (highlighting the debate over the scope of federal antitrust laws as applied to restraints in labor markets).

150. It is inappropriate and contrary to the Act's purpose to use the Sherman Act to promote efficiency in the labor market. *Id.* at 183. *See generally id.* at 184-92 (providing the legislative history of section one of the Sherman Act). "[T]he legislative history of the Sherman Act does not support the proposition that Congress intended [it] to be used to regulate employer competition in labor markets." *Id.* at 184. "[Senator John] Sherman [of Ohio] saw federal antitrust legislation as a solution for the depression of wages by trusts, not because his bill had any applicability to labor markets, but because his bill would promote competition in markets for goods and services." *Id.* at 188. The product market is "the commercial market where firms sell their goods and services." *Id.* at 174.

151. *Id.* at 180-81. The scope of the Sherman Act is of crucial significance to employee plaintiffs who challenge multiemployer activity restraining labor markets. *Id.* at 182. Jerry and Knebel further note that when multiple employers unilaterally restrain the labor market, the employees' principal grievance is likely to be a wage reduction, stabilization, or depression. *Id.* at 180. However, "[a] plaintiff who challenges a multiemployer labor market restraint on the ground that it has depressed wages or otherwise affected conditions of employment fails to state a Sherman Act claim." *Id.* at 241.

152. *See id.* at 181-82.

> In an economic sense, any change in the cost of producing a product can be said to have some influence upon that product's price. If price is defined as the cost of production plus a reasonable profit, then decreasing the cost of one input to the product will permit the firm either to decrease price without decreasing profit or to increase profit without increasing price. Thus, if employers conspire to prevent wages from rising above a certain level, employers can either decrease prices without decreasing profits or increase profits without increasing prices. A change in a production cost may not result in a price change, but it has relationship to, and can be said to affect, price.

Id. "If rising labor costs are restrained, the consumer may benefit from a stable or more slowly increasing price." *Id.* at 182.

Notwithstanding that no court has ruled directly on the issue of restraints in the professional labor market,[153] a court will likely conclude that the Sherman Act does regulate labor markets. Even those who support excluding labor markets from the protections of the Sherman Act concede that the judiciary's willingness to scrutinize restraints in professional athletics suggests that a court will conclude that the Sherman Act applies to professional labor markets.[154]

Like professional athletics, the hospital industry relies heavily upon individual practitioners who come together as a team. A hospital's sole product is its medical services. Without question, the value of these services depends entirely on the ability of resident doctors and support staff to provide quality medical care. It is difficult to imagine how a restraint on competition for physician services would not negatively affect a hospital's product market since a hospital's product is its services. For this reason, the *Jung* court will most likely classify medical residents as independent contractors selling professional services in product markets,[155] thus bringing them under the ambit of section one of the Sherman Act.

1. Procompetitive Justifications

Defendants will likely argue that the NRMP is procompetitive because it 1) brings efficiency and fairness to a previously chaotic process; 2) optimizes the preferences of the participating medical students and hospitals; 3) allows students to make more educated decisions about what specialties they wish to pursue; 4) minimizes disruption on medical school; 5) increases the supply of residents; 6) improves the caliber of resident training; and 7) improves the overall quality of healthcare in the United States.[156] While clearly beneficial from a practical perspective, these justifications are unlikely to be considered procompetitive. Assuming arguendo that the benefits are

153. *See id.* at 237 (stating that the most prominent cases relating to professional labor services involve restraints in professional athletics where athletes have frequently challenged employer-imposed restraints, such as player drafts and free agent rules, as combinations condemned by antitrust laws).

154. For example, courts reviewing cases involving professional sports have consistently applied section one protections, reasoning that teams sell to the public the services of their players. *Id.* at 238. Since the service supplied to the public is highly dependent on the ability of individual players employed by the club, any restraint on competition for the services of players inevitably affects the product market. *Id.*

155. *See id.* at 238-39 (noting that it is well-settled law that professionals who sell their services to the public are independent contractors and that supplying of a service by an independent contractor is not a labor market transaction but is instead a product market transaction).

156. Schnell, *supra* note 30, at 3-4.

procompetitive, the residents will need to show that all of the NRMP's legitimate justifications could have been achieved through a less restrictive alternative.[157]

Given that programs can still compete within the NRMP since they remain free to set terms that they feel will be most attractive to prospective residents, the court may conclude that the Match is not an unreasonable restraint.[158] It is in a hospital's best interest to make its terms as attractive as possible to ensure high placement on preferred candidates' match lists.[159] Still, even though hospitals can create distinctively attractive terms if they wish, there remains suspicious salary uniformity among residency programs despite some disparity in program prestige, resident merit, medical specialty, and variable cost of living.[160]

2. Learned Profession Exemption

The defendants will not avoid the Sherman Act by arguing that the medical community, as a learned profession, must be allowed to self-regulate. At one time, learned professions received special treatment under antitrust laws.[161] In *Goldfarb v. Virginia State Bar*,[162] however, the Supreme Court dispelled this notion and held that the learned professions deserve no sweeping exemption from the Sherman Act.[163] To gain an exemption, defendants would have to look

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157. *Id.* at 4.

158. *Id.*

159. *Id.*

160. Adam Liptak, *Medical Students Sue Over Residency System*, N.Y. TIMES, May 7, 2002, at A1. Notwithstanding the various nonwage related competitive advantages between programs, these factors do not justify uniformly low resident salaries.

161. Michael A. Kaplan, Annotation, *"Learned Profession" Exemption in Federal Antitrust Laws (15 U.S.C.A. §§ 1 et seq.)*, 39 A.L.R. FED. 774, § 2(a) (1978). It was stated in dictum in *The Schooner Nymph*, 18 F. Cas. 506 (C.C.D. Me 1834), that wherever any occupation, employment, or business is carried on for the purpose of profit, or gain, or a livelihood, "not in the liberal arts or in the learned professions," it is consistently called a trade. *Id.* Also in dictum, the Supreme Court, in *FTC v. Raladam Co.*, 283 U.S. 643 (1931), stated that medical practitioners "follow a profession and not a trade." *Id.*

162. 421 U.S. 773 (1975).

163. Kaplan, *supra* note 161, § 2(a) (citing Goldfarb v. Virginia State Bar, 421 U.S. 773 (1975)). It seems well-established that a learned profession exemption argument must fail since the Court has consistently held that the Sherman Act strikes widely enough that every person, regardless of occupation, is subject to its strictures when that person engages in a proscribed restraint of trade. *Id*; *see also* James F. Blumstein, Student Protests: Is the National Resident Matching Program in Violation of Antitrust Laws?, 4 Med. Crossfire 31, 31 (2002), http://medicalcrossfire.com/debate_archive/2002/Jul02/StudentProtests.pdf (last visited Sept. 1, 2003). In 1975, the Supreme Court applied the antitrust laws to the practice of law, in 1978 to the practice of engineering, and in 1986 to the practice of dentistry. Dennis R. Bartholomew,

to the legislature.[164] Congress has the power to create exemptions from the antitrust laws for specific circumstances and specific industries if it determines that public policy requires it to do so.[165] However, such congressional exemptions are rare.[166]

3. Public Policy Defense

The purpose of the Sherman Act is to promote behavior that maximizes consumer welfare through unrestricted competition, which is believed to increase economic efficiency.[167] As a result, defendants cannot successfully argue that the NRMP remedies inherent flaws in the free labor market. The Sherman Act presumes that competition is in the best interests of the public and the economy.[168]

The defendants may argue that the medical profession's collusive behavior is necessary as part of its commitment to public

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Comment, *Antitrust and the Professions: Where Do We Go from Here?*, 29 VILL. L. REV. 115, 117 (1984).

164. *See infra* Part V.B (discussing a possible legislative exemption from antitrust laws).

165. Blumstein & Sloan, *supra* note 88, at 29.

166. *See* Bartbolomew, *supra* note 163, at 120-22 (explaining that the 1945 McCarran-Ferguson Act, 15 U.S.C. § 1011, provided for a limited federal antitrust exemption for the insurance industry, which is heavily regulated by states); *infra* note 213 and accompanying text. *See generally* Eric Peter Gillett, Comment, *The Business of Insurance: Exemption, Exemption, Who Has the Antitrust Exemption*, 17 PAC. L.J. 261 (1985) (providing useful background on the McCarran-Ferguson Act, 15 U.S.C. § 1011, and its impact on the insurance industry).

167. Piraino, *supra* note 105, at 1767-68. The Sherman Act reflects Congress's judgment that "competition is the best method of allocating resources in a free market." Jerry & Knebel, *supra* note 89, at 175 (citing National Society of Professional Engineers v. United States, 435 U.S. at 679, 695 (1978)). The efficient allocation of resources enhances consumer welfare because competition lowers prices and results in better goods and services. *Id.*

168. "The purpose of a rule of reason analysis is to 'form a judgment about the competitive significance of the restraint; it is not to decide whether a policy favoring competition is in the public interest, or in the interest of the members of an industry.'" Blumstein & Sloan, *supra* note 88, at 28 (citing *National Society of Professional Engineers*, 435 U.S. at 692). Even the "worthy purpose" defense for professional associations, first articulated in *Wilk v. AMA*, 719 F.2d 207 (7th Cir. 1983) is unlikely to excuse anticompetitive restraints on resident labor. The worthy purpose defense permits values other than competition to enter into the antitrust analysis as a justification for certain types of anticompetitive professional activity. Blumstein & Sloan, *supra* note 88, at 29 (citing *Wilk*, 719 F.2d at 207). The defense originated when the Seventh Circuit purported to rely on Justice Blackmun's concurring opinion in *National Society of Professional Engineers*. *Id.* at 30 (citing *National Society of Professional Engineers*, 435 U.S. at 699-701 (Blackmun, J., concurring)). The Seventh Circuit read Justice Blackmun's opinion to state that a more flexible approach should be used when dealing with professional associations in order to recognize benefits that are important to a profession's proper ordering, other than those of increased competition. *Id.* (citing *Wilk*, 719 F.2d at 226). Nonetheless, the worthy purpose defense lacks credibility because the Seventh Circuit ostensibly relied upon "what is, in effect, a dissenting opinion to carve out a defense seemingly barred by a majority of the Supreme Court." *Id.* at 30-31.

service.[169] Antitrust law assumes that all commercial entities are motivated, almost solely, by maximizing profit.[170] Professionals, however, may not fit this assumption.[171] There are considerable expectations placed upon doctors, especially medical residents, to provide their services without regard to potential profit.[172] Such expectations increase the ethical standards of the medical profession and serve to regulate those members who do not live up to the minimum expectations. Treating doctors like profiteers, as antitrust laws currently do, may create a self-fulfilling prophecy where doctors are driven solely by profit to the detriment of patient care.[173] Still, the *Jung* court is unlikely to be persuaded by policy arguments in favor of the Match for the same reasons that preclude an exemption defense.[174]

D. Balance Weighs in Residents' Favor

The plaintiffs have a strong chance at prevailing on their claim that the NRMP is anticompetitive under section one of the Sherman Act. Defendants' market power coupled with the lack of wage competition has the general effect of severely limiting applicants' employment options and terms. Although the NRMP does not directly establish resident salaries or working conditions, its single placement assignment effectively eliminates salary competition between programs. Overall, defendants' possible justifications for the Match appear to be largely policy-based, rather than legally grounded. Even if defendants present strong evidence of efficiencies created by the NRMP, the court will likely find that such efficiencies can exist within a less restrictive structure.

The consequences of a plaintiff-favoring verdict are significant for residents, participating programs, and patients. If the court certifies the case as a class action,[175] the plaintiff class could include

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169. *See* Christopher J. Gawley, *Protecting Professionals from Competition: The Necessity of a Limited Antitrust Exemption for Professionals*, 47 S.D. L. REV., 233, 233, 246-48 (2002) (observing that "professionals continue to engage in concerted bebavior that would otherwise be unlawful under tbe antitrust laws, but for their professional status").

170. Gawley, *supra* note 169, at 233, 247.

171. *Id.*

172. *Id.*

173. *Id.* at 233, 248.

174. *See* Kaplan, *supra* note 161, § 2(a) (citing the holding of Goldfarb v. Virginia State Bar, 421 U.S. 773 (1975), which does not allow professionals special treatment under antitrust law); *see also supra* notes 161-166 and accompanying text (stating that learned professions are not immune from antitrust scrutiny).

175. At the time of publication, the court had not yet certified the case as a class action. Nat'l Resident Matching Program, Save the Match, FAQ, Why is Class Certification Important to the Plaintiffs?, *at* http://www.savethematch.org/faq/all/aspx (last visited Nov. 11, 2003). One or

more than 200,000 persons[176] with the defendant class including more than 1,000 entities nationwide.[177] Pecuniary damages, which are tripled in antitrust cases, could easily cost the defendants several hundred million dollars.[178] Such a blow could send the entire health care industry into financial turmoil.[179] Aside from the financial consequences, the United States healthcare system faces the prospect of being forced to change the way that generations of doctors have been trained.[180] Without the NRMP, hospitals would again confront the possibility of accepting too many or too few residents.

From the residents' point of view, a court order mandating changes in the NRMP would significantly impact their professional lives. With the ability to entertain competing offers, most applicants would undoubtedly benefit. Still, the extent to which programs would be willing and able to offer increased salaries remains unclear.

Importantly, patient care would be affected in both positive and negative ways. Patient care may improve if residents are allowed to influence their working conditions.[181] On the other hand, injecting a financial incentive into the resident placement equation might enable well-funded private programs to lure the best candidates. Given that a significant portion of the population cannot afford treatment in

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more members of a class may sue as representative parties on behalf of the group if: "1) the class is so numerous that joinder of all members is impracticable, 2) there are questions of law or fact common to the class, 3) the claims or defenses of the representative parties are typical of the claims or defenses of the class, and 4) the representative parties will fairly and adequately protect the interests of the class." FED R. CIV. P. 23(a)

176. Complaint, *supra* note 5, ¶ 52. "Plaintiffs bring the suit on behalf of themselves and as a class action . . . on behalf of all persons employed as resident physicians in ACGME-accredited residency programs . . . since May 7, 1998." *Id.* ¶ 51.

177. *Id.* ¶ 59. The Defendant Class consists of the following: 1) all NRMP institutional participants since May 6, 1998, 2) all AAMC member hospitals since May 7, 1998 and 3) all ACBME-accredited sponsoring institutions since May 7, 1998. *Id.* ¶ 58. The Defendant Class excludes all government entities, including hospitals and counties. *Id.*

178. A plaintiff alleging economic injury flowing from any violation of federal antitrust laws is entitled to recover treble damages. John P. Ludington, Annotation, *Measure and Elements of Damages Under 15 U.S.C.A. § 15 Entitling Person Injured in His Business or Property by Reason of Anything Forbidden in Federal Antitrust Laws to Recover Treble Damages*, 16 A.L.R. FED. 14 (1973); *see also* 54 AM. JUR. 2D *Monopolies and Restraints of Trade* § 601 (2003) (stating that the burden of showing injury-in-fact requires only that the plaintiff prove the defendant's illegal conduct was a material cause of the injury incurred). In this case, for example, if damages of $1000 per plaintiff were awarded then automatically tripled to $3,000, a class consisting of 200,000 people would carry a total judgment of $600,000,000. Nat'l Resident Matching Program, Save the Match, FAQ, Why Is Class Certification Important to the Plaintiffs?, *at* http://www.savethematch.org/faq/all.aspx (last visited Nov. 11, 2003).

179. Schnell, *supra* note 30, at 4.

180. Liptak, *supra* note 160.

181. *See id.* (quoting Dr. Jung as stating that "[r]esidents want to be treated fairly, and patients want to be treated well. Patient care will improve if you let residents have more say in their working conditions.").

private hospitals, those patients seeking care at government-funded public programs would have to be satisfied with potentially less qualified residents. Finally, if hospitals employ fewer residents because of the higher recruitment and salary costs associated with open competition, residents may have to work longer hours and treat more patients.

Given these concerns, what should be the solution if the court finds the Match to be in violation of antitrust laws? Conversely, even if the court upholds the legality of the NRMP, it may be time to revise the current system. Either way, the *Jung* case forces all parties involved to re-evaluate the employment conditions facing medical residents.

V. RESUSCITATING THE MATCH: THREE POSSIBLE OUTCOMES IN A POST-*JUNG* ERA

If the *Jung* plaintiffs are successful and the NRMP disappears, the medical community must solve the problems posed by medical resident employment. Should the court enjoin the Match, leaving residents with a free labor market? Will Congress intervene to create a legislative exemption? This Part will analyze three possible scenarios ultimately concluding that a compromise provides the most promising resolution.

The unique nature of the residency system merits a novel approach that goes beyond simply abandoning or maintaining the current placement mechanism. With few exceptions, the residency program is distinct among professions in its need for an exact number of entrants to satisfy staffing and budgetary concerns. Furthermore, medical training is distinctive in that it requires extensive postgraduate training over a period of several years. This long-term commitment magnifies the effects that a placement system has on residents and hospitals alike.

A. Overhaul the NRMP in Favor of Free Market Approach

Elimination of the NRMP is the most obvious outcome if a court concludes that the Match violates the Sherman Act. On its face, this appears to be an acceptable and uncomplicated resolution, given that virtually all jobs in the United States are unregulated. Assuming that the *Jung* suit is successful in invalidating the NRMP, a free market for resident labor is a distinct possibility.

In a free labor market, medical students would apply for residencies in the same way that most other people apply for jobs.[182] Since fourth-year students already apply for positions and participate in on-site interviews, much like the general labor market, this shift appears relatively inconsequential.[183] A free market approach would merely replace the NRMP with a negotiable interchange of offers and acceptances, giving medical students the opportunity to individualize the terms of their employment prior to accepting an offer.

This structure proved unsuccessful in the 1950s.[184] However, a limited free market approach may still be possible.[185] For example, some observers suggest restrictions on the free market model, such as a uniform deadline for student applications and hospital decisions combined with a common student response date.[186] This model mirrors, in some respects, the National Association for Law Placement, which is the law student's version of the NRMP.[187] The success of the modified free market in legal recruiting makes this approach more appealing.

A restricted free labor market suggests, however, that some aspects of the NRMP may be appropriate in the resident placement context. While a market-based system would theoretically increase the fair market value of resident services and would comport with antitrust law, at least four significant concerns overshadow the potential benefits of the free market approach.

First, even in an open market, residents may have little real ability to negotiate employment contracts. As with many jobs, the terms of employment may be effectively fixed for all candidates.

Second, the institution of a free labor market would circumvent the purpose behind the NRMP. An important benefit of the Match is its efficient, organized selection process in which all parties submit and receive placement preferences at the same time.[188] In a free labor

182. Blumstein, *supra* note 163, at 32.

183. Nat'l Resident Matching Program, *supra* note 9, at 4; Davis, *supra* note 144.

184. *See* Nat'l Resident Matching Program, *supra* note 9, at 2 (describing the "chaos" of the pre-Match era).

185. *See* Blumstein, *supra* note 163, at 32.

186. *Id.*

187. *See* Nat'l Ass'n for Law Placement, History (stating that NALP was founded in response "to a perceived need by many law schools and legal employers for a common forum to discuss issues involving placement and recruitment"), *at* http://www.nalp.org/about/history.htm (last visited Sept. 1, 2003). Virtually all American Bar Association-accredited law schools and many of the nation's legal employers voluntarily comply with the NALP guidelines. *See* Nat'l Ass'n for Law Placement, Principles and Standards, *at* http://www.nalp.org/pands/index.html (last visited Sept. 22, 2003).

188. *See supra* Part II.B.

market, residency programs would likely spend more time and money recruiting medical students since the placement burden would shift from the externally operated NRMP onto the internal resources of individual hospitals. Higher costs associated with recruiting activities are an attendant evil of the free market employment process.

Third, a market-based system creates the possibility that a residency program will receive more acceptances than it can accommodate. This is a daunting prospect for programs, which have strict budgeting and staffing needs. In a free labor market, hospitals would invariably risk under- or overstaffing. While most employers face this dilemma in the recruiting process, in a hospital setting patient care is tied to physician staffing. Simply put, hospitals are the last places where society wants unpredictable staffing.

Finally, a free labor market would introduce politics into the resident placement process. The NRMP was designed, in part, to foster merit-driven competition by creating a non-political placement mechanism.[189] The increased presence of politics in resident hiring could lead to inferior patient care if resident positions were no longer awarded solely on the basis of merit. Assuming that the NRMP does, in fact, minimize the influence of politics, completely abandoning the current system may not provide an optimal solution.

B. Keep the Current System: Legislative Exemption from Antitrust Laws

If a court concludes that the Match violates the Sherman Act, saving the NRMP will require federal legislation.[190] Since the Supreme Court decisively ruled in *Goldfarb*[191] and *National Society of Professional Engineers v. United States*[192] that learned professions are not inherently immune from antitrust scrutiny, Match proponents would have to convince Congress that the NRMP promotes the public's

189. *See, e.g.*, Nat'l Resident Matching Program, *supra* note 9, at 2-3 ("The lack of a formal system during the pre-Match era was tailor-made for an 'old-boy's' network. Students fortunate enough to have the backing of a well-known member of the medical education community had an advantage over other qualified applicants in securing the most coveted positions.").

190. Blumstein, *supra* note 163, at 32.

191. 421 U.S. 773 (1978); *see* Bartholomew, *supra* note 163, at 126-29 (noting that the Sherman Act does apply to the professions); *supra* notes 161-163 and accompanying text (discussing the holding and impact of *Goldfarb*).

192. 435 U.S. 679 (1978). *See* Bartholomew, *supra* note 163, at 130-32 (stating that the Supreme Court, in *Professional Engineers*, reaffirmed that no broad exemption under the rule of reason exists for professions); *supra* notes 161-163 and accompanying text (discussing the holding and impact of *Professional Engineers*).

best interest despite its anticompetitive effects.[193] With an exemption, the NRMP could continue to exist in its present form.[194]

Setting aside the legal issues surrounding the NRMP, the process does have some definite advantages over a free labor market. First, its formalized structure and efficient administration cannot be ignored. Uniform deadlines combined with computer-generated placement lists undoubtedly simplify the entire process for both hospitals and students.[195] Second, the Match does appear to maximize applicant preferences and acceptances. In 2003, over 63% of fourth-year medical students who participated in the NRMP were matched to their first choice program.[196] Another 15% matched to their second choice program with 8% matching to their third choice program.[197] Thus, over 86% of medical school seniors matched to one of their top three choices in 2003.[198] Third, the NRMP ensures that the majority of hospitals will employ the exact number of incoming residents that they need.[199] Fourth, after having been a part of the residency experience for more than fifty years, the Match remains firmly ingrained in the culture of the medical community.[200] As a result, overhauling the NRMP is unlikely to occur without resistance from those inside the medical profession who feel that the legal system should not interfere with the placement of residents.[201]

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193. *See generally* Gillett, *supra* note 166, at 265-66 (examining the application of a legislative exemption, via the McCarran-Ferguson Act, 15 U.S.C. § 1011, to the insurance industry).

194. *See id.*

195. *See* Am. Med. Ass'n, National Residency Matching Program (NRMP) Antitrust Litigation: Frequently Asked Questions and Answers, at http://www.ama-assn.org/ama/pub/category/8231.html (last modified July 30, 2003).

196. Nat'l Resident Matching Program, Save the Match, FAQ, Why Do Students and Programs Have Such High Confidence in the Match?, *at* http://www.savethematch.org/faq/all.aspx (last visited Nov. 11, 2003).

197. *Id.*

198. *Id.*

199. *See* Nat'l Resident Matching Program, *supra* note 9, at 5 (discussing the post-Match "scramble" that occurs if any residency programs fail to fill all of their positions during the regular Match).

200. Nat'l Resident Matching Program, *supra* note 27. Today's NRMP has been in existence since 1952, and it seems that the old guard continues to support the concept of the NRMP for its ease in administration and perceived improvements over the pre-NRMP free market. *See supra* Part II.B.

201. *See* Dr. John Sergent, *Doctors Shouldn't Stray From Residency Tradition*, THE TENNESSEAN, May 14, 2002, at A9 ("Maybe I'm old enough to be nostalgic about the past, but I hate to see too many changes in the traditional view. . . . The post-doctoral medical education process in the United States is the envy of the world, but it is a fragile institution. If this lawsuit is reduced to a simple antitrust battle, with no consideration of the education and training of these physicians, it is not only the hospitals who will lose. We all will."), *available at* 2002 WL 19905420.

Still, congressional creation of statutory shelter leaves a problematic structure in place while prohibiting residents from seeking recourse under antitrust laws. A study documenting the experiences of medical students during the 1998 match evidences the tension between the medical establishment and residents' opinion of the NRMP.[202] The study revealed that only 40% of residents surveyed believe the Match to be a reasonable placement process requiring no changes.[203] 52% of residents surveyed felt the process could be improved, 4% believed it needs to be overhauled, and another 4% advocated its elimination.[204] Finally, concluding that the NRMP's prohibition on prematch commitments is often ignored by both applicants and programs, the survey also indicates that the Match does not necessarily deter "unprofessional behavior and gamesmanship."[205]

Low salaries, allegedly resulting in part from the Match, rank chief among resident complaints. Despite their advanced education, long work hours, and valuable patient care services, first-year residents earned an average salary of only $35,700 during the 2000-2001 employment year, equating to roughly $10 per hour.[206] Adjusted for inflation, the average first-year resident salary has remained virtually unchanged for more than thirty years.[207] Compared to other hospital employees, such as nurse practitioners and physician assistants, residents earn less on both an annual and hourly basis.[208]

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202. *See* Kimberly D. Anderson et al., *Is Match Ethics an Oxymoron?*, 177 AM. J. SURGERY 237, 237-39 (Mar. 1999) (reporting the results of a study designed to examine ethical dilemmas faced by students and programs during the Match).

203. *Id.* at 238.

204. *Id.*

205. *Id.* at 239. A survey of 314 senior medical students from three medical schools revealed that 43% of students perceive that programs make "informal" pre-match commitments, 33% feel that programs lie to them, and 21% believe that programs encourage unethical behavior to secure a match. *Id.*; *see* Peter J. Carek et al., *Recruitment Behavior and Program Directors: How Ethical Are Their Perspectives about the Match Process*, 32 FAMILY MED. 258-60 (Apr. 2000) (stating that 94% of family practice program directors surveyed felt the NRMP placed their program in the position of having to be dishonest with applicants in order to match their top choice candidates, thus concluding that the action of many program directors and applicants may not be consistent with the NRMP's written policies); *see also* Peter J. Carek & Kimberly D. Anderson, *Residency Selection Process and the Match: Does Anyone Believe Anybody?*, 285 JAMA 2784, 2784-85 (June 2001) (summarizing various studies regarding NRMP ethical violations and concluding that the NRMP does perpetuate unfairness in the recruiting process despite claims to the contrary).

206. Complaint, *supra* note 5, ¶ 93; *see* Coyle, *supra* note 24 (quoting class counsel Michael Freed of Chicago's Much Shelist Freed Denenberg Ament & Rubenstein, who represent named plaintiff Dr. Paul Jung). Following their first year, residents are paid only slightly more based on their year of seniority. *Id.*

207. Complaint, *supra* note 5, ¶ 95.

208. *Id.*

To demonstrate that resident wages are set below competitive levels, the *Jung* plaintiffs highlight the fact that residents can earn substantially more than their hourly rate by moonlighting, even though many hospitals prohibit this practice.[209] Moreover, resident salaries remain suspiciously uniform nationwide.[210] By contrast, post-residency physicians earn compensation that varies widely depending on geographic location and medical specialty.[211]

Regardless of the Match's debatable advantages and disadvantages, congressional action seems unlikely. First, Congress is historically reluctant to create antitrust exceptions.[212] Second, the NRMP does not resemble other exempt industries. Exempt industries are generally either regulated by other governmental agencies charged with protecting the public interest[213] or are thought to require the special protection that unrestricted unionization provides.[214] No state or federal government agency regulates the NRMP. Further, competition between employers is generally thought to benefit applicants.

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209. *Id.* ¶ 93; *see* Transcript of Motions Hearing (A.M. Session), Jung v. Ass'n of Am. Med. Colls., No. 02-0873 (D.D.C. filed May 7, 2002), at 65 (using moonlighting as an example of wage depression since residents often earn higher salaries moonlighting than they earn in their actual program), *at* http://www.aamc.org/newsroom/jungcomplaint/amtranscript.pdf (last visited Sept. 1, 2003).

210. Complaint, *supra* note 5, ¶ 94; *see* Coyle, *supra* note 24 (quoting plaintiffs' class counsel, Michael Freed, who stated in the interview that salaries don't vary more than $3,000 across the country). One of plaintiffs' claims is that teaching hospitals regularly exchange survey results about resident salaries. AAIM, *supra* note 70. Plaintiffs say the result is a Matching Program that enables employers to obtain residents without engaging in a bidding war, thereby artificially fixing, depressing, standardizing and stabilizing compensation below competitive levels. *Id.* However, the residency programs named as defendants in this case will likely argue that factors such as program prestige, medical specialty and geographic location provide sufficient competition, eliminating a legal need to modify current resident salaries. Complaint, *supra* note 5, ¶ 94.

211. Complaint, *supra* note 5, ¶ 94.

212. *See supra* Part IV.C.2.

213. Insurance companies and stock exchanges are the best examples of industries exempted due to government agency regulation. Under the McCarran-Ferguson Act, 15 U.S.C. § 1011, federal antitrust laws are not applicable to the business of insurance to the extent that it is regulated by state law. In *Gordon v. New York Stock Exchange*, 422 U.S. 659 (1975), the Court held that although the 1934 Securities Exchange Act contains no express exemption from antitrust laws, an exemption was implied because application of antitrust laws to commission rates would "unduly interfere . . . with the operation of the Securities Exchange Act." *Id.* at 685-86. In both industries, exemptions apply because of state government regulation and federal regulation by the Securities and Exchange Commission.

214. Agricultural organizations, for example, are expressly exempted from antitrust laws under the Clayton Act, 15 U.S.C. § 6 (2000), as well as under the Capper-Volstead Act, 7 U.S.C. § 291 (2000), because such organizations are "instituted for purposes of mutual help." 15 U.S.C. § 6 (2000).

C. Reform the Current System: Combine the Free Market Approach and Match Process

Both a free labor market and the maintenance of the status quo leave much to be desired in the context of medical resident placement. Combining elements of both, however, so as to modify rather than eliminate the NRMP, offers the optimal solution to this dilemma.

This Note proposes revising the NRMP to incorporate one of the most important characteristics of a market-based system: freedom of choice. The existing Match framework should be altered to allow applicants to receive *two* possible matches. After receiving up to two choices, students would have a set period of time to make a final, binding decision. During this period of "binding dual matching," students would have the opportunity to choose between the matches but would still be required to accept one of the offers. This relatively small change goes a long way toward creating a system that resembles a free labor market since applicants would be free to choose from one of two competing offers.

By allowing students to entertain two simultaneous offers, the modified NRMP combines the free market system with the existing placement structure to accomplish seven objectives: 1) students gain some degree of bargaining power by virtue of their ability to entertain competing offers; 2) students are better positioned to choose where they will live and work for the next several years; 3) programs continue to use a familiar resident placement process; 4) programs are able to better compete for candidates; 5) programs retain the degree of hiring precision required in an industry dedicated to providing patient care;[215] 6) the NRMP continues to administer an efficient system that requires modification rather than elimination; and 7) the reformed NRMP minimizes alleged restraints on trade by injecting the element of competition into the current placement process.

Allowing students to entertain competing offers helps cure antitrust concerns because programs would finally be forced to offer competitive advantages above and beyond prestige and facilities in order to secure their top candidates. The *Jung* complaint states that the current NRMP "eliminates a free and competitive market . . . [by] assigning resident physicians to a single, specific and mandatory residency position."[216] It further claims that the NRMP has the "effect of depressing, standardizing and stabilizing compensation and other

215. *See supra* Part V.A (noting that the free market leads to unpredictability in staffing); *supra* Part V.B (observing that the Match prevents overbooking).

216. *See generally* Complaint, *supra* note 5, ¶¶ 83-86.

terms of employment."[217] The three alleged anticompetitive restraints include mandatory participation in the Match,[218] lack of individual contract negotiations,[219] and policies that mandate compliance with the restraints.[220] Mandatory participation and compliance practically ensure that there will be no competition between programs with regard to compensation. Thus, infusing competition would likely dispose of these two grievances. In addition, allowing two options decreases the necessity of individual contract negotiations since programs would inevitably be forced to offer competitive salaries and better overall employment terms.

While program prestige is an undoubtedly strong determinant in a candidate's decision to rank a particular program, its importance is likely amplified by the current uniformity in resident compensation. Given a choice between two similarly regarded programs, an applicant is likely to prefer the most prestigious program even if the other offers a slightly higher salary. Under the current placement process, programs remain completely free to capitalize on this reality without the threat of losing a preferred candidate to a higher paying program. However, if a program knows that an applicant is likely to have a competing offer, that program may increase its salary to ensure obtaining its preferred candidates.[221] The possibility of a competing offer thereby compels programs to adopt a free market mentality with regard to compensation. As a result, binding dual matching represents a small yet important step toward allowing a competitive job market to determine the fair market value of resident services.

Although binding dual matching could result in too many or too few incoming residents, the magnitude of this consequence is minimized because applicants would be required to accept one of the matches and would have only two outstanding offers. Hospitals could therefore plan accordingly. Moreover, the slight increase in staffing uncertainty experienced under a revised Match would still be less

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217. *Id.* ¶ 83.

218. *Id.* ¶ 86.1. The NRMP requires that participating programs offer all first-year positions through the Match. Nat'l Resident Matching Program, Save the Match, Basic Rules, *at* http://www.savethematch.org/include/popup.aspx?id=000320873205 (last visited Oct. 24, 2003). Moreover, student participation is effectively mandatory given that the overwhelming majority of programs participate in the Match. *See supra* Part II.B.

219. *Id.* ¶ 86.2.

220. *Id.* ¶ 86.3; *see supra* Part II.B.3 (addressing the consequences of a Match violation).

221. *Contra* Muriel Niederle & Alvin E. Roth, *Relationship Between Wages and Presence of a Match in Medical Fellowships*, 290 JAMA 1153-54 (Sept. 3, 2003) (concluding, after an empirical study, that because fellowship wages are unrelated to the presence of a match, eliminating the resident match would not necessarily increase residents' wages).

than that experienced in a free labor market with an indefinite number of offers.

The proposed modification of the NRMP represents a starting point for reform. As a general matter, a court is much more likely to either preserve or abolish the Match than it is to articulate specific guidelines for reform.[222] Thus, faced with possible liability under its present structure, the NRMP should consider making proactive changes independent of a court order. On its own, a free labor market proved an unworkable system[223] yet the current system faces criticisms that go beyond antitrust legality issues.[224] The unique nature of required postgraduate resident training for an extended period of years warrants an innovative approach to the medical resident job placement process. While the most vigorous reform proponents will likely argue that two matches are still too few, it is important to remember that this proposal represents a compromise rather than a complete victory for either side.

VI. REFORMING THE MATCH HARMONIZES THE COMPETING INTERESTS OF PROGRAMS AND APPLICANTS

The abolition or modification of the NRMP carries the greatest impact for students and programs. Students hope to gain leverage in their employment placement process while hospitals feel pressure to fill spots efficiently, maintain a budget, and still attract the best possible candidates. Reforming the NRMP through binding dual matching offers a satisfactory solution for both parties.

Students gain ultimate decisional power—the fundamental advantage of a free labor market—which fosters competition among programs. Students further benefit by continuing to obtain residency positions through a familiar and efficient placement process that optimizes student preferences.[225] Hospitals also benefit in at least four ways. First, the matching process remains outsourced to the care of the NRMP, saving programs from the burden of internal administration of resident placement.[226] Second, with only two possible matches, programs can anticipate staffing concerns and adjust their preference lists to ensure efficient fulfillment of resident

222. Importantly, a court is not qualified to do so. The matter is beyond judicial competency. *See* 32 AM. JUR. 2D *Federal Courts* § 8 (2003) (outlining the scope of judicial powers and the need to exercise "restraint and discretion in judgments).

223. *See supra* Part II.B.1 (discussing the history of the Match).

224. *See supra* Part V.B (examining some notable downfalls of the NRMP).

225. *See supra* Part V.B.

226. *See supra* Part V.A-B.

slots.[227] Third, programs are better able to attract top candidates by offering more competitive salary packages. Fourth, patient care improves when hospitals have the most talented and qualified residents they can afford.

Finally, Medicare spending on graduate medical education would likely remain constant even if resident salaries increased since the majority of such funding comes from the fixed payment of recipient services.[228] Therefore, remodeling the NRMP to allow students to entertain competing offers benefits each interested party.

VII. CONCLUSION

The *Jung* legal challenge underscores the need to reform the potentially unlawful NRMP. Given that the Match was formed in response to problems associated with placing residents through a free labor market, abandoning the current system in favor of a free market seems an unattractive solution.[229] Additionally, many medical professionals would argue that the NRMP has worked successfully for over fifty years.[230] Indeed, some features of a matching process are well-suited for the unique context of graduate medical education. Precise matching, the efficiency of uniform deadlines, and a centralized structure appear to alleviate chaos in resident placement.[231] Still, a competitive free market offers students undeniable advantages in choosing between offers and bargaining for better employment terms.[232]

227. *Id.*

228. *See supra* Part II.

229. *See supra* Parts II.B, V.A.

230. *See supra* notes 195-200 and accompanying text.

231. *See supra* Part V.B.

232. *See supra* Part V.A.

A compromise between a free labor market and the current matching process offers a communally beneficial framework for reform. Revising the Match to include fundamental free market choice furthers the interests of residents, programs, and the government while protecting the legality of the medical resident placement process. Accordingly, the NRMP should proactively seek ways, like binding dual matching, to introduce vital competition into the presently stagnated system.

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