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# A MATCH MADE IN ANTITRUST HEAVEN? A LIBERALISTIC EXPLORATION OF THE MEDICAL MATCH'S ANTITRUST EXEMPTION

MELISSA MAYEUX\*

## ABSTRACT

*In the 2004 case Jung v. Association of American Medical Colleges, a group of resident physicians brought a class action suit challenging the legality of the National Residency Matching Program, a system that controls essentially all appointments to medical residency programs. The plaintiffs claimed the Match artificially depressed wages and created an anticompetitive labor market. The lawsuit was met with a swift end by the codification of an antitrust exemption to the Match. Although the Jung case is over, medical residents continue to face unreasonable restraints on their liberty. This note begins with an overview of medical education and the residency match process and details the Jung litigation and resulting antitrust exemption. Then, the focus shifts to a philosophical exploration of classic ideas of liberty and how the Match contradicts theories of classical liberalism and economics. Finally, the note concludes with proposed alternatives and modifications that can be implemented to improve the Match process and working conditions of medical residents.*

## INTRODUCTION

After completing four years of medical school, newly graduated physicians must undergo additional training by completing a residency program.<sup>1</sup> Residency programs can last between three and seven years, depending on the medical specialty.<sup>2</sup> Successful completion of a residency program and passage of all associated board exams are prerequisites to becoming a licensed physician in the United States.<sup>3</sup> The recruitment and hiring process for first year residents is unlike traditional labor markets. There is no negotiation or bargaining aspect because a tightly regulated

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1. See, e.g., Kristin Madison, *The Residency Match: Competitive Restraints in an Imperfect World*, 42 HOUS. L. REV. 759, 767–68 (2005).

2. See, e.g., *Length of Residencies*, WASH. UNIV. SCH. MED., <https://residency.wustl.edu/residencies/length-of-residencies/> [<https://perma.cc/REF2-F5EX>].

3. See Madison, *supra* note 1, at 767–68.

system known as the National Residency Matching Program, or “the Match,” controls essentially all appointments to residency programs.<sup>4</sup>

The Match was implemented in 1952 to streamline the hiring process, which had become progressively more chaotic throughout the early 1900s.<sup>5</sup> Because hospitals wanted to avoid the risk of not meeting future staffing demands and wanted to secure the most competitive applicants, medical students were being pressured to accept job offers at earlier and earlier points in their education.<sup>6</sup> Binding contracts were often entered into before either party had enough knowledge to make an educated decision.<sup>7</sup> The Match offered the convenient solution of a centralized matchmaking service capable of determining the best match between employer and employee based on preferential rankings provided by both parties.<sup>8</sup>

Though successful at streamlining the process, the Match has serious drawbacks. Except in very rare circumstances, participation in the system is mandatory.<sup>9</sup> Both hospitals wishing to hire new residents and new residents wishing to be hired are obligated to participate in the Match in order to maintain accreditation within the United States.<sup>10</sup> Participation in the program creates an irrevocable, binding commitment for both parties.<sup>11</sup> There can be no outside negotiation between the parties and all matches produced by the computerized algorithm are final.<sup>12</sup> The Match has stripped medical residents of any semblance of bargaining power and has thus artificially depressed wages and created an environment that fosters harsh, oftentimes unsafe, working conditions.<sup>13</sup>

A group of resident physicians challenged the legality of the match in the 2004 case, *Jung v. Association of American Medical Colleges*.<sup>14</sup> The suit, filed on behalf of all resident physicians and directed at a number of

4. *Id.* at 768–69.

5. *See, e.g.*, Alvin E. Roth, *The Origins, History, and Design of the Resident Match*, 289 JAMA 909 (2003) [hereinafter *Origins*].

6. *Id.* at 909.

7. *Id.* at 910.

8. *Id.* at 910–11.

9. *See, e.g.*, Frances H. Miller & Thomas L. Greaney, *The National Resident Matching Program and Antitrust Law*, 289 JAMA 913 (2003).

10. *Id.* at 914.

11. Robert N. Wilkey, *The Non-Negotiable Employment Contract—Diagnosing the Employment Rights of Medical Residents*, 44 CREIGHTON L. REV. 705, 715–16 (2011).

12. *Id.*

13. *See, e.g.*, Laura K. Barger, Najib T. Ayas, Brian E. Cade, John W. Cronin, Bernard Rosner, Frank E. Speizer & Charles A. Czeisler, *Impact of Extended-Duration Shifts on Medical Errors, Adverse Events, and Attentional Failures*, PLOS MED. (Dec. 12, 2006), <https://doi.org/10.1371/journal.pmed.0030487> [<https://perma.cc/PYC3-F58F>].

14. 339 F. Supp. 2d 26 (D.D.C. 2004).

named teaching hospitals and medical organizations,<sup>15</sup> alleged collusion among the defendants to artificially depress wages and create an anticompetitive market in violation of federal antitrust laws. The lawsuit, despite its merit and early success in court, met a swift end in 2004 when the Pension Funding Equity Act of 2004 was signed into federal law. Within the act is a provision entitled “Confirmation of Antitrust Status of Graduate Medical Resident Matching Programs” that codifies an antitrust law exemption to the Match.<sup>16</sup> The provision, which is unrelated to the titled purpose of The Act, was undoubtedly a pork-barrel insertion resulting from heavy special interest lobbying on the behalf of defendant medical organizations and associated groups.<sup>17</sup> The provision was never publicly debated before signing and, other than the text of the code itself, has never been justified or explained by Congress.<sup>18</sup>

Though there have been a handful of news stories and journal articles published criticizing the Match since the *Jung* case, the federal government’s official endorsement of the Match’s antitrust exemption has practically ended all organized criticism of the system. After the dismissal of the *Jung* case at the district court level, the plaintiffs petitioned the Supreme Court for review but were denied.<sup>19</sup> The *Jung* case might be over but medical residents continue to face an unreasonable restraint on their liberty.

Part I of this paper will provide an overview of the medical education process. This information is vital to understand the harsh reality faced by both medical students and residents and will serve as a foundation for understanding the weight of their sacrifice of liberty. Part I will also provide a simplified introduction of the Match and discuss the emotional, psychological, and economical ramifications of the system. Part II details the *Jung* litigation, including the exact nature of the complaint and the ultimate passage of the antitrust exemption. In Part III the focus shifts to a philosophical exploration of classic ideas of liberty and explores how the

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15. Named defendants included the Association of American Medical Colleges (“AAMC”), the National Resident Matching Program (“NRMP”), the American Medical Association (“AMA”), the Accreditation Council for Graduate Medical Education (“ACGME”), and numerous teaching hospitals such as Barnes-Jewish Hospital, Cedars-Sinai Medical Center, and Yale-New Haven Hospital. Complaint, *Jung v. Ass’n of Am. Med. Colls.*, 339 F. Supp. 2d 26 (D.D.C. 2004) (No. CIV.A.02–0873 PLF).

16. Pension Funding Equity Act of 2004, Pub. L. No. 108-218, § 207, 118 Stat. 596 (codified at 15 U.S.C. § 37b).

17. Sarah L. Geiger, *The Ailing Labor Rights of Medical Residents: Curable Ill or a Lost Cause?*, 8 U. PA. J. LAB. & EMP. L. 523, 535 (2006).

18. Madison, *supra* note 1, at 762–63.

19. *Jung v. Ass’n of Am. Med. Colls.*, 549 U.S. 1156 (2007) (denying Plaintiff’s request for a writ of certiorari).

Match contradicts theories of classical liberalism and economics. Part IV explores more specifically how antitrust exemptions interfere with liberty and threaten a free society. Finally, Part V proposes alternatives and modifications that could be implemented to improve the Match system.

## I. OVERVIEW OF THE MEDICAL MATCH AND RESIDENT LIFE

Doctors are not made overnight. The process is long, arduous, and expensive. Aspiring physicians must first complete a four-year undergraduate degree and take all courses required for medical school admission (generally a minimum of one year of biology, two years of chemistry, and one year of English, though specific requirements vary based on the institution).<sup>20</sup> A showing of academic success is not enough to obtain admission to medical school; competitive applicants will have volunteer hours, physician shadowing experience, leadership positions, extracurricular activities, and a high score on the Medical College Admission Test (“MCAT”).<sup>21</sup> Once admitted, the new medical student faces another four years of intensive education, fraught with more highly competitive battles.<sup>22</sup> Early in the fourth year of medical school, students enroll in the National Residency Matching Program (“the Match”), which matches students to residency programs across the country.<sup>23</sup>

### A. The Match Process

Upon graduation from medical school, all students must complete a medical residency program to become a licensed physician. Since 1952, a system affectionately known as “the Match” has controlled appointment to

20. *Admission Requirements*, ASS’N AM. MED. COLLS., <https://students-residents.aamc.org/applying-medical-school/applying-medical-school-process/medical-school-admission-requirements/admission-requirements/> [<https://perma.cc/7ZB7-RHRC>].

21. *Id.*

22. For an eye-opening look into the human experience (and sometimes tragedy) of medical education, see David Muller, *Kathryn*, 376 NEW ENG. J. MED. 1101, 1102 (2017):

Every time students achieve what looks to the rest of us like a successful milestone—getting into a great college, the medical school of their choice, a residency in a competitive clinical specialty—it is to some of them the opening of another door to a haunted house, behind which lie demons, suffocating uncertainty, and unimaginable challenges. Students bravely meet these challenges head-on while we continue to blindly ratchet up our expectations.

From their very first shadowing experience to their first foray in the lab; from high school advanced-placement courses and college admissions tests to grade point averages and the Medical College Admissions Test (MCAT); with helicopter parents, peer pressure, violins and varsity soccer, college rankings, medical school rankings, medical licensing exams, and the residency Match, we never let up on them—and it’s killing them.

23. *Intro to Main Residency Match*, NAT’L RESIDENT MATCHING PROGRAM, <http://www.nrmp.org/intro-to-main-residency-match/> [<https://perma.cc/5MPL-QJL7>].

these programs.<sup>24</sup> The now computer-controlled algorithm was implemented to help alleviate the chaos and simplify the hiring process of the graduating medical students that enter the workforce each year.<sup>25</sup>

Indeed, some kind of uniform system was needed; the resident job market prior to 1952 lacked organization and often resulted in less-than-favorable employment outcomes.<sup>26</sup> The demand for new doctors grew throughout the early 1900's and hospitals scrambled to secure the most competitive medical students for their programs. To maintain an edge, hospitals were forced to begin choosing their future physicians earlier and earlier in the education process—often as early as the beginning of the student's junior year of medical school.<sup>27</sup> “This was regarded as costly and inefficient both by the hospitals, who had to appoint interns without knowing their final grades or class standings, and by the students . . . who found that much of the senior year was disrupted by the process . . . .”<sup>28</sup> Earlier hiring also meant that medical students were pressured into accepting offers before they were sufficiently informed of all of their employment options.<sup>29</sup> By 1945, the problem had reached a peak<sup>30</sup> and institutions decided to set and enforce a uniform date before which no appointments could take place.<sup>31</sup> This strategy seemed helpful for a while, but within several years residency programs again began pressuring students to make hasty decisions by calling students directly and requiring them to either accept or reject an employment offer before the phone call ended.<sup>32</sup> Finally, in 1952, with input from medical school deans and students, the Association of American Medical Colleges (“AAMC”) formulated and implemented the first version of the centralized matching system still used today.<sup>33</sup>

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24. See Roth, *Origins*, *supra* note 5, at 909.

25. *Id.*

26. *Id.*

27. Alvin E. Roth, *The Evolution of the Labor Market for Medical Interns and Residents: A Case Study in Game Theory*, 92 J. POL. ECON. 991, 993 (1984) [hereinafter *Evolution*].

28. *Id.* at 993.

29. “The chief symptom that something was amiss in the early market for interns was that hospitals began to try to hire interns earlier than their competitors, so medical students often could only consider offers from one hospital at a time, without knowing their prospects at other hospitals.” Roth, *Origins*, *supra* note 5, at 909.

30. In 1944, a program director wrote to the Association of American Medical Colleges expressing his concern that sophomore medical students were contacting him with employment enquiries—a full two years before their employment would even begin. Roth, *Evolution*, *supra* note 27, at 994.

31. Roth, *Origins*, *supra* note 5, at 909.

32. *Id.* at 910. Needless to say, students resented this practice; oftentimes, students would panic on the phone and accept the offer out of sheer nervousness. *Id.*

33. *Id.* Over the years, the Match has been occasionally modified to reflect the improvements in technology and the changing demands in medicine. For example, today the Match is entirely

The Match system is designed to take into account the preferences of both applicants and hiring institutions.<sup>34</sup> In simple terms, applicants rank their preferred institutions, the institutions rank their preferred applicants, and the algorithm determines the highest common ranking match between the two.<sup>35</sup> In theory, the Match will result in the pairing of the most appropriate applicant with the most appropriate institution. At noon on the third Friday in March, fourth year medical students will open a letter with trembling hands and learn not only where they will be working for the next four years, but also what specialty of medicine they will spend their life pursuing.<sup>36</sup> About half of applicants will be placed in their top choice; the other half will inevitably experience some degree of disappointment.<sup>37</sup>

The system succeeds at fulfilling its 1952 vision of streamlining the resident hiring process, but the costs that come with this success are high, even for those applicants that are fortunate enough to be placed in their first choice program. For all practical purposes, participation in the Match is mandatory for all domestic medical students who wish to become a licensed physician in the United States.<sup>38</sup> Once enrolled in the program, participants are explicitly barred from agreeing on any employment terms during the interview and ranking process.<sup>39</sup> Participants are forbidden from even asking one another about how they plan to rank their choices.<sup>40</sup> One critic notes, “the mere registration of a medical student into the NRMP matching process inevitably invokes unequal bargaining and negotiating power with respect to the terms, conditions, and nature of the resident’s anticipated . . . program and hospital employment.”<sup>41</sup> Furthermore, both applicants and

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computerized. Also, the modern Match allows for couples that seek to be matched in the same geographic area to be ranked together. *Id.* at 911.

34. *Id.* at 910.

35. *Id.* The algorithm does not penalize students for ranking institutions they are unlikely to be matched with (i.e. students should rank according to their actual preference, not according to how they think institutions will rank them). *Id.* at 911.

36. *Match Week & SOAP for Applicants*, NAT’L RESIDENT MATCHING PROGRAM, <http://www.nrmp.org/match-week-soap-applicants/> [<https://perma.cc/KZ54-S8U6>].

37. Brendan Murphy, *If You’re Feeling Disappointed on Match Day, You Are Not Alone*, AM. MED. ASS’N (Mar. 15, 2019), <https://www.ama-assn.org/residents-students/match/if-you-re-feeling-disappointed-match-day-you-are-not-alone> [<https://perma.cc/3APU-SE32>]. “If something feels off or feels wrong, it’s really common, a lot of unexpected things can happen and no one really has control over the algorithm,” said AMA Member Laura Halpin, MD. “The disappointment is a real challenge because most people find out about their match in a formal ceremony and the room is full of people screaming with excitement. It’s easy to feel you failed or did something wrong if you don’t get your top choice.” *Id.*

38. Frances H. Miller & Thomas L. Greaney, *The National Resident Matching Program and Antitrust Law*, 289 JAMA 913, 914 (2003).

39. *Id.*

40. See *infra* quote accompanying note 44.

41. Wilkey, *supra* note 11, at 715.

hiring institutions are *irrevocably bound* to whatever match the algorithm produces.<sup>42</sup>

Once a match is made, there is no flexibility—neither the hiring program nor the applicant can release the other from the match commitment.<sup>43</sup> Violations are reported to the applicant’s medical school and the state medical boards and can result in the applicant’s expulsion from medical school or a three-year (sometimes permanent) ban from participating in the Match.<sup>44</sup> Additionally, after successfully matching, applicants are not allowed to discuss or enter into any employment contract outside of the Match with their matched institution or any other institution.<sup>45</sup>

In summary, to become a physician in the United States, students must complete a residency program after graduation from medical school. To complete a residency program, students must enroll in the Match. Enrolling in the Match bars the student from engaging in any negotiation with prospective employers. Students are contractually bound to whatever match the algorithm produces. That means the student *must* begin their matched residency program, even if that program is their last choice, not in their preferred specialty, or across the country from where they would like to be

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42. Miller, *supra* note 38, at 914.

43. Wilkey, *supra* note 11, at 716 (“Once a medical student accepts a match, the student is contractually obligated to the terms of the program contract, including a start date.”).

44. Gregory Dolin, *Time to Enter a “Do Not Resuscitate” Order on the National Resident Matching Program’s Chart*, 8 QUINNIPIAC HEALTH L.J. 59, 66–67 (2004) (“Given the fact that participation in the Match is almost obligatory if one is serious about securing a residency, a bar on the participation can potentially bar an individual from becoming a licensed physician for up to three years.”). Furthermore, “violations” has a broad meaning:

Under the NRMP rules, not only are the programs and applicants forbidden from signing a contract prior to the Match, but they are also forbidden from enticing each other into ranking them higher on the rank order list. The programs and applicants are forbidden from even asking one another about how they plan to rank each other. Thus, an applicant is essentially prevented from bargaining with the program for employment conditions prior to the release of the Match results.

*Id.*

45. Miller, *supra* note 38, at 914. Not matching into a program at all is rare, but it happens about 5% of the time. Murphy, *supra* note 37. For these students, the next step is to enter into the Supplemental Offer and Acceptance Program (“SOAP” also colloquially, “the scramble”). *Id.* Students enrolled in SOAP apply for and are offered positions that remain unfilled after the Match. *Id.* Even then, some students are unsuccessful at finding a job through the SOAP process as well. These students are not allowed to care for patients and have no choice but to sit out a year, strengthen their application with additional degrees, clinical observerships, or research positions (often unpaid), and then reapply for the Match the following year. Timothy M. Smith, *What If You Don’t Match? 3 Things You Should Do*, AM. MED. ASS’N (Mar. 7, 2019), <https://www.ama-assn.org/residents-students/match/what-if-you-don-t-match-3-things-you-should-do> [<https://perma.cc/Y5J6-6GP4>]. Students in this position are expected to begin repaying their student loans unless they are eligible for deferment or forbearance. *If You Don’t Match: Steps to Manage Student Loans*, ASS’N AM. MED. COLLS., <https://students-residents.aamc.org/applying-residency/article/if-you-dont-match-steps-manage-student-loans/> [<https://perma.cc/WG4J-2RLH>].



located. A waiver will be granted only on very rare occasions if the match would cause “serious and extreme hardship” to the student.<sup>46</sup>

### *B. Realities of Residency and Why Bargaining Matters*

Once the thrill and excitement of the Match is over, first-year doctors must face the reality of their new positions. For the vast majority of these new doctors, medical residency will involve extremely long hours and low wages.<sup>47</sup>

The Accreditation Council for Graduate Medical Education (“ACGME”) limits residents to working eighty hours per week (averaged over four weeks).<sup>48</sup> In addition, the ACGME caps shift lengths at twenty-four hours, with up to four additional hours allowed for patient care transition and resident education.<sup>49</sup> On average, these twenty-eight hour work “days” are required about four times a month.<sup>50</sup> These standards seem brutal enough, but to make it worse, almost half of all residents report working more than allowed by the ACGME and falsifying duty hour reports.<sup>51</sup>

The inevitable sleep deprivation resulting from such long work hours has a significant impact on the health of residents and the medical outcomes of their patients.<sup>52</sup> Studies have shown that being awake for eighteen to twenty

46. See Wilkey, *supra* note 11, at 716 n.61.

47. See, e.g., Ryan Park, *Why So Many Young Doctors Work Such Awful Hours*, ATLANTIC (Feb. 21, 2017), <https://www.theatlantic.com/business/archive/2017/02/doctors-long-hours-schedules/516639/> [<https://perma.cc/A4ZB-F9E4>]. Many residents also struggle with mental health issues—28.8% of medical residents will struggle with depression or depressive symptoms, a rate nearly five times higher than the general population. Douglas A. Mata, Marco A. Ramos, Narinder Bansal, Rida Khan, Constance Guille, Emanuele Di Angelantonio & Srijan Sen, *Prevalence of Depression and Depressive Symptoms Among Resident Physicians*, 314 JAMA 2373, 2381 (2015).

48. ACGME Common Program Requirements (Residency), 2018 ACCREDITATION COUNCIL FOR GRADUATE MED. ED. 45, <https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRResidency2019.pdf> [<https://perma.cc/892Z-HPPH>].

49. *Id.* at 48–49.

50. Park, *supra* note 47.

51. Brian C. Drolet, Matthew Schwede, Kenneth D. Bishop & Staci A. Fischer, *Compliance and Falsification of Duty Hours: Reports from Residents and Program Directors*, J. GRADUATE MED. ED. 368, 371 (2013). Furthermore, a 2006 study found:

[83.6%] of interns reported work hours in violation of the standards during 1 or more months. Working shifts greater than 30 consecutive hours was reported by 67.4% . . . Averaged over 4 weeks, 43.0% . . . reported working more than 80 hours weekly, and 43.7% . . . reported not having 1 day in 7 off work duties.

Christopher P. Landrigan, Laura K. Barger, Brian E. Cade, Najib T. Ayas & Charles A. Czeisler, *Interns’ Compliance with Accreditation Council for Graduate Medical Education Work-Hour Limits*, 296 JAMA 1063, 1063 (2006).

52. See, e.g., Lindsay Kalter, *Residents are Sleep Deprived. So What’s New?*, ASS’N AM. MED. COLLS. (Apr. 18, 2019), <https://www.aamc.org/news-insights/residents-are-sleep-deprived-so-what-s->

hours leads to a “cognitive and motor skill impairment equivalent to being drunk.”<sup>53</sup> Despite this, shifts often require residents to be awake and making critical patient care decisions for even longer.<sup>54</sup> A 2006 study exploring the relationship between extended shifts and adverse patient outcomes found that “serious medical errors” occurred 36% more frequently when residents worked extended shifts.<sup>55</sup>

Residents are not particularly well compensated for their efforts, either. In 2019, the median salary for a first year resident was \$56,912.<sup>56</sup> Adjusted for inflation, this figure has remained substantially unchanged for five decades, and is actually decreased from the median salary in 1972.<sup>57</sup> Compensation varies little between geographic regions; residents in the Northeast are paid about the same as residents in the Midwest, despite having generally higher costs of living.<sup>58</sup> Similarly, virtually all institutions pay residents the same starting salary, regardless of their specialty.<sup>59</sup> Thus, hypothetically, a surgery resident working an average of eighty or more hours per week<sup>60</sup> will earn the same salary as a family medicine resident who works a more “normal” fifty to sixty hours per week.

In a traditional labor market, work hours and wages can be negotiated. But, the Match, attempting to “[create] order out of the chaos of a free labor market also contributes to industry norms of punishing hours and low pay, by restricting competition among employers that could result in better wages and working conditions.”<sup>61</sup> The strict requirements of the Match essentially prevent bargaining.

new [<https://perma.cc/7ZB7-RHRC>]. Sleep deprivation leads to depression, social isolation, and weight gain. *Id.*

53. *Id.* See also Barger, *supra* note 13 (“[T]he adverse effects after 24 h of continuous wakefulness on neurobehavioral performance are comparable to that of a blood alcohol concentration of 0.10%.”).

54. Barger, *supra* note 13.

55. *Id.* (reporting that studies showed the scheduling of 24 hour or greater work shifts poses significant increased safety hazards to patients, contributes to preventable fatal and nonfatal adverse events, and interferes with resident education).

56. ASS’N AM. MED. COLLS., SURVEY OF RESIDENT/FELLOW STIPENDS AND BENEFITS REPORT 5 (2019), <https://www.aamc.org/system/files/2019-11/Survey%20of%20Resident%20Fellow%20Stipends%20and%20Benefits%20Report%202019-2020.pdf> [<https://perma.cc/LRA5-FSTE>].

57. The mean inflation-adjusted salary was \$8,070 in 1972 compared to \$7,749 in 2019. *Id.* at 7.

58. Weighted mean salary for first year residents in 2019 was \$61,549 in the Northeast, compared to \$56,987 in the Midwest. *Id.* at 9.

59. 98.7% of responding institutions reported that salaries are the same across all specialties. *Id.* at 15.

60. Interestingly, surgical residents are the most likely to falsify their duty-hour reports (62.1%). Drolet, *supra* note 51, at 370 fig.1.

61. Park, *supra* note 47.

The implication of the match's restrictions and the participants' behavior is that there is little foundation for negotiation with individual candidates. . . . [A]pplicants do not have the extra leverage that they would have in a conventional labor market characterized by unfettered, individualized competition among both future employers and future employees.<sup>62</sup>

The Match creates a binding agreement between the resident and the employing institution.<sup>63</sup> Furthermore, residents cannot hold multiple offers that could otherwise be used as leverage for better hours or wages.<sup>64</sup>

## II. LEGAL CHALLENGES TO THE MATCH

There is very little case law concerning issues related to medical resident employment.<sup>65</sup> When such cases have been heard, generally “courts have not necessarily furthered or enhanced the employment rights of medical residents, rather courts have adversely affected, limited, and potentially hindered such rights.”<sup>66</sup> Although courts have occasionally been required to consider cases related to resident discrimination, termination, and unemployment compensation,<sup>67</sup> there is only one notable case, *Jung v. Association of American Medical Colleges*,<sup>68</sup> that challenged the Match process itself.

### A. *The Jung Case and Resulting Antitrust Exemption*

In 2002, three resident physicians filed a complaint on behalf of all resident physicians under the federal antitrust laws against the Association of American Medical Colleges (“AAMC”), the National Resident Matching Program (“NRMP”), the American Medical Association (“AMA”), the Accreditation Council for Graduate Medical Education (“ACGME”), and a number of other medical organizations and individually named teaching hospitals.<sup>69</sup> Plaintiffs alleged:

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62. Madison, *supra* note 1, at 775–76.

63. See *supra* text accompanying note 42.

64. Dolin, *supra* note 44, at 71 (“[A] given applicant does not know how many programs are actually willing to extend an offer to him, therefore, he is in no position to leverage his marketability.”).

65. Wilkey, *supra* note 11, at 731.

66. *Id.*

67. See Wilkey, *supra* note 11, at 731–43 (summarizing case law concerning medical resident employment issues).

68. 300 F. Supp. 2d 119 (D.D.C. 2004).

69. Complaint, *Jung v. Ass’n of Am. Med. Colls.*, 339 F. Supp. 2d 26 (D.D.C. 2004) (No. CIV.A.02–0873 PLF).

Defendants and others . . . illegally contracted, combined, and conspired among themselves to displace competition in the recruitment, hiring, employment and compensation of resident physicians, and [imposed] a scheme of restraints which have the purpose and effect of fixing, artificially depressing, standardizing, and stabilizing resident physician compensation and other terms of employment.<sup>70</sup>

Plaintiffs argued that Defendants restrained competition by stabilizing wages below competitive levels, placing residents in programs only through the Match process, and establishing anticompetitive accreditation standards.<sup>71</sup> According to the Plaintiffs, these practices caused significant harm to resident physicians by artificially establishing wages far below what would result under normal market conditions.<sup>72</sup>

In their complaint, Plaintiffs claimed that the Match replaces a free market system with a “centralized, anticompetitive allocation system [that assigns] prospective resident physicians . . . to a single, specific and mandatory residency position.”<sup>73</sup> This centralized system acts as a substitute to (and, in fact, prohibits) any external employment negotiations that could allow applicants to bargain for increased wages or more desirable working conditions.<sup>74</sup> The Plaintiffs further contend that the problem is made worse because the ACGME, the organization responsible for granting institutions with accreditation, has the authority to regulate the number of residency positions offered by institutions, thereby placing an external limitation on the resident job market.<sup>75</sup>

In light of the analysis of Part I of this paper, the Plaintiffs’ claims that there is a “collusion” of sorts between the reigning medical agencies to suppress wages does not seem farfetched. Residents provide hospitals with high-skilled, cheap labor. “[Residents] are paid a fixed, modest salary that, on an hourly basis, is on par with that paid to hospital cleaning staff—and even, on an absolute basis, about half of what nurse practitioners typically earn, while working more than twice as many hours.”<sup>76</sup> In an academic hospital, patients receive the majority of their care from medical residents.<sup>77</sup>

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70. *Id.* ¶ 2.

71. *Id.* ¶ 3.

72. *Id.* ¶ 72.

73. *Id.* ¶ 83.

74. *Id.* ¶ 86, a-c.

75. Complaint ¶ 88, a-d.

76. Park, *supra* note 47.

77. Geiger, *supra* note 17, at 523 (“Patients of academic hospitals receive most of their direct care from medical interns, residents, and fellows who are one, two, three, or more years out of medical

This labor is valued at approximately \$1.6 billion dollars annually, yet hospitals get it for far less.<sup>78</sup>

In February of 2004, the court issued an order addressing certain defendants' motions to dismiss for various reasons but allowed the suit to proceed for several of the defendants.<sup>79</sup> However, shortly thereafter, on April 10, 2004, President George W. Bush signed into law the Pension Funding Equity Act of 2004, which contains a provision entitled "Confirmation of Antitrust Status of Graduate Medical Resident Matching Programs."<sup>80</sup> This provision, codified at 15 U.S.C. § 37b states that:

It shall not be unlawful under the antitrust laws to sponsor, conduct, or participate in a graduate medical education residency matching program . . . . Evidence of any of the conduct described in the preceding sentence shall not be admissible in Federal court to support any claim or action alleging a violation of the antitrust laws.<sup>81</sup>

This official confirmation of the antitrust status of the Match resulted in a swift end to the *Jung* case. In August of 2004, the district court granted the remaining defendants' motion for judgment on the pleadings and dismissed the case.<sup>82</sup> All subsequent attempts by the plaintiffs to appeal the decision were denied.<sup>83</sup>

### *B. Congressional Justification of the Exemption*

Neither the House nor the Senate held public debates about the exemption prior to the bill being signed into law.<sup>84</sup> One critic writes, "The legislation thus formed a prime example of pork barrel legislation tacked onto a bill which was intended to update interest rates for the purposes of reducing employer contributions to pension funds. As the bill went into

school. . . . [R]esidents are offered virtually no labor law protection by virtue of their position as employees of hospitals.").

78. Wilkey, *supra* note 11, at 713. Replacing a surgical resident with another physician would cost a hospital approximately \$215,000 to \$315,000. See *infra* quote accompanying note 89.

79. 300 F. Supp. 2d at 174.

80. Pension Funding Equity Act of 2004, Pub. L. No. 108-218, § 207, 118 Stat. 596 (codified at 15 U.S.C. § 37b).

81. 15 U.S.C. § 37b(b)(2).

82. 339 F. Supp. 2d at 26.

83. See *Jung v. Ass'n of Am. Med. Colls.*, 184 F. App'x 9 (D.C. Cir. 2006), *cert. denied*, 127 S. Ct. 1041 (2007).

84. See, e.g., Madison, *supra* note 1, at 762-63 ("Congress made no attempt to resolve this question publicly when in 2004 it created an antitrust exemption for the residency match. . . . [The Act] passed both the House and Senate with no mention of any residency-related antitrust exemption. It was not until the final bill emerged that . . . [the residency exemption] first appeared.").

conference meetings, the [anti-trust status] rider did not exist.”<sup>85</sup> Several senators had strong responses to the covert addition of the exemption provision.<sup>86</sup> Wisconsin Senator Herb Kohl was particularly worried (and rightly so) that the exemption would cut short the *Jung* litigation:

The exemption will end many of the claims in an ongoing lawsuit brought by a number of medical students and residents that has already survived efforts to have it dismissed. The students contend that through the matching program, the hospitals depress wages and cause residents to work inordinately long hours to the detriment of patient care. This exemption appears to eliminate all of the students’ claims with the exception of their allegation of price fixing.

....

In general it is bad policy to provide exemptions to the antitrust laws. It is certainly unusual to enact an exemption that ends part or all of an ongoing lawsuit. We should have had the opportunity to debate this issue and determine whether there was any merit to the exemption, rather than see the exemption mysteriously appear on an unrelated bill. It appears that this provision, enacted in this way, is nothing more than a giveaway to one particular special interest.<sup>87</sup>

New Mexico Senator Jeff Bingaman joined the criticism and was additionally concerned with the effect the exemption would have on the constitutional rights of medical residents:

Section 207 of the conference report creates an antitrust exemption for the graduate medical residency program that currently assigns medical students to hospitals where they are required to work for 60 to 100 hours per week for an average of \$9 or \$10 an hour. To people who are not familiar with the way this place functions in recent years, they would be surprised to find that we have written into the pension bill a retroactive exemption from the antitrust laws related to this issue of medical residency programs. . . .

[T]he antitrust exemption that is established by subsection (b)(2) raises grave constitutional concerns. There has been no justification

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85. Geiger, *supra* note 17, at 535.

86. 150 CONG. REC. S3981 (daily ed. Apr. 8, 2004) (statement of Sen. Feingold) (“For the managers of this bill to insert a controversial provision with no Senate debate or discussion is the worst way to legislate, particularly in the complicated area of antitrust law.”).

87. 150 CONG. REC. S3979 (daily ed. Apr. 8, 2004).

presented to this Congress, to any committee of this Congress for depriving medical residents of the same protections under the antitrust laws that are enjoyed by other workers and other Americans. I do not see how it is constitutionally permissible to take away the equal protection and the due process rights of medical residents without any showing that is necessary or beneficial.<sup>88</sup>

The sly signing of the exemption into law was undeniably due to intense lobbying efforts by the AMA and AAMC, both named defendants in the *Jung* lawsuit, who had a strong interest in preventing the litigation from proceeding:

Coincidentally, the AAMC, named as one of the defendants in the *Jung* suit, stepped up its lobbying efforts after *Jung* filed suit and expressed uncompromising support for the above amendment. Allowing the unraveling of the match would greatly diminish the AAMC's power over post-graduate medical training . . . . Offering more labor rights to medical residents would cost academic hospitals inordinate amounts of money. The cost of replacing one surgical resident with a “physician extender,” or other physician, is \$210,000 to \$315,000 a year.<sup>89</sup>

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88. 150 CONG. REC. S3991–92 (daily ed. Apr. 8, 2004). Senator Bingaman’s statement also included the transcript of a letter he and Senators Craig, Feingold, and Kohl sent to the Majority Leader expressing their concerns. The body of the letter will also be reproduced here, as it is highly relevant to the issues explored in this note:

GENTLEMAN: We are writing to express our concern about legislative proposals that have the potential to undermine ongoing antitrust litigation against the National Resident Match Program (known as the “Match”) by granting the “Match” a retroactive antitrust exemption.

It is our view that Congress should subject proposals like this one that hold widespread implications for patient safety and the working conditions of hundreds of thousands of medical residents to the regular legislative process—including hearings and consideration in the appropriate committees—before allowing it to move through Congress. This is particularly important considering that such proposals would retroactively interfere with pending litigation, in which the factual record has not yet been developed and the court has not yet ruled on the merits of the claims. In addition, it is important for the Committee to consider the specific language of any such proposal, as legislation intending to exempt the Match could have broader, unintended effects, including effectively immunizing price-fixing and other anticompetitive practices alleged in the litigation.

By permitting such a bill to go forward without full consideration of all the factual and legal issues, we would set a precedent that will encourage defendants in all types of pending litigation to come to Congress for relief.

*Id.* at S3992.

89. Geiger, *supra* note 17, at 537–38.

Congress has never clearly articulated the justification for the exemption in the sixteen years since its passage.<sup>90</sup> The only semblance of an explanation is found in the text of § 37b itself, which touts the effectiveness of the Match in streamlining the hiring process and credits it with producing “the finest physicians and medical researchers in the world.”<sup>91</sup> Notably, Congress also claims in § 37b that the process is “pro-competitive.”<sup>92</sup> In saying this, “it seems that Congress made an independent finding that the match does not violate the Sherman laws, but it [provides] no data to support this finding.”<sup>93</sup>

### *C. The Medical Labor Market Monopsony*

As discussed in Part I of this paper, the centralized Match system replaced an open market hiring process for first year medical residents in the 1950s.<sup>94</sup> In the years since, economist Alvin E. Roth has made significant contributions and improvements to the matching algorithm.<sup>95</sup> Roth attributed the chaos of the pre-Match hiring process to an “unraveling” of the medical labor market that forced both students and employers to seek out employment contracts earlier and earlier in the medical education process before either side had enough information to make the best

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90. “It is unclear whether Congress’ main motivation for its passage was a perceived effect on medical education or another reason.” *Id.*

91. 15 U.S.C. § 37b.

92. *Id.*

93. Geiger, *supra* note 17, at 538.

94. See George L. Priest, *Timing “Disturbances” in Labor Market Contracting: Roth’s Findings and the Effects of Labor Market Monopsony*, 28 J. LAB. ECON. 447, 449 (2010).

95. *Id.* Roth was heavily involved with developing the modern match algorithm:

[Roth’s] concept of optimal match consists of an optimal ordinal match of preferences as between workers and firms. An ordinal match is one in which a worker is matched with its first-choice employer where that worker was the first choice of the employer; subsequently, second choices are matched with second choices (because their respective first choices were otherwise matched with first-choice matches), and so on. Given this formulation of the model, it is obvious why Roth and the Roth tradition so strongly advocate the introduction of a centralized matching mechanism, such as the medical residency match, since ordinal matching is exactly what that mechanism can accomplish.

*Id.* Roth has also developed matching systems for various other markets, including UK medical resident hiring, undergraduate sorority/fraternity recruitment, and has argued for the adoption of a similar matching program for appellate judicial clerks. *Id.*



decision.<sup>96</sup> Roth argued that hiring decisions made outside of the official Match process would always carry the risk of suboptimal placement.<sup>97</sup>

In a 2010 paper, economist and antitrust expert, George L. Priest, critiqued Roth's logic.<sup>98</sup> Though Priest praised the ingenuity of the Match algorithm, he argued that Roth failed to consider the underlying cause of the "early contracting market phenomena."<sup>99</sup> Priest pondered the reason why the medical resident market unraveled, but other, similar markets, such as the hiring process of other graduating professionals, did not seem to suffer from the same pre-emptive hiring issues.<sup>100</sup> The reason seems obvious once Priest points it out. The labor market for first year medical residents is different because wages are not a driving force.<sup>101</sup> Through collusion, like that alleged in the *Jung* case, or some other kind of agreement, hospitals have set an artificial wage depression on medical residents, effectively creating an employment monopsony—a single entity controlling an entire labor market.<sup>102</sup>

96. See *supra* text accompanying notes 26–33. "The Roth tradition has analyzed this early contracting as a form of market failure: as the 'unraveling' of the market as employers (e.g., hospitals) and employees (e.g., medical students) enter employment contracts at increasingly early times, prior to the possibility of either to perfectly determine optimal employment decisions." Priest, *supra* note 94, at 448.

97. Priest, *supra* note 94, at 449 ("Roth views such activities as deficient because any agreement reached outside the operation of the centralized matching mechanism introduces, according to the model, a risk of suboptimality.").

98. *Id.*

99. *Id.* at 450.

100. Priest offers a very enlightening comparison between the hiring of first year residents and the hiring of first year attorneys. He points out that medical and law students are similar in that some students will be more competitive academically, and thus the prestige of entry-level jobs will vary greatly amongst members of the same graduating class. He reasons, then, that the *range* of entry-level salaries should be similar. However, this is not the case:

For medical school graduates in the Northeast section of the country, resident salaries differed between the 75th percentile and 25th percentile by \$3,471. In contrast, for law school graduates, first-year attorney salaries in New York differed between the 75th and 25th percentiles by \$77,500, over 22 times as much . . . . Note also the absolute differences in starting salaries. In New York in 2001, a 75th percentile law graduate earned \$125,000; a 75th percentile medical resident, \$39,401; in California, a 75th percentile law graduate earned \$125,000; a 75th percentile medical resident, \$35,220.

How can these differences be explained? Are medical residents more homogeneous in talent than law school graduates to explain the much more narrow range of medical than law graduate salaries? And more homogeneous by 20–30 times? Can the comparative absolute salary levels be explained? A legal education requires 3 years of generalized study prior to taking a full-time law job; a medical education, four years of study prior to residency. Is there an economic reason that a 75th percentile law graduate in California with 3 years of graduate education should earn a starting salary 3.55 times that of an equivalent medical resident in California with 4 years of graduate education?

*Id.* at 464.

101. *Id.* at 450.

102. *Id.* A monopsony is "[a] market situation in which one buyer controls the market . . . . 'Monopsony is often thought of as the flip side of monopoly. A monopolist is a seller with no rivals; a

Furthermore, Priest contends that the Match program, though intelligently designed, only serves to strengthen the monopsony that created the problem in the first place.<sup>103</sup> Priest cites two reasons for this. First, the lack of price as a driving force eliminates any need for hospitals and residency programs to bargain for more competitive applicants with higher wages or better working conditions.<sup>104</sup>

Secondly, the Match weakens the medical labor market by removing the ability for hospitals to show the *intensity* of preferences by offering a higher wage.<sup>105</sup> A “more sensitive placement according to intensity of preference” is replaced by an “ordinal ranking.”<sup>106</sup> Match participants are able to rank their preferences but a simple ordinal ranking system oversimplifies the reality of the situation.

For instance, in a hospital’s ranking of prospective candidates, employee choice one ranks higher than choice two, but what if choice two ranks much, much higher than choice three? What if choice two ranks so much higher than choice three that the hospital is willing to substantially increase the salary offer? The system does not, and cannot, account for this level of fine-tuning. If choice three creates what the algorithm views as “the best match,” it will award the hospital with choice three- even if the hospital would have been more than willing to pay a premium price for choice two.<sup>107</sup>

Priest contends that the only way to truly solve the medical resident labor market crisis is to eliminate the monopsony conditions “and [allow] price to serve as the market clearing mechanism.”<sup>108</sup> Removing extraneous forces on the market is consistent with the ideas of classical liberalism.

monopsonist is a buyer with no rivals.” *Monopsony*, BLACK’S LAW DICTIONARY (11th ed. 2019) (quoting LAWRENCE A. SULLIVAN & WARREN S. GRIMES, *THE LAW OF ANTITRUST: AN INTEGRATED HANDBOOK* 137–38 (2000)).

[W]hat Roth and his colleagues have viewed as “timing problems” represents the working out of competitive market forces in the context of external market constrictions . . . with respect to labor markets, the problems of transaction timing identified by Roth and his colleagues are responses to market monopsony.

Priest, *supra* note 94, at 451. This also explains the discrepancy between salary ranges of graduating medical students and law students as discussed *supra* note 99. The average salary range of graduating law students varies appropriately among students because the legal market, though competitive, is not subject to a monopsony.

103. Priest, *supra* note 94, at 451 (“[T]he central effect of matching programs of this nature is to shore up and buttress these employer monopsonies, an effect that cannot generally be defended on social welfare grounds.”).

104. *Id.* at 466–67. (“In an open market, hospitals at a disadvantage in terms of the provision of nonwage benefits could remain competitive by offering higher wage compensation. The hospital oligopsony, sustained by the matching program, eliminates this possibility.”).

105. *Id.*

106. *Id.*

107. *Id.* (“In other markets, price is a means of allowing intensity of preference to guide purchase and sale decisions.”).

108. Priest, *supra* note 94, at 450.

## III. THE VALUE OF LIBERTY

Before delving into any kind of liberalistic analysis of the Match's antitrust exemption, it is vital to first define "liberalism" and differentiate classical liberalism from the modern, partisan definition of liberalism. "Liberalism," as used in this paper, refers to the classical liberalism of the eighteenth and nineteenth centuries. Classical liberalism was closely tied to classical economic theory, which advocated "the obvious and simple system of natural liberty and opposed unjustified or excessive governmental intervention into economic affairs."<sup>109</sup> Classical liberal thinkers generally have an optimistic outlook on human nature and value individual happiness, equality, and, above all, personal liberty in all aspects of life.<sup>110</sup> Lewis E. Hill contrasts classical liberalism with the modern shift to what he refers to as "welfare liberalism."<sup>111</sup> If classical liberalism is the removal of unnatural restraints, welfare liberalism is the positive addition of beneficial alternatives.<sup>112</sup>

Importantly, one aspect of liberalism that has remained unchanged is "the belief that individuals should be left free to decide their own values and shape their own lives."<sup>113</sup> This freedom extends to business associations and economical choices. Henry Simons, an early member of the Chicago school of economics, wrote, "[a] free society must be organized largely through voluntary associations. Freedom to associate or to dissociate, to belong or not to belong, especially in economic activities".<sup>114</sup> This is a stark contrast to the more pessimistic, traditional conservative approach which views individuals as being incapable of knowing what is best for themselves, thus driving the need for government intervention in order to maintain desirable "social norms."<sup>115</sup>

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109. Lewis E. Hill, *On Laissez-Faire Capitalism and 'Liberalism'*, 23 AM. J. ECON. & SOC. 393, 394 (1964) (internal quotation omitted).

110. Edward O. Correia, *Antitrust and Liberalism*, 40 ANTITRUST BULL. 99, 107–08 (1995); see also Hill, *supra* note 109, at 394 ("Liberty was thought to be the natural state of affairs which required no positive action. It was believed to be necessary only to remove the unnatural restraints from man in order to insure that liberty would naturally result."); HENRY C. SIMONS, *ECONOMIC POLICY FOR A FREE SOCIETY* 3 (1948) ("Liberalism is an optimistic view of man and society.")

111. Hill, *supra* note 109, at 394. Hill cautions that welfare liberalism should not be confused with Marxian socialism, which is not consistent with welfare liberalism's objective of freedom. *Id.* at 394 n.7.

112. *Id.* at 394. Hill explains that the shift from classical liberalism to welfare liberalism was due to both economic and political reasons, including the advancement of technology, political democracy, and the increased presence of morality in politics. *Id.* at 395.

113. Correia, *supra* note 110, at 111.

114. SIMONS, *supra* note 110, at 3.

115. *Id.* at 111–12.

*A. Classical Liberalism and the Roles of the State*

John Stuart Mill, one of the most influential thinkers of classical liberalism, defined social liberty as “the nature and limits of power which can be exercised by society over the individual.”<sup>116</sup> Mill urged that society must only exercise power over the individual if such power is necessary to prevent harm to others.<sup>117</sup> “Over himself, over his own body and mind, the individual is sovereign.”<sup>118</sup> An individual of mature mind and faculties, therefore, cannot be made to do something simply because it is what society deems is “best” or “right” for him.

His own good, either physical or moral, is not a sufficient warrant. He cannot rightfully be compelled to do or forbear because it will be better for him to do so, because it will make him happier, because, in the opinions of others, to do so would be wise, or even right. These are good reasons for remonstrating with him, or reasoning with him, or persuading him, or entreating him, but not for compelling him, or visiting him with any evil in case he do otherwise.<sup>119</sup>

An individual must “be allowed, without molestation, to carry his opinions into practice at his own cost.”<sup>120</sup> This kind of freedom—one that allows individuals to make their own choices based on their own knowledge of themselves—does not hinder society, but improves it.<sup>121</sup> One who allows the flow of society to decide his path is merely mimicking others before him, but the individual “who chooses his plan for himself . . . must use observation to see, reasoning and judgment to foresee, activity to gather materials for decision, discrimination to decide, and when he has decided, firmness and self-control to hold to his deliberate decision.”<sup>122</sup> Even the brightest thinkers and innovators when “forced into one of these moulds” become useless to society.<sup>123</sup>

The Match forces all American doctors into what is essentially an assembly-line production that bears a frightening similarity to the useless

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116. JOHN STUART MILL, ON LIBERTY 73 (David Bromwich & George Kateb eds., Yale Univ. Press 2003) (1859). In this work, Mills emphasizes the importance of individuality and the freedom of thought, discussion, and self-expression.

117. *Id.* at 80.

118. *Id.* at 81. “In the part which merely concerns himself, his independence is, of right, absolute.” *Id.*

119. *Id.* at 80.

120. *Id.* at 121.

121. *Id.* at 83. “Mankind are greater gainers by suffering each other to live as seems good to themselves, than by compelling each to live as seems good to the rest.” *Id.*

122. *Id.* at 124.

123. *Id.* at 129.

“moulds” Mill warns about. According to Mill, individualism fosters innovation; likewise, placing limitations on and forcing individuals into societal “norms” hinders innovation. “Genius can only breathe freely in an *atmosphere* of freedom.”<sup>124</sup> This logic is no less true for medical professionals. It is a disservice to the advancement of the medical arts to take some of the brightest minds in our society and send them through a one-size-fits-all processing plant<sup>125</sup> for the sake of streamlining a system that is inevitably, and necessarily, complicated. In trying to simplify the system, it seems Congress failed to consider that perhaps the system should not be simple in the first place—perhaps the system should be left to the design of market alone.

### B. Natural Liberty

Adam Smith, known as “The Father of Economics,” believed an ideal society would be guided by a system of “natural liberty.”<sup>126</sup> Natural liberty is the level of free choice that exists when all external restraint systems are stripped away. “Every man, as long as he does not violate the laws of justice, is left perfectly free to pursue his own interest his own way, and to bring both his industry and capital into competition with those of any other man, or order of men.”<sup>127</sup> Individuals, so long as their actions do not break the law or harm others, should be left free to pursue whatever path they choose.

An additional benefit of natural liberty is that it frees the State from any responsibility of the impossible task of “superintending the industry of private people.”<sup>128</sup> The State is left, then, with only three duties:

[F]irst, the duty of protecting the society from the violence and invasion of other independent societies; secondly, the duty of

124. *Id.*

125. In describing the Match process, I cannot help but visualize it as the production of overly processed American cheese slices. American cheese is usually cheddar cheese that is broken down, sterilized, reconstituted into a square mold, cut, and packaged into identical, individual slices. Popular brands of American cheese products are so heavily modified and processed that they can no longer be legally labeled as “cheese,” but must be labeled as “pasteurized prepared cheese product.” *See, e.g.,* Stephanie Strom, *A Cheese ‘Product’ Gains Kids’ Nutrition Seal*, N.Y. TIMES (Mar. 12, 2015), <https://well.blogs.nytimes.com/2015/03/12/a-cheese-product-wins-kids-nutrition-seal/>. I do not think it is necessary to emphasize that physicians are very different from cheese products. Yet I find that a shocking comparison can be made. The bright, eager minds of future physicians are broken down by the realities of medical education, programmed to function in an increasingly homogenous environment, and then reconstituted via the Match which places all doctors into practically identical employment “packages.”

126. ADAM SMITH, AN INQUIRY INTO THE NATURE AND CAUSES OF THE WEALTH OF NATIONS 444 (Jonathan B Wight ed., Harriman House Ltd. 2007) (1776).

127. *Id.*

128. *Id.*

protecting, as far as possible, every member of the society from the injustice or oppression of every other member of it, or the duty of establishing an exact administration of justice; and, thirdly, the duty of erecting and maintaining certain public works, and certain public institutions . . . .<sup>129</sup>

Outside of those duties, Smith and other natural liberty idealists believe that the State should refrain from interfering with the day-to-day dealings of individuals, especially dealings involving employment. Smith viewed the value of labor as “the original foundation of all other property, so it is the most sacred and inviolable.”<sup>130</sup> To interfere with this property right would prevent an individual “from employing this strength and dexterity in what manner he thinks proper, without injury to his neighbor” and would constitute “a plain violation of this most sacred property.”<sup>131</sup> The Match, a tightly regulated and obligatory system, seems exactly like the kind of “external system” that Smith would argue should be stripped away.

#### IV. THE DANGERS OF ANTITRUST EXEMPTIONS TO LIBERTY

One of the main goals of federal antitrust laws is to protect competition, which is considered beneficial to the public.<sup>132</sup> Competition is necessary for “real freedom of association—and [for] real power dispersion. All monopolies, and all very large organizations of sellers (or buyers), are impairment of that freedom.”<sup>133</sup> Antitrust exemptions are essentially legal monopolies and directly conflict with this purpose of protecting competition. Thus, exemptions have been enacted sparingly.<sup>134</sup> Historically, the majority of statutory exemptions have been enacted in response to temporal pressures and special interest lobbying.<sup>135</sup> “Many scholars believe that, regardless of the rationale stated during debate, statutory exemptions

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129. *Id.*

130. *Id.* at 80.

131. *Id.*

132. *See, e.g.,* Madison, *supra* note 1.

133. SIMONS, *supra* note 110, at 4.

134. *Id.*

135. *See* text accompanying *infra* notes 139–41. *See also* Anne McGinnis, *Ridding the Law of Outdated Statutory Exemptions to Antitrust Law: A Proposal for Reform*, 47 U. MICH. J.L. REFORM 529 (2014).

Today, the antitrust community largely views statutory exemptions as special interest legislation that is harmful both to the legitimacy of the government's regulation of the economy and to economic progress. Many exemptions have aroused this sentiment since the time of their passage. However, supporters of each statutory exemption were able to proffer at least some public policy reasons for each exemption's necessity.

*Id.* at 540.

are often special interest legislation, passed at the behest of a particular industry without full consideration of the larger social or economic impact.”<sup>136</sup> Henry Simons warned “private monopolies with the blessing of regulation and the support of law are malignant cancers in the system.”<sup>137</sup> When faced with competition, monopolies seek government regulation and antitrust exemptions to maintain control.<sup>138</sup> Critics of antitrust exemptions have rightly pointed out that government implementation of exemptions is disjointed, inconsistent, and often in response to passing or temporal pressures.<sup>139</sup> “Some of these exemptions are partial, others complete. Some apply to particular industries or organizations, others immunize specific activities and practices. Some were originally installed in periods of depression, others in periods of war or defense mobilization. Some are de jure, others de facto.”<sup>140</sup> Monopolists, disguising their motives as the promotion of a public purpose, have been able to use their political influence to persuade the government to grant them a special commercial advantage.<sup>141</sup>

Simons cites this hodgepodge method of government interference as one of the main reasons for ridding the economy of private monopolies. Every legal monopoly inevitably requires government intervention through regulation.<sup>142</sup> Government regulation begins a cycle that ultimately leads to even more government regulation.<sup>143</sup> “[E]very interference by government on behalf of one group necessitates . . . additional interference on behalf of others.”<sup>144</sup> The accumulation of government interference and regulation creates an “enterprise economy paralyzed by political control.”<sup>145</sup>

## V. PROPOSED ALTERNATIVES

It is not the author’s belief that the Match should be disposed of completely. It has served a positive function in the medical education system for over 60 years. The legislature’s concern that without the Match there would be chaos and increased burdens on medical students is not

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136. McGinnis, *supra* note 135, at 544.

137. SIMONS, *supra* note 110, at 86.

138. *Id.* at 87.

139. Walter Adams & James W. Brock, *The Political Economy of Antitrust Exemptions*, 29 WASHBURN L.J. 215, 216 (1990).

140. *Id.*

141. *Id.* On the subject of the insurance exemption, Adams and Brock noted “[i]n practice, however, this exemption, like so many others, has been little more than a mask for privilege and power.” *Id.* at 217.

142. SIMONS, *supra* note 110, at 87–88.

143. *Id.* at 87.

144. *Id.*

145. *Id.* at 88.

unfounded. Clearly, before implementation of the Match, students were facing unnecessary pressure to make premature decisions. However, the manner in which the Match is currently implemented allows for abuse of the system by employers and medical regulating agencies.

Especially worrisome is how the antitrust exemption the Match enjoys is actually *codified* and explicitly supported by the legislature, leaving no room for argument in the judiciary branch regardless of how valid the case may be. Henry Simons wrote, “The only good power is that of law based on overwhelming voluntary consensus of free men and built and rebuilt by gradual experimentation, organized discussion, and tolerant compromise.”<sup>146</sup> By that definition, the Match’s antitrust exemption is not “good power.” The codification of the Match’s antitrust exemption was implemented suddenly in response to a lawsuit seen to the powers-that-be as inconvenient. There was no “gradual building and rebuilding” or “experimentation.” There was never any public discussion prior to signing the bill into law. The *Jung* plaintiffs attempted to have an “organized discussion” but were almost immediately shut down.

Instinctually, the author feels that medical residents need the ability to freely contract with their prospective employers in the way any other professional is able to freely contract. The Match puts a constraint on residents that would be unacceptable to nearly every other professional field. While it is interesting to entertain the thought of removing all monopsony conditions and letting price control the market, as proffered by Priest,<sup>147</sup> it is clear that, realistically, a total reorganization or disposal of the system may not be feasible or even desirable. Instead, the author adopts a similar view to that of Robert Wilkey who advocated for substantial reform in his 2011 *Creighton Law Review* article.<sup>148</sup>

First, the employment status classification of medical residents needs to undergo a transformation. Medical residents continue to suffer from the misconception that they are not “employees,” but rather “physicians in training.”<sup>149</sup> “[F]or medical residents to ever have equal standing with other professions, it is important that they be designated, classified, and afforded the status of employees.”<sup>150</sup> Although medical residents are “employees”

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146. *Id.* at 23.

147. *See supra* text accompanying note 108.

148. Wilkey, *supra* note 11, at 743–47 (“[I]t is clear that substantial reform, including addressing the continued workplace inequities faced by medical residents, is still needed.”).

149. *Id.* (“[T]he perception that medical residents lack an employment status is shaped by well-established historical and traditional views of a residency program, whereby medical residents are and continue to be understood as “physicians in-training.””).

150. *Id.* at 744.



for tax purposes,<sup>151</sup> this luxury has not been extended to the labor rights context.<sup>152</sup> The ACGME has made an official statement clarifying their position that medical residents are students rather than employees.<sup>153</sup> This misclassification seriously hinders the ability of medical residents to recover under labor law statutes, which typically only apply to “employees.” Despite the educational aspect of their training, medical residents make up a large percentage of many hospitals’ workforce and certainly function in the capacity one might expect of an “employee.”<sup>154</sup> For medical residents to be afforded full protection under the law, it is absolutely vital that the controlling medical agencies begin referring to them as employees.<sup>155</sup>

Second, medical residents need to be provided with a copy of their prospective employment contracts before entering into any binding agreements. “[A]lthough the National Resident Matching Program (“NRMP”) purports to require that GME programs provide applicants an advance copy of the appointment contract, there is no assurance by the NRMP that the appointment contract is made available, accessible, or contains accurate information.”<sup>156</sup> Because the Match is a legally binding program as soon as an individual enrolls, this effectively means that residents enter into a contract without ever being given the opportunity to review the terms. In any other scenario, this would be unconscionable. Giving residents the ability to fully know and understand the contract they are about to enter would be a start to restoring the balance of bargaining power. As it is, one party is all-knowing and all-controlling, and the other party is left in the dark, bound to whatever contract the system matches her with.

Third, Wilkey argues that there must be implementation of uniform grievance policies and procedures.<sup>157</sup> The ACGME is the accrediting agency for medical residencies. Therefore, it is fully within the agency’s power to implement and enforce policies by stripping a program of their accreditation.<sup>158</sup> Although Wilkey focuses his discussion on how such procedures could protect residents from problems involving non-renewal or

151. *Mayo Found. for Med. Educ. and Rsch. v. United States*, 562 U.S. 44 (2011) (affirming the district court’s decision that medical residents, although having the characteristics of students, are not students for tax exemption purposes).

152. Wilkey, *supra* note 11, at 744.

153. *Id.*

154. See *supra* text accompanying notes 76–78.

155. Wilkey, *supra* note 11, at 744 (“Thus, until medical residents are definitively clarified as ‘employees,’ they will continue to be subjected to inequitable employment standards, rights, and protections.”).

156. *Id.* at 744–45.

157. *Id.* at 746.

158. *Id.*

non-promotion,<sup>159</sup> a uniform grievance procedure could also aid in the enforcement of duty hour restrictions, which as discussed in Part I, are often not followed.<sup>160</sup> For such a highly regulated system as the Match, an equally regulated *and enforced* grievance system does not seem out of bounds.

Finally, there is one last thing that must be addressed—the artificial depression of wages.<sup>161</sup> There is no hard evidence of collusion among hospitals and medical organizations, but all signs indicate there must be *something* going on beneath the surface that has caused homogenous salaries across all specialties and geographic regions.<sup>162</sup> It is the author's firm belief that the *Jung* plaintiffs were justified in their allegation of collusion. It is unfortunate the case was cut short and the public can no longer benefit from any information that may have been uncovered during discovery and litigation. For this problem, there is no easy solution. Until there is either a total redesign of the Match system, drastic legislative or judicial action, or collective action by medical residents, residents will continue to be woefully undercompensated and overworked.

#### CONCLUSION

In almost every respect, the healthcare system is complex, frustrating, and imperfect. These maladies extend to the hiring process of medical residents. Often, graduating medical students are young adults facing their first foray into the working world. They may have never once been expected to negotiate any kind of legally binding contract but will soon be thrust into a world where they will be expected to gracefully handle *actual* life-or-death decisions on a daily basis. These new doctors will make critical

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159. Wilkey, *supra* note 11, at 746.

[T]he ACGME does seemingly very little to enforce, audit, or otherwise assess the integrity of such process. 249 Rather, the ACGME has and continues to refuse to consider, review, or assess any decision by a GME program with respect to a medical resident's termination, discipline, dismissal, suspension, and/or termination.

Accordingly, a medical resident faced with a non-renewal of appointment or non-promotion is subjected to the GME's own internal policies and procedures that may or may not be consistent with ACGME guidelines and, in many situations, may not provide any recourse for appeal. Furthermore, nothing in ACGME's compliance policies provides that the GME must report to the ACGME annual data concerning the number of medical residents that utilized such grievance procedures and the outcome. The net result is that medical residents with respect to potential employment issues relating to non-renewal of appointment or non-promotion continue to be at a severe disadvantage, especially often in the absence of a neutral arbitrator or third-party decision maker.

*Id.* at 746–47.

160. *See supra* text accompanying notes 48–51.

161. *See supra* text accompanying notes 56–60, 101–02.

162. *See supra* notes 58–59.

decisions about the lives of other people yet, ironically, are not afforded the same level of discretion in deciding their own employment future.

This is not to say that the Match is a failure or that it always produces undesirable results. In fact, placement statistics show that the majority of residents will be placed into their first choice program.<sup>163</sup> Furthermore, these programs, whether they were the resident's first choice or not, *do* succeed at producing some of the highest quality physicians in the world.<sup>164</sup> The Match undoubtedly helps to streamline this production process.<sup>165</sup>

However, looking only at statistics to judge the success of the Match overlooks the humanistic element of medical residency. The statistical success of the Match does not answer questions like: How many new physicians are *actually* happy with their residency positions? What kind of changes could be implemented to increase resident happiness and decrease burnout? Are residents able to maintain healthy social relationships outside of work? Do the residents have enough time to sleep? Eat? Engage in exercise? The answers to these questions have far-reaching effects.<sup>166</sup> The Match may succeed at streamlining an "inefficient, chaotic, and unfair"<sup>167</sup> process, but at what cost? The public relies on physicians to take care of its individuals, but these physicians must also receive proper care. This care must start in the medical education process by supporting the natural liberty of medical residents and allowing them to bargain for and enter into properly negotiated employment contracts.

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163. See *supra* text accompanying note 37.

164. 15 U.S.C. § 37b(a)(1) ("For over 50 years, most United States medical school seniors and the large majority of graduate medical education programs . . . have chosen to use a matching program . . . . These matching programs have been an integral part of an educational system that has produced the finest physicians and medical researchers in the world.")

165. 15 U.S.C. § 37b(a)(1).

166. See, e.g., Barger, *supra* note 13 (discussing the relationship between adequate physician sleep and patient outcomes).

167. 15 U.S.C. § 37b(a)(1)(B).