No other professional field of employment in the United States is subject to such employment constraints. Reform of the NRMP to allow resident physicians to consider multiple offers simultaneously would provide an opportunity for negotiation, which is the basis for all equitable contracts. At the very least, an open and transparent discussion of the legality of the NRMP is warranted.

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Conflict of Interest Disclosures: Both authors have completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest and none were reported.


In Reply Drs Kirsch and Drolet misapprehend the nature of the matching process and the procedures used by the NRMP. Match procedures allow applicants and program directors to assess each other through applications and interviews and to make training selection decisions based on their own preferences and the criteria important to each.

Kirsch and Drolet propose allowing applicants to receive multiple offers simultaneously—exactly the problem a matching program is designed to rectify. Prior to creation of the NRMP, an applicant could receive multiple offers and hold those offers indefinitely, to the detriment of other applicants who might have no offers at all. In other cases, an applicant could receive an offer with a short deadline for acceptance and feel compelled to act on it before knowing whether other, more desirable, offers would be extended. In contrast to such chaos, the NRMP allows applicants and program directors to consider all options simultaneously and to rank those options in order of preference. The Match yields a best result because no applicant or program could achieve a better outcome than the one produced by the matching algorithm. The binding nature of the NRMP match commitment is essential to ensuring the integrity of the process, because an applicant’s failure to honor that commitment disadvantages not only the matched program that is left with a vacant position but also other applicants who might have matched to a less-preferred program or not matched at all.

Kirsch and Drolet assert that the NRMP’s antitrust exemption, which applies to all graduate medical education training selection decisions, is anticompetitive because “it prevents fair negotiations at the heart of all employment agreements.” However, the NRMP has nothing to do with the employment agreement between applicants and residency programs other than requiring the program to share the agreement prior to the deadline for submitting rank order lists. In truth, the purpose of the Match is to create a level playing field for all participants by promoting fairness and transparency in the process by which applicants and program directors make training selection decisions.

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Additional Information: Ms Signer is the president and chief executive officer and Dr Curtin is the chief policy officer of the National Resident Matching Program.

CORRECTION

Incorrect Spelling of an Author’s Name and Data Error: In the article entitled “Effect of Tumor-Treating Fields Plus Maintenance Temozolomide vs Maintenance Temozolomide Alone on Survival in Patients With Glioblastoma: A Randomized Clinical Trial” published in the December 19, 2017, issue of JAMA, an author’s name was spelled incorrectly (Jordi Bruna, MD) in the author list and a data error occurred in Table 2, in the between-group difference and confidence intervals for the year-1 survival. This article was corrected online.


Incorrect Cervical Length Category Definitions: In the Original Investigation entitled “Effect of Cervical Pessary on Spontaneous Preterm Birth in Women With Singleton Pregnancies and Short Cervical Length: A Randomized Clinical Trial” published in the December 19, 2017, issue of JAMA,4 cervical length categories were incorrectly defined on page 2318, in the Randomization and Masking subsection of the Methods. The correct categories are <20 mm and ≥20 mm – 25 mm. This article was corrected online.


Incorrectly Described Data: In the Special Communication entitled “Health Care Spending in the United States and Other High-Income Countries” published in the March 13, 2018, issue of JAMA,5 national health care spending data were incorrectly reported as gross domestic product. The sentence should have read “The United States had high levels of administrative burden; this was notable in particular for administrative spending, for which the United States was an outlier (8% of national health care spending spent on administration and governance compared with a mean of 3% of national health care spending) (eTable 1 in Supplement 1).” Additionally, in Figure 8C, the x-axis should have been labeled “No. of Hospital Bed Days per Capita.” This article was corrected online.