Uninspiring Aspiring Fellows (UNAFs): An Emerging Infectious Disease

Aaron E. Glatt
Division of Infectious Diseases, St. Vincent’s Catholic Medical Centers, Brooklyn/Queens Region, Jamaica, and Associate Dean, New York Medical College, Valhalla, New York

I vividly remember my own experience applying for residency and fellowship in the middle 1980s. There was a significant amount of uncertainty and apprehension, not unexpected, since this process would determine where I would spend the next 5 years of my life. Sitting now on the other side of the desk, as a Program Director and interviewer for a 5-fellow Infectious Diseases (ID) training program, I try to remember those concerns and anxieties, and I try to treat the aspiring fellows fairly, honestly, and truthfully. Of course, I expect no less in return. My experience has led me to conclude, however, that my expectations are far too high.

Since becoming an ID Program Director in 1992, I have become slightly jaded. During these past 8 years, 5 of our fellow applicants who signed contracts—definitively and unequivocally stating that they would begin their training with us—subsequently broke their word (and legally binding contract) and did not start their fellowship with us. One of the 5 applicants never even bothered to inform me that he had taken an ID fellowship position elsewhere; he just did not show up. This was despite the fact that I had spoken with him at least monthly and had corresponded with him on numerous occasions preceding the time he was supposed to enter our program. He actually enrolled several months before that date in another fellowship program, but apparently “neglected” to tell that program that he was already under contract at mine. The other program (unknowingly) took the applicant, and to my knowledge they allowed him to successfully complete his fellowship.

Two other aspiring fellows also somehow neglected to inform me on their own that they would be unable to honor their contractual obligations. Having been forewarned by my experience with the first such case, I should not have been so easily misled and duped. Yet, despite repeated conversations with these applicants, I found out only subsequently that both were also going to be “no shows.” At least in these latter 2 cases I had an entire month prior to the start of the fellowships to scramble and find other applicants.

A fourth aspiring fellow also did not volunteer the information that she would not honor her commitment, but I discovered it several months prior to the start of her fellowship. Only 1 of the 5 informed me on her own (1 year prior to the start of her fellowship) that she would be unable to join us because of an illness in her family. I thanked her for her honesty and truthfulness, released her from her contract, and offered her a fellowship for the next academic year when the family crisis would be over. She declined.

None of the first 4 applicants offered me a rational and clear reason for their action. Nor did any of them appear particularly contrite or concerned that they were in breach of contract. Apparently, their word and signed accord had little ethical or practical meaning to them. At least 1 of them trained in ID that very year; I do not know what the others did. I did not pursue legal or other action against any of them, but I did write a letter to the American Board of Internal Medicine outlining their conduct, stating that their behavior was, at best, highly improper and unprofessional, and recommending that they not be allowed to sit for the Boards. To my knowledge, no disciplinary action was instituted against them by anyone.

As ID physicians are wont to do, I recognized a new clinical syndrome, albeit one that is multifactorial in nature. I have labeled this newest emerging Infectious Diseases problem “Uninspiring Aspiring Fellow” (UNAF, pronounced “enough”) syndrome. Before this syndrome becomes epidemic (if it hasn’t already), and recognizing that there is a scant likelihood that an E-CSF (Ethical Colony
Stimulating Factor) will be developed in the near future to deal with this entity, I have analyzed the problem and suggest several prophylactic and treatment options.

I am unaware of any hard data on UNAF syndrome (I searched MEDLINE using the key words “UNAF,” “#@$&%,” "rogue," “dirtball,” and “scum of the Earth”). However, on the basis of my conversations with colleagues and scans of the classified advertisements, I conclude that the incidence and prevalence of UNAF syndrome appears to be increasing. A survey of training program directors (I’d be happy to be the principal investigator on a proposal for a large grant for this from the Centers for Disease Control and Prevention) is therefore necessary to address the problem. Is this syndrome unique to New York City, (hey, one of the applicants to my program was born just west of the Nile) or has it spread beyond our metropolis? There does not appear to be a predominance of men or women affected (in my limited series, the ratio of men to women was 2:3; \( P > .05 \)), and fortunately (!) the size of my sample is not sufficient to comment on other demographic characteristics. However, all the applicants had nice letters of recommendation and good test scores, and all interviewed well. Their behavior is reminiscent of syphilis, that other great mimic. Maybe I should screen all future applicants with a VDRL (venereal disease research laboratory) test?

Are we inadvertently precipitating new cases of UNAF syndrome? The current extended application process begins approximately 1.5–2 years prior to the start of fellowship. Are we asking too much of trainees by requiring them to decide on a major career choice and fellowship decision immediately on completion of the difficult and grueling internship year? Might it not be better to delay the filing of applications to the very beginning of postgraduate year 3 and condense the application process into the first 3 months of the third year? My recommendation would be to complete the Match process in the January immediately preceding the start of the academic year. Hopefully, this would allow applicants to mature, to act more deliberately, and to choose their careers carefully, resulting in better adherence and compliance with signed agreements. As we all know in ID, the best diagnoses and therapies are worthless without good compliance!

I recognize that extenuating circumstances unfortunately arise, and even the most honest and ethical fellows may possibly become incapable of fulfilling their obligations. As long as an aspiring fellow immediately notifies the training program to which they were matched and with which they have signed a contract that they are unable to attend, and as long as there is no evidence of frivolous abuse of the Match system, the baseline incidence of UNAF syndrome should not increase precipitously.

What can the Infectious Diseases Society of America (IDSA) and other subspecialty societies do to control the spread of UNAF syndrome? In addition to delaying the application process to postgraduate year 3 and insisting that all residents and all programs participate in the Match system, I believe there are several other practices that might nip UNAF syndrome during its incubation period or preclinical stage. The American Board of Internal Medicine (ABIM) should maintain a database to which all training programs would be required to submit the names of applicants who have signed onto their fellowship. Trainees with contracts would be forbidden to interview (and certainly forbidden to sign a contract) with any other program for that same period, unless they withdrew their acceptance and notified the Program Director. Directors could check this database prior to accepting (interviewing?) any applicant, to prevent duplicity. Universal implementation of such procedures would protect all training programs, whether they accepted a fellow through the Match or outside it. I have noticed that a significant percentage of the applicants to be ID fellows have concurrently or previously applied to other “more lucrative” subspecialty training programs. (I maintain a hefty file of applicant recommendation letters addressed to me stating how so and so would make such a fine cardiologist!) This would serve to prevent applicants from securing a position in a less competitive field while still trying their luck playing “Who wants to be a (gastroenterologist) millionaire”?

UNAF syndrome has many significant short- and long-term sequelae. Immediate program-threatening complications include the dreaded “open-fellowship slotitis,” which, if left unfilled, can seriously and rapidly cavitate and abscess, compromising a training program and years of hard work. At a minimum, it certainly adversely impacts the training of the other fellows in the program. Obviously, the timing of the breach of contract in relation to the start of the fellowship is the key determinant in quantifying how much damage has been done. This can be expressed by the formula: \[ \frac{1}{[(\text{number of months prior to July}) \times 180}] = \text{pulse rate}. \] However, Faget’s sign (relative bradycardia) has been reported to occur in program directors who have wanted to skin the UNAF, an occurrence similar to what is seen in patients with tularemia. The pathophysiology is unknown.

Scrambling in late June (and certainly in July or August, as reported by some colleagues!) to find a fellow can be a very frustrating, painful, and time-consuming experience for which there is no simple pharmacological cure. However, ethanol imbibement and/or the appropriate mix of antianxietyotics q.d. for the entire staff makes the condition somewhat less discomforting. Some have recommended administration of double doses or combination therapy for the Program Director, but there is a dearth of data to support this recommendation.

The quality of the candidate ultimately found to replace the UNAF is another
major issue with a potentially adverse outcome. While I have been pleasantly surprised by the high quality of several of the late applicants that we have recruited, obviously the size of the pool of strong candidates has sharply diminished so late in the year. The pool is especially shallow when you have only days or weeks to recruit. At that late date, some of the applicants clearly do not have ID as their primary interest; they may be taking a fellowship in ID only for suboptimal reasons. Are these the trainees that we wish to have as colleagues in our specialty in the years to come? The advertising costs for these positions should also not be ignored; such unbudgeted money is frequently difficult to find. Resistance (administrative) is a growing problem.

Finally, and possibly most important, is the public (health) consideration. By having a UNAF sign a contract, it prevents other interested and qualified candidates from considering that program. It is a great disservice to trainees who wish to obtain a particular position, but are unable to do so because the slot they truly desire is filled. This phenomenon, known as competitive inhibition, is usually irreversible.

Sometimes it is necessary to debride or amputate diseased tissue to preserve the remaining viable tissue. UNAFs who sign a contract and then callously disregard that binding commitment should not be allowed to participate in any (ID) training program during the period of time covered by the contract they signed or for a stated number of years. Obviously, in situations where legitimate extenuating circumstances exist, no penalty should be imposed. But for cases of grossly unethical conduct—interviewing for another position while under a signed contract, unilaterally deciding to not show up at the expected start date, signing a contract for other positions for the same time period, etc.—appropriate penalties should be instituted. Such behavior should also raise questions regarding the candidate’s moral and ethical fiber and prevent them from sitting for ABIM/ID certification. Also, they should not be permitted to enroll for a specified duration in any program sponsored by the IDSA or other subspecialty society, or to submit research abstracts to the annual meeting of the IDSA. Membership in the IDSA and/or other subspecialty societies, and its privileges, should not be proffered or should be retracted; and other appropriate punitive action should be considered that will hopefully prevent such inexcusable conduct. Participation as a subject in a live unattenuated HIV vaccine trial or multiple needle-stick exposure study would be acceptable in lieu of the above.

UNAF syndrome exists in the forma fruste state as well. Not showing up for interviews without providing explanation or notice, supplying misinformation or incorrect data regarding prior work experience and/or research, not providing requested information in a reasonably timely fashion, etc., are all signs of potential genetic case of UNAF. A forme tardive (late appearing) type of UNAF also exists: some fellows are disingenuous (lie) about their visa status and are suddenly ineligible to start their second year of training (we have had 2 cases of this entity—but that is another paper!).

It is truly a shame that I (we?) accept and are no longer even surprised by the unprofessional actions of a minority (certainly not all) of the trainees in the application process. It is even more disconcerting, however, to realize that these UNAFs, whether they have forme fruste or full-blown syndrome, are providing medical care to sick patients who rely on them for ethical, humane attention. I can only hope that UNAF syndrome is an isolated phenomenon limited to irritating and annoying selected ID program directors in New York. However, sadly, I suspect that it is a far more serious problem in health care provision and education than has been previously recognized.

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