The impact of the COVID-19 pandemic on the 2020 pediatric anesthesiology fellowship application cycle: A survey of applicants

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Abstract

Background: The COVID-19 pandemic created a situation with an urgent need to produce a virtual system for the 2019–2020 pediatric anesthesiology fellowship cycle. With fellowship interviews beginning in April 2020, there was minimal time to adapt. Each program rapidly developed its own platform, expectations, materials, and process for interviews, and applicants were exposed to a wide array of variability in the process—all while under the stress of interviewing for fellowship positions.

Aims: The aim of this survey-based study was to obtain input from applicants to help guide program decisions about “best practice” for the future for both pediatric anesthesiology and other graduate medical education matches.

Methods: A 28-question survey was developed utilizing Qualtrics. An anonymous link was sent to all pediatric anesthesiology program directors for distribution of the survey link to all recently matched applicants. Incoming fellows who were accepted outside of the match process were also invited to respond.

Results: Fifty respondents completed the survey, for a response rate of 30% based on the 167 matched fellowship positions nationwide (50/167). A majority of the respondents reported they felt virtual interviews allowed them to learn the following things equally as well compared with a traditional interview about fellowship programs: salary and benefits, available academic opportunities, available clinical opportunities, clinical schedule of the fellowship, mentorship opportunities, clinical experience and training of the fellowship, and expected work-life balance during fellowship. Respondents report that the most important factors in making their rank list were perceived goodness of fit, desired geographic location, and perception of program leadership. Additionally, respondents ranked the types of information and interactions that they found most helpful to make decisions. All respondents reported the benefit of cost savings compared to a traditional application cycle, with the most commonly reported estimated savings being $3,000–$5,000 per respondent.
INTRODUCTION

The first case of COVID-19 in the United States (US) was confirmed on January 21, 2020, and within 8 weeks the World Health Organization had declared the infection a pandemic. During this time, multiple states began to issue official "stay-at-home" orders, effectively shutting down travel; also, a majority of teaching hospitals restricted visitors, outside rotators, and travel for essential personnel. While the COVID-19 pandemic was drastically changing every aspect of personal and professional life in the US, the US-based pediatric anesthesiology fellowship interview cycle was just preparing to launch. This created an urgent situation for pediatric anesthesiology fellowship program directors (PDs), who scrambled to quickly create a virtual interview process to identify top candidates while showcasing their fellowship programs. Similarly, anesthesia residents applying to pediatric anesthesia fellowship program directors (PDs), who scrambled to quickly create a virtual interview process to identify top candidates while showcasing their fellowship programs. Similarly, anesthesia residents applying to pediatric fellowships were simultaneously compelled to adapt to a virtual interview format and to flex into novel roles to meet the needs of their home medical institutions, the latter being overwhelmed with patients in many places.

Published studies of virtual interviews in anesthesiology graduate medical education (GME) are limited. There are several perceived benefits from the trainee standpoint for virtual interviews, including increased flexibility to schedule interviews, less time away from residency for travel days, and decreased financial burden for each applicant. There are also several anticipated benefits for programs, including decreased hosting/food-related costs, and access to more remote candidates. Despite these benefits, as well as near-universal access to critical videoconferencing technologies in the years leading up to 2020, there was no significant interest in completing GME interviews virtually until both programs and applicants were obligated by necessity to utilize a virtual format.

Due to the COVID-19 pandemic, there was a sudden urgent need to create a virtual system for interviews. Each program rapidly and independently developed its own platform, expectations, materials, and process for interviews. Applicants overcame and adapted to a wide array of variability in the process—all while under the stress of interviewing for fellowship positions. The purpose of this survey-based study was to obtain input from applicants, following the conclusion of the fellowship match, to help guide program decisions about "best practice" for the future for both pediatric anesthesiology and other GME matches. In addition, while it is likely that 2021 will be a year dependent on virtual interviews for many specialties, the question exists as to whether the benefits of virtual interviewing may warrant continuation of the format even after in-person interviews are once again safe and permitted. This manuscript describes the process and results for a survey of pediatric anesthesiology fellowship applicants in 2020; a complementary survey of all pediatric anesthesiology program directors was completed simultaneously and will be reported separately.

Conclusions: These results allow recommendations for "best practices" for virtual interviews to include programs providing an electronic packet of information prior to the interview day, providing dedicated time for applicants to interact with current fellows, providing applicants an understanding of the city/region of the location of the program, and offering a completely optional postinterview visit, when possible. Based on the results of this survey, we recommend that programs continue to offer virtual interviews as a penalty-free option for applicants, even when in-person interviews may be feasible.

KEYWORDS
anesthesiology, COVID-19, education, fellowship, survey, virtual interview

What is already known about the topic
Graduate medical education interviews have traditionally been conducted in-person but the COVID-19 pandemic required the rapid creation and execution of a virtual interview process. In-person interviews are both financially and temporally burdensome to medical students and residents and also detract from clinical training in some cases. There are no current data published on how pediatric anesthesia applicants feel they can either (1) present themselves or (2) evaluate a fellowship program virtually. Additionally, there are little published data on whether applicants prefer virtual or in-person interviews.

What new information this study adds
This study informs us on applicant perceptions with respect to presenting themselves virtually to fellowship programs and virtual program evaluation for ranking. It also informs educators what specific elements of virtual interviews applicants found both most and least helpful in evaluating programs virtually.
METHODS

Institutional Review Board exemption was obtained from Children’s Hospital of Philadelphia.

The 28-question survey instrument (Appendix S1) was developed utilizing Qualtrics (Qualtrics; Provo, Utah), a web-based tool for creating and conducting online surveys, by a multi-institutional panel including one fellow (M.D.) and several faculties (E.L.S., M.C.L., M.C., J.L.L.). The survey instrument was pilot tested for clarity by anesthesia residents prior to distribution.

Following the National Resident Matching Program (NRMP) fellowship match in October of 2020, an introductory letter was sent to all program directors of ACGME-accredited pediatric anesthesia fellowships via the Pediatric Anesthesiology Program Directors’ Association (PAPDA) electronic mailing list. The letter included a request for program directors to distribute an invitation to participate, along with the survey instrument link, to all recently matched applicants as well as incoming fellows who were accepted outside of the NRMP process. The link was accompanied by a message informing respondents that the survey was completely anonymous and voluntary, and that responding would have no impact on their training experience. The survey remained open for 1 month (through November 16, 2020) and one reminder email was sent 2 weeks after the initial message. The authors did not directly contact applicants and solely relied upon individual program directors to distribute the anonymous survey link.

Data were analyzed using Qualtrics internal reporting statistics. Data are presented as percentages where appropriate. Visual analog data (such as rankings for best platform or most important feature of the process) were assigned a numerical value on a 0–100 scale and results for visual analog data are reported as means and standard deviations.

RESULTS

A total of 50 respondents completed the survey, for a response rate of 30% based on the 167 matched fellowship positions nationwide (50/167) and an assumption that every program director provided the survey link to their matriculating fellow(s). There is an unknown number of fellowship positions offered outside of the match, making a definitive response rate determination impossible.

Demographics

The majority of respondents were Clinical Anesthesia-2 (3rd postgraduate year) categorical anesthesia residents (38/50, 76%) at the beginning of the application cycle (Table 1). The most commonly reported age rate was between 30 and 34 years (22/50, 44%), and a majority of respondents identified their gender as female (28/50, 56%).

| Training | CA-2 | 38 | 76% |
|----------|------|----|-----|
| CA-3     | 10   | 20%|
| Combined pediatric-anesthesiology resident | 1 | 2% |
| Practicing anesthesiologist | 1 | 2% |

| Age     | 25–29 | 13 | 26% |
|---------|-------|----|-----|
| 30–34   | 22    | 44%|
| 35–39   | 13    | 26%|
| 40–44   | 1     | 2% |
| Prefer not to answer | 1 | 2% |

| Gender  | Female | 28 | 56% |
|---------|--------|----|-----|
| Male    | 22     | 44%|

3.2 Interview and logistics

Forty-four percent (22/50) of respondents identified historical self-perceptions of comfort level with virtual interviews as either extremely or somewhat comfortable. Twenty percent (10/50) reported that they were either extremely uncomfortable or somewhat uncomfortable and 36% (18/50) were neither comfortable nor uncomfortable with virtual interviews prior to the 2020 virtual interview cycle.

Respondents were asked to give their impressions of each of the various platforms used for virtual interviews with a visual analog scale. The highest-rated virtual platform for conducting the interviews was Zoom (Zoom; San Jose, CA) (M = 82.76, SD = 20.58) followed by WebEx (Cisco; Milpitas, CA) (M = 66.72, SD = 23.50) and Microsoft Teams (Microsoft; Redmond, WA) (M = 61.25, SD = 27.78). When asked what virtual platform was most preferred, the majority of respondents selected Zoom (26/44, 63.4%), followed by no preference (7/44, 17.0%), Microsoft Teams (3/44, 7.3%), WebEx (2/44, 4.9%), and BlueJeans (Verizon; San Jose, CA) (2/44, 4.9%).

A majority of respondents reported that, before or during their virtual interviews, most or almost all programs provided them with the following: time to ask questions about the program (49/50, 98%), one-on-one time with the PD (48/50, 96%), time to speak with current fellow(s) (47/50, 94%), time to speak with faculty (other than program leadership) (45/50, 90%), live-hosted presentation with an overview of the program (42/50, 84%), one-on-one time with the associate/assistant program director (APD) (42/50, 84%), and electronic documents containing an overview of the program (37/50, 74%). A majority of respondents reported that no programs provided a live virtual tour of facilities (29/50, 58%) and few programs or some programs provided a prerecorded virtual tour of facilities (31/50, 62%). Information about the area surrounding the medical center (such as where fellows commonly live) was mixed; a majority (28/50, 56%) reported that some, few, or
no programs provided such information with the remaining (22/50, 44%) reported they were provided with this information by all or almost all programs or most programs.

Applicant ability to learn about programs was assessed and compared to traditional interviews after being broken into different domains (Figure 1). A majority of applicants felt virtual interviews conveyed the following items equal to or better than traditional interviews: salary and benefits (39/42, 92.9%), available academic opportunities (36/43, 83.7%), available clinical opportunities (35/43, 81.4%), clinical schedule of the fellowship (34/42, 81.0%), mentorship opportunities (30/43, 69.8%), clinical experience and training of the fellowship (29/43, 67.4%), and expected work-life balance during fellowship (25/43, 58.1%). The majority of applicants felt that the following items were conveyed slightly worse or much worse than a traditional interview: characteristics/personality of the program director/leadership (23/43, 53.5%), characteristics of faculty members (25/43, 58.1%), goodness of personal fit for the fellowship (26/43, 60.5%), characteristics of current fellow(s) (33/43, 76.7%), culture and community of the institution (34/43, 79.1%), and culture and community of the program (35/43, 81.4%). A majority of applicants found that the culture and livability of the city/region were conveyed much worse virtually compared to a traditional interview (23/42, 54.8%).

Regarding how well applicants could share information about themselves (Figure 2), a majority of respondents felt virtual interviews were equal to or better than traditional for demonstration of work ethic (33/44, 75%), clinical abilities (30/41, 73%), and citizenship/engagement (26/44, 59.1%). Respondents felt slightly worse or much worse representation by virtual interviews for the categories of personality (24/46, 52.2%), communication skills (24/46, 52.2%), demonstrated interest in the program (25/44, 56.8%), and overall sense of “who I am” (28/46, 60.9%).

Respondents report that their virtual interviewers did extremely well or very well at making the interview feel natural/not artificial, and this appears to be true despite the type of interviewer: PD (34/42, 80.9%), APD (32/42, 76.2%), other faculty (26/41, 63.4%), chair/chief of the division (22/39, 56.4%), and fellows (22/41, 53.7%). They were also extremely satisfied or somewhat satisfied with the time they were given with interviewers: PD (39/42, 92.9%), APD (38/42, 90.5%), other faculty (36/41, 87.8%), fellows (28/41, 68.3%), and chair/chief of the division (27/40, 67.5%).

3.3 Evaluation and program ranking

When provided with a list of factors that respondents found to be helpful when evaluating a program after the interview (Figure 3), the most important (via visual analog scale) were time to speak with current fellows (M = 91.64, SD = 15.39), time to ask questions about the program (M = 90.64, SD = 10.92), and one-on-one time with the PD (M = 90.26, SD = 13.88). The least helpful factors were a live virtual tour of the facilities (M = 43.65, SD = 27.19), time to speak with the chair/chief of the division/department (M = 60.05, SD = 24.65), and prerecorded video or presentation about the program (M = 61.27, SD = 24.65). When

![Applicant Ability to Learn About Programs Virtually](image1)

**FIGURE 1** Applicant ability to learn about programs virtually
**FIGURE 2** Applicant ability to present themselves virtually

**FIGURE 3** Important factors in postinterview program evaluation
separately asked what one single factor was most helpful for evaluating a program, 35.7% (15/42) reported time speaking with current fellows, 23.8% (10/42) reported one-on-one time with the PD, and 23.8% (10/42) reported a live hosted presentation with an overview of the program.

Regarding creating rank lists (Figure 4), respondents report that the most important factors for their decision making were perceived goodness of fit (M = 90.93, SD = 13.20), desired geographic location (M = 85.33, SD = 16.27), and perception of program leadership (M = 82.62, SD = 14.61). The least important factors were benefits/moonlighting/salary (M = 47.19, SD = 26.23), the number of fellowship positions available (M = 52.95, SD = 25.36), and the opportunity for advanced training/subspecialty fellowship (M = 57.56, SD = 27.82).

3.4 | Future cycles/best practice

A majority of respondents reported that they did not apply to more fellowship programs once they learned that interviews were going to be conducted virtually (38/42, 90.5%), and that they did attend more interviews virtually than they would have in-person/traditionally (23/42, 54.8%). A majority would have liked to attend an optional postinterview program visit if that had been possible in 2020 (33/42, 78.6%).

The preference of virtual versus in-person interviews was varied among the respondents, with a nearly normal distribution pattern: 4.9% (2/41) highly prefer virtual interview, 34.2% (14/41) prefer virtual interviews, 19.5% (8/41) were neutral, 34.2% (14/41) prefer in-person interviews, and 7.3% (3/41) highly prefer in-person interviews. All respondents reported saving money compared to a traditional application cycle, with the most commonly reported savings range being $3,000–$5,000 (13/42, 31%) and a range that extended up to $7,000–$10,000 (5/42, 11.9%).

A hybrid model of interviews is one where program directors would decide individually to have only virtual interviews, only in-person interviews, or offer applicants the option of either a virtual or an in-person interview. 47.6% (20/42) of respondents favored a hybrid interview model for 2021, while 52.4% (22/42) were against a hybrid model because of perceptions of differential ranking depending on the mode of interview they selected (20/42) or a combination of reasons (2/42). No respondents stated that they would be against a hybrid model because they only wanted virtual interviews or they only wanted in-person interviews.
3.5 | Comments

A free text area was provided to respondents to capture thoughts or perspectives that were not otherwise addressed in the survey. These were reviewed by the study team and thematic duplicates were eliminated. Representative comment themes are shown in Table 2.

4 | DISCUSSION

This survey of pediatric anesthesiology fellowship applicants elicited respondent preferences in order to develop “best practices” for future virtual interviews. Key findings include the importance of providing an electronic “packet of information” prior to each interview day, providing dedicated time for applicants to interact with current fellows, providing applicants with background information about the geographic location of the program, and offering a completely optional/obligation-free postinterview visit, when possible. Importantly, study results indicate that when feasible to resume in-person interviews, most applicants would accept the option of virtual interviews if offered penalty-free for those applicants who prefer it.

Respondents of this survey felt they were able to convey most attributes about themselves to programs as well virtually as they could in a traditional interview which supports current published literature. Vining et al. reported that all of the CGSO fellowship applicants (16/16) to their single center reported a good or very good understanding of the program after the virtual interview day. On the other hand, Hill et al. found that only 39% (25/64) of CGSO fellowship applicants agreed or strongly agreed that a virtual interview allowed them to decide if a program was the “right fit.” The reported data did not ask respondents how well they felt virtual interviews did at conveying the information but rather compared it to the standard of a traditional interview. Despite this virtual interview cycle being put together with no advance warning, several different aspects were transmitted to the applicant as well virtually as if it were a traditional interview. Our hope is that program directors can use the data provided to identify areas for improvement in future virtual interviews with the luxury of time for organization and planning.

To date, there are no published data describing the factors influencing pediatric anesthesiology fellow applicant decision making when creating a rank list. Chun et al. surveyed pediatric otolaryngology fellowship applicants (32/47, 68%) and found that the most important factor in creating a rank list was a strong opportunity to gain experience in otology and airway management, location, and faculty reputation. Niesen et al. surveyed 143 orthopedic surgery residents applying for a fellowship and found that surgical experience, the prestige of the program, previous fellow experience, and

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location most important in rank list across all fellowships. The findings of this survey provide a sampling of data on how applicants evaluate programs (Figure 3) and the most important factors in making their rank lists (Figure 4). It should be noted that the most important factor in making a rank list was “perceived goodness of fit” (Figure 4) yet a majority of respondents (26/43, 60.5%) found virtual interviews to be worse at learning the goodness of personal fit for the fellowship (Figure 1). This may be the largest obstacle to overcome in the continuation of virtual interviews, and it is our hope that the presented data (Figure 3) can be used to help programs re-factor their virtual interview processes to best meet the needs of the applicants. This area may warrant further study in the future.

In-person interviews are both financially and temporally burdensome to medical students and residents. Medical students applying to urology spent a median of $4000 each per interview cycle and spent an average of 20 days on the interview trail. Pediatric surgery fellowship applicants spent an average of $8722 and an average of 23.2 days away from residency training. Orthopedic surgery residents applying for fellowship spent an average of $4671 and spent a mean of 10 days away from residency training. This study is consistent with these findings, as respondents reported saving money compared to a traditional application cycle, with the most commonly reported savings being $3,000–$5,000 and a range that extended up to $7,000–$10,000. Given the high debt burden carried by many graduate medical education trainees, these savings should not be understated.

In contrast to this study, a majority of CGSO fellows preferred live interviews compared to the virtual interviews they underwent. However, based on the responses it is clear that pediatric anesthesia applicants harbored fear that virtual interviews in a hybrid system would be differentially evaluated by programs. It is possible that this also factored into the Vining study. Vadi et al. offered applicants to their anesthesiology residency a choice of a virtual or traditional interview and found no significant difference in their admission rate between either interview type; further study of this type could help to alleviate some of the concerns about interview type discrimination in the future.

Limitations of this study include selection bias, a 30% response rate, recall bias and response bias. Since the mode of survey distribution depended on program director assistance, selection bias may also have been amplified if some program directors were more prone to comply with the request. However, we selected this method because it is the only feasible way to reach all incoming fellows due to the complex nature of the match in pediatric anesthesia (particularly with an unknown number of out-of-match fellowship position offers). The response rate reported is not a response rate in a traditional sense as there is no way to determine the number of matched applicants provided the opportunity to complete the survey (the denominator) due this mode of distribution. Thirty percent (50/167) is a roughly accurate measure of percentage for possible individuals who could have taken the survey; while this is a relatively low response rate, there is no evidence we are aware of (nor is it our subjective experience) that respondents and non-respondents should differ significantly for these data. We presume that, due to the survey distribution method, there may have been entire programs where none of the matched fellows participated in this survey. In order to maintain respondent anonymity, we did not collect data on matched program, number of interviews, or which programs they completed an interview. However, as virtual interviews were practically never used in medical education prior to 2020, all applicants likely had similar previous experience with virtual interviews.

Regarding questions about the virtual interview process, it is similarly important to note both that no programs had significant experience with virtual interview processes and that a vast majority of applicants’ interview at multiple programs. As such, while particular programs may have been outliers in either excellent or poor performance, questions about the process as a whole are likely enhanced by this broader experience. Thus, our respondent population should be able to provide helpful insights about the process despite the ample limitations.

It is worth noting that, to date, this is the largest sample of GME applicant attitudes toward virtual interviews reported. Nonetheless, since the survey was completed after completion of the match process, an important limitation is recall bias, which may have skewed results depending on an individual respondent’s satisfaction with match results. Finally, surveys are always subject to response bias particularly in their construction by the investigators; we attempted to mitigate this by piloting the survey and iteratively revising the survey prior to distribution.

Despite these limitations, we believe that this survey provides meaningful, previously unpublished data about virtual interviews that can help improve future fellowship interviews in pediatric anesthesia. Moreover, the findings confirm our belief that many applicants consider virtual interviews a viable long-term alternative to traditional interviews for pediatric anesthesia fellowship. We believe these data are likely extrapolatable to other anesthesia subspecialty fellowships given the similar applicant pool (anesthesiology residents) and fellowship structures (one year), but this is an area for further study. Finally, a study of program director attitudes surrounding virtual interviews has already been completed and will complement these results to form a more complete picture of future best practices in this area.

**DATA AVAILABILITY STATEMENT**

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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**SUPPORTING INFORMATION**

Additional supporting information may be found online in the Supporting Information section.

**How to cite this article:** DiGiusto M, Lupa MC, Corridore M, Sivak EL, Lockman JL. The impact of the COVID-19 pandemic on the 2020 pediatric anesthesiology fellowship application cycle: A survey of applicants. Pediatr Anaesth. 2021;00:1-9. https://doi.org/10.1111/pan.14226