OPINION

Myth Busted! Dispelling Myths Surrounding Pediatric Radiology as a Career

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INTRODUCTION

Pediatric radiology is a unique subspecialty of diagnostic radiology with high job satisfaction [1,2]. Pediatric radiologists frequently report enjoying the diversity of their work, the mission of helping children, and the community of their colleagues. However, trainee interest in pediatric radiology has decreased since 2013 and remains low (Fig. 1) [3-5]. At the heart of why trainees do not choose pediatric radiology lies a series of myths about the subspecialty [5]. Some myths may pertain more to general radiology or adult subspecialties, whereas pediatric radiology is an outlier. Correcting these myths is paramount in increasing trainee interest in pediatric radiology.

MYTH #1: PEDIATRIC RADIOLOGISTS DO NOT INTERACT WITH PATIENTS OR REFERRING PROVIDERS

Busted: Pediatric radiologists have frequent contact with patients and their families, which is one of the most rewarding aspects of our work. In particular, pediatric interventional and neurointerventional radiologists diagnose, treat, and follow patients like other surgical specialists. Although imaging examinations can be challenging for children, child life specialists help ease their fears using distraction techniques. We also enjoy frequent contact with referring providers and are routinely sought out for consultation. We participate in many success stories, and our impact on patients can last a lifetime.

MYTH #2: PEDIATRIC RADIOLOGY IS NOT GENDER DIVERSE

Busted: Although women now account for the majority of US medical school applicants and graduates, the percentage of women in radiology remains low at 28%, up slightly from 23% in 2018 [6]. In contrast, almost half of pediatric radiologists are women, with 48% of active members of the Society for Pediatric Radiology (SPR) identifying as women (A. Davis, SPR, personal communication). In the 2021 ACR/Radiology Business Management Association Workforce Survey, 57% of female respondents reported practicing pediatric radiology compared with 28% of all respondents [7]. The only other radiology subspecialty to exceed this is breast imaging, at 75% (K. Willis, Society of Breast Imaging, personal communication).

MYTH #3: PEDIATRIC RADIOLOGISTS ARE LIMITED IN THE MODALITIES THEY CAN READ

Busted: Pediatric radiology is unlike any other radiology subspecialty because it is a microcosm of all other radiology subspecialties. Pediatric radiologists read all imaging modalities, including radiography, ultrasound, fluoroscopy, CT, MRI, and nuclear medicine. In addition to general pediatric radiology, subspecialization is available in pediatric neuroradiology, cardiothoracic, body, musculoskeletal, fetal, nuclear medicine, emergency, interventional radiology (IR), and neurointerventional radiology. Many of these subspecialties can be practiced without additional dedicated fellowship training.

MYTH #4: PEDIATRIC RADIOLOGY LIMITS CAREER OPPORTUNITIES

Busted: Pediatric radiologists have diverse job opportunities across all practice types and geographic regions. Practice types generally include academic, private, and teleradiology groups. Jobs vary in the percentage of on-site versus remote work and the percentage of pediatric versus adult imaging. Private groups are more likely to require pediatric radiologists to interpret adult and pediatric imaging to varying degrees, whereas academic practices often allow radiologists to practice 100% pediatric imaging. Various shift-work models, including evening and overnight hours, are available to suit different lifestyles. Pediatric radiology does not limit one's ability to change from one practice type to another throughout their career.

Although many children's hospitals are located in urban and suburban areas, employers may offer remote

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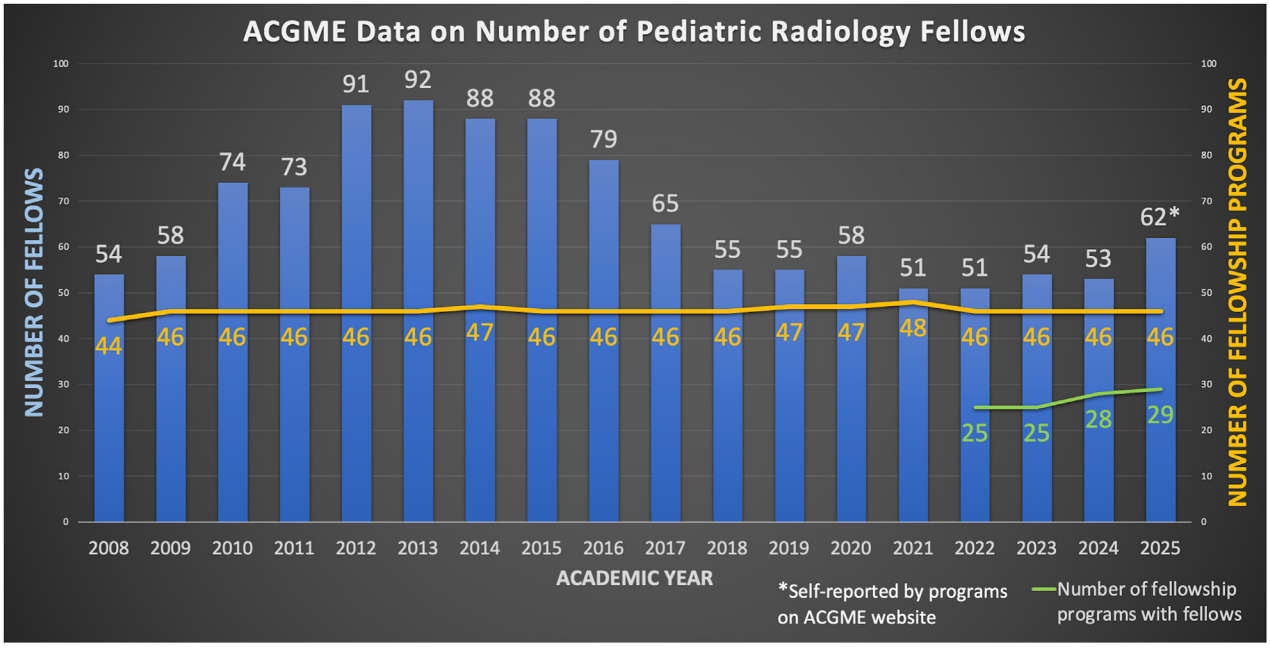

Fig. 1. Summary of pediatric radiology fellows showing the peak in number of fellows in 2013 and subsequent decline through 2018. From 2018 to 2023, there was less variability in the number of fellows, with an average of 54. The 62 fellows in 2025 is likely falsely elevated as it represents self-reported data from fellowship programs. The final number, when published in the 2025 ACGME Data Resource Book in the fall, will likely be lower. The number of ACGME-accredited fellowship programs remains largely unchanged at 46 [3,4]. The x axis indicates the end of each academic year.

work enabling pediatric radiologists to live anywhere in the United States or even internationally. Private practices highly value pediatric radiologists, as they may serve a dedicated children's hospital, a pediatric floor or wing within an adult hospital, and/or perform pediatric imaging at adult facilities across their network.

The SPR and ACR Career Centers confirm the current demand for pediatric radiologists. The SPR Career Center has had a total of 1,360 jobs posted from October 2023 to January 2025 (Fig. 2) [8]. This underestimates the number of available jobs, as some postings represent more than one available job, whereas others are not posted at all [7].

In terms of professional development and growth opportunities, pediatric radiologists are not limited in their work beyond children's hospitals. For example, pediatric radiologists are department chairs, deans, practice leaders, hospital- and systemwide quality and safety officers, informatics officers, chief medical officers, and health policy leaders.

MYTH #5: PEDIATRIC RADIOLOGY CALL IS TOO BURDENSOME

Busted: Call responsibilities are highly variable across practices and can change over time. Call might be split evenly among pediatric radiologists, divided on the basis of subspecialty (ie, body radiology, neuroradiology, and IR), or shared with adult radiology call in private practice. Some jobs may not require call if they are 100% remote and the group has 24/7 on-site coverage.

Fluoroscopy is one of the primary responsibilities for after-hours pediatric call coverage. However, this is decreasing as more children's hospitals adopt ultrasound to evaluate for midgut volvulus [9]. Additionally, new literature supports that intussusception reductions are urgent rather than emergent procedures, which can be safely performed up to 8 hours after presentation [10]. With these paradigm shifts in managing after-hours emergencies, it is likely that the call burden will diminish at many practices.

MYTH #6: FELLOWSHIP IS REQUIRED TO BECOME A PEDIATRIC RADIOLOGIST

Busted: The ABR recently approved an integrated 15-month training pathway to diagnostic radiology certification and pediatric radiology subspecialty certification, similar to that of nuclear medicine [11]. Additionally, a candidate with diagnostic radiology, general radiology, or combined IR/diagnostic radiology certification can attain pediatric radiology subspecialty certification without an accredited fellowship if they serve as a faculty member at a single institution that has a residency training program at 1.0 full-time equivalent (FTE) for 2 consecutive years with $\geq$75% clinical responsibility in pediatric radiology or 1.0 FTE for three consecutive years

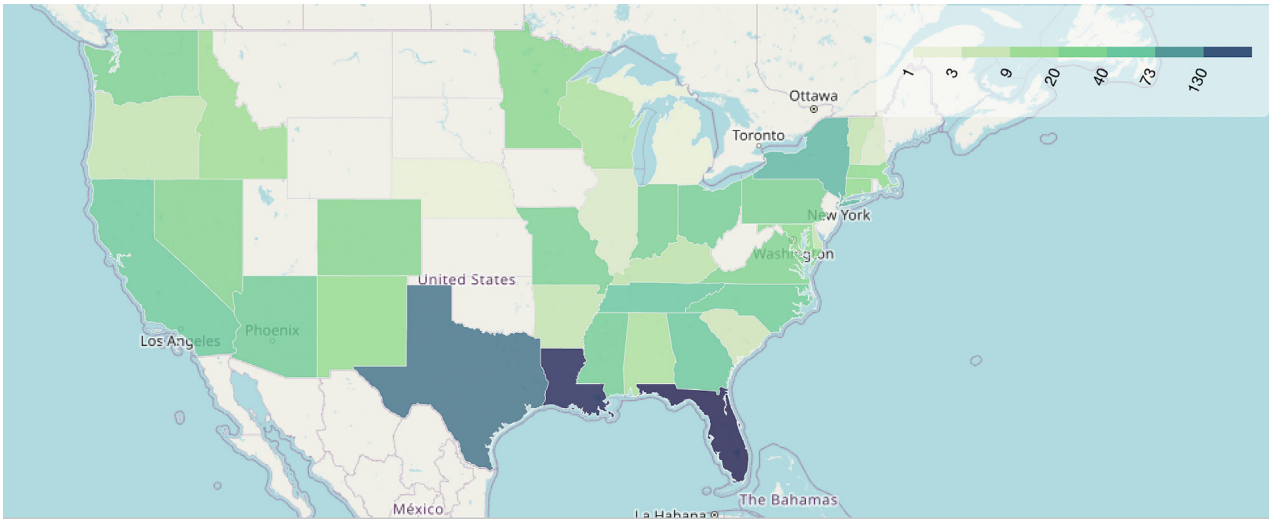

Fig. 2. Heatmap showing the geographic distribution of the 1,360 jobs posted on the Society for Pediatric Radiology Career Center from October 2023 to January 2025 [8].

with ≥50% clinical responsibility in pediatric radiology [12]. This certification pathway is also available for part-time faculty members (≥0.6 FTEs). This may provide an appealing alternative to the traditional pediatric radiology fellowship for trainees who want to enter practice directly after residency or to pursue fellowship in another subspecialty [12].

MYTH #7: PEDIATRIC RADIOLOGISTS HAVE LOWER SALARIES THAN ADULT RADIOLOGISTS

Busted: No salary disparity exists between pediatric and adult radiologists in noninterventional subspecialties. The 2019 Association of Administrators in Academic Radiology Faculty Salary & Productivity Survey revealed that the salaries of academic pediatric radiologists at the 50th percentile are on par with those of most noninterventional adult subspecialties [5]. The 2023 surveys by the Association of Administrators in Academic Radiology and Society of Chiefs of Radiology at Children's Hospitals confirm that pediatric and adult radiologists at the 50th percentile have essentially the same total compensation at each academic rank (ie, assistant professor, associate professor, and professor). Furthermore, data from the 2023 ACR/Radiology Business Management Association Workforce Survey show no significant difference in mean salary for pediatric and adult radiologists in noninterventional subspecialties [13].

The 2019 Society of Chiefs of Radiology at Children's Hospitals survey demonstrated that salaries were generally higher for pediatric radiologists in private practice than in academics, while productivity was essentially the same [5]. In private practice, there is a general expectation that radiologists will be productive. Private practice compensation models differ from academics and also vary depending on the group. In some groups, partners may have the same salary with bonuses equally distributed. Other groups may issue productivity-based bonuses, typically benchmarked to the subspecialty. Benefits also factor into total compensation. These include insurance (health, vision, dental, disability, and malpractice), retirement contributions, and academic funds, which often cover professional membership and licensing fees.

MYTH #8: PEDIATRIC RADIOLOGY HAS FEWER RESEARCH OPPORTUNITIES

Busted: Research continues to advance the practice of pediatric radiology, and there are endless opportunities, both within pediatric radiology and through collaboration with other specialties. Research can be clinical, translational, bench, educational, or nonclinical. The SPR Research and Education Foundation awards a variety of grants each year to pediatric radiology researchers at all career stages. However, research does not require funding or a large institution with robust infrastructure. Additionally, many pediatric radiologists involved in research still practice clinically.

Although abundant opportunities exist for those interested, research is not required to obtain a pediatric radiology fellowship or job. Furthermore, research is not necessarily required for career advancement, even in the academic setting. At academic institutions, promotion pathways are often divided into academic and clinical tracks. The academic track typically has more rigorous research and publication requirements. In the clinical track, research can help but is generally not required for promotion.

MYTH #9: PEDIATRIC RADIOLOGISTS FACE GREATER MALPRACTICE RISK THAN ADULT RADIOLOGISTS

Busted: Often, students and trainees believe that they can be sued for any

medical error until the patient becomes an adult and that their malpractice insurance will be higher as a result. This is not always true, as medical malpractice statutes are very complex and vary by state.

Using Missouri as an example, section 516.105(3) of the Revised Statutes of Missouri (2018) states, "In cases in which the person bringing the action is a minor less than eighteen years of age, such minor shall have until his or her twentieth birthday to bring such action" [14]. Comparatively, for adult patients in Missouri, the statute of limitations for medical malpractice is 2 years, and for medical malpractice injury resulting in death, it is 3 years. The start of the limitations period can be considered the date of treatment or the date of death, except in minors, for whom the law states, "In no event shall any action for damages for malpractice, error, or mistake be commenced after the expiration of ten years from the date of the act of neglect complained of or for two years from a minor's eighteenth birthday, whichever is later" [14]. This limitation period can overlap with other exceptions, and when it does, the longer time period generally applies. Nonetheless, many states have a statute of repose that limits the number of years that a lawsuit can be filed, regardless of exceptions.

In addition, malpractice insurance costs vary on the basis of the insurance carrier's underwriting policies. For example, some insurance companies assess risk on the practice or procedure rather than on whether the patient is a child or an adult. However, even though the potential liability period for children is longer and more uncertain, pediatric providers may actually have lower rates than general providers [15].

MYTH #10: PEDIATRIC IMAGING VOLUMES ARE MUCH LOWER, ALLOWING MORE TIME TO INTERPRET EACH EXAMINATION

Busted: For better or worse, pediatric radiologists are just as busy as our adult colleagues. We might be erroneously viewed as less productive because pediatric imaging examinations, on average, yield fewer relative value units (RVUs) compared with adult imaging. Most pediatric imaging is composed of radiography and ultrasound, with MRI, CT, fluoroscopy, nuclear medicine, and IR representing important but smaller percentages of the overall volume. With the goal of reducing radiation exposure in this vulnerable population, fewer CT examinations are performed, and modalities without ionizing radiation are used when clinically feasible. MRI volumes also tend to be lower, as many young patients require sedation, which has its own inherent risks. In addition, pediatric practices may perform more fluoroscopic examinations, which can be time consuming while also representing low RVU-generating examinations. Therefore, although the total RVUs produced by pediatric radiologists are sometimes less than by adult radiologists, the total number of examinations is still high because of the volume of radiographic and ultrasound studies. Pediatric radiologists across all practice types are very busy and remain valued by their adult colleagues despite the differences in RVU productivity. In fact, because pediatric radiologist salaries are equivalent to those of noninterventional adult radiologists, in theory, pediatric radiologists earn more money per RVU.

CONCLUSIONS

Myths surrounding the pediatric radiology subspecialty are largely unfounded. Pediatric radiologists enjoy rewarding careers with myriad opportunities for professional growth. Trainees should not exclude pediatric radiology on the basis of perceived call responsibilities because the wide range of available opportunities allows job seekers to find one with call responsibilities that fit their preferences. Although compensation tends to be comparable with other radiology subspecialties, salary is only part of finding the right career opportunity; arguably more important factors to consider include group culture and how you are valued by colleagues. It is our opinion that given job market fluctuations over time, trainees should choose a subspecialty they are passionate about to maximize happiness and career longevity.

Answers to commonly asked questions about pediatric radiology are available on the SPR website (Supplemental Material).

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