No gender-related trends found when pediatric dentists select a second specialty

Michael W. Roberts, DDS, MScD F. Thomas McIver, DDS, MS Ceib L. Phillips, PhD, MPH

The number of women entering dental school in the United States continues to rise. In 1993, 36.7%[1] of students entering dental school were female. It has been projected that 30% of dentists in the United States will be women by the year 2030.[2,3]

The increase in the number of female dentists also has been reflected in the gender distribution in pediatric dentistry. The number of women first-year students entering pediatric dentistry training programs surpassed 50% in 1990,[4] and comprised 56.5% in 1993.[5] In addition to changes in the gender composition of the profession, a number of existing pediatric dentists have returned to school seeking training in a second dental specialty. The purpose of this study was to examine the gender profile of dual-trained pediatric dentists.

Methods

A questionnaire was mailed to 2,612 US members of the American Academy of Pediatric Dentistry (AAPD). Specific information was requested regarding age, gender, and additional training in other recognized dental specialties. No follow-up correspondence was sent. The Cochran-Mantel-Haenszel general association statistic was used to assess gender proportional differences. Level of significance was set at 0.05.

Results

A total of 1,422 completed responses were returned. The gender response distribution was 1,139 males (80%) and 283 females (20%). Information presented in this report is a subset of data obtained from a survey that was the subject of a previous publication.[6]

The mean age of male respondents was 47 (range: 27–88), female respondents 38 (range: 27–68). Seventy-five males and 23 females reported to be trained in an American Dental Association-recognized specialty in addition to pediatric dentistry. The proportion of women who selected a second specialty was not statistically different from men ($P = 0.38$). Both genders reported dual training in orthodontics most often, followed by public health. Of those who selected a second specialty, there was no statistical difference between the proportion of males and females who selected orthodontics ($P = 0.19$) or public health ($P = 0.09$; Table). Men comprised 1% and women 2% of responders citing public health as a second specialty.

TABLE. RESPONDERS WITH DUAL TRAINING

	Additional Specialty		
Specialty	*Female (%)*	*Male (%)*	*Total*
Orthodontics	15 (5.0)*	59 (5.0)*	74
Public health	7 (2.0)*	11 (1.0)*	18
Endodontics	—	2 (0.2)†	2
Periodontics	—	1 (0.1)†	1
Oral pathology	1 (0.4)†	2 (0.2)†	3
All specialties	23 (8.0)*	75 (7.0)*	98

* No significant difference between proportion of males and females.

† Insufficient data for statistical analysis.

Discussion

The gender distribution of the AAPD is 79.5% male and 20.5% female. Respondent bias in surveys is difficult to address. However, the gender distribution and the mean age of the respondents were very similar to the membership profile of the AAPD. The gender distribution of respondents reporting dual training in orthodontics reflected closely the AAPD membership profile.

The current study suggests a trend — of those who seek a second specialty, a greater number of women (7/23) than men (11/75) choose public health. Although in this study 15% more females had additional training in public health, the sample size was not adequate to detect a significant difference. Specialists in public health often hold administrative positions and provide fewer hours per week of primary patient care. On the other hand, some public health positions entail providing direct patient care, often in settings where disease is more extensive than encountered in private practice. The lack of statistical significance and small response make it difficult to do more than speculate as to primary care impact.

Dr. Roberts is associate professor and Dr. McIver is professor, department of pediatric dentistry; Dr. Phillips is research professor, department of orthodontics; University of North Carolina at Chapel Hill.

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5. Personal communication: American Academy of Pediatric Dentistry, Chicago, IL, 1994.
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Fewer side effects should increase drug compliance rates

Newer drugs also being used to treat chronic mild depression

The development of drugs with far fewer harmful side effects should improve the outlook for treating depression, an illness often made worse by low compliance rates among patients who don't maintain treatment programs, says a University of Pennsylvania psychiatrist.

Karl Rickels, MD, Stuart and Emily B.H. Mudd Professor of Human Behavior, and Professor of Psychiatry, University of Pennsylvania, Philadelphia, spoke at an American Medical Association news briefing on mental health in December.

"Because of the more favorable side effect profile, the newer drugs are also being used to treat chronic mild depression," says Rickels. The new drugs have opened up a whole new arena of therapy for patients "that we couldn't treat with drugs before," says Rickels. Physicians often did not treat mild depression with the older drugs because of the many side effects.

Side effects are "very important when you have to treat patients for a long period of time, which you have to do with depression," Rickels says. "Depressions respond to medication — the most consistent treatment," he adds. The benefit of the newer generation of antidepressants are "you can use them for longer periods of time and give them to fewer sick patients."

The newer antidepressants are safer in overdose, don't harm the heart, don't produce weight gain, and don't cause seizures. "Because of their safety, they are the drugs of choice for the elderly," Rickels says. Patients who do experience side effects from the newer drugs often adapt to them, and symptoms like nausea or queasiness disappear with time. Rickels says another benefit of the newer drugs is that patients respond to lower dosages, further decreasing the risk of any side effects.

The new drugs are more expensive than the older versions, but that cost is expected to decrease as more of the drugs come on the market, Rickels says. "The new drugs are more similar than dissimilar," he concludes.

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