EDITORIAL

Female Physician Suicide Compared to the General Population

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US physicians' elevated risk for depression has been well established in the past decade[1]—however, the risk of physician suicide relative to the general public remains unclear. In this issue of *JAMA Psychiatry*, Makhija and colleagues[2] use data from 97 915 US suicides from 2017 to 2021, drawn from the US National Violent Death Reporting System, to estimate sex-specific suicide incidence rates among physicians and the general population. The authors' findings indicate that rates of suicide are higher among female physicians and lower among male physicians compared to sex-matched nonphysicians in the general population.

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Prior studies comparing physician suicide rates to rates of sex-matched nonphysicians in the general population are either outdated or focus primarily on individuals outside the US. Given the ever-changing health care landscape, a more accurate estimate of the sex-specific national incidence of suicide for physicians is crucial. Consistent with results of a recent international meta-analysis,[3] Makhija and colleagues'[2] findings suggest that female physicians have higher rates of suicide than nonphysician female individuals in the general US population, while the same was not true for male physicians. Taken together with comparable data on female nurses and suicide risk,[4] these findings suggest that there is something fundamentally different about the experience of female physicians in health care that disproportionately increases suicide risk compared to other work environments.

Differences in depressive symptoms—a major risk factor for suicide—between male and female physicians are primarily driven by increased work hours and, in particular, heightened work-family conflict.[5] A 2023 study[6] shows a decrease in work hours among physician-fathers over the past 2 decades, while physician-mothers' work hours increased. At the same time, female physicians were more likely to be a part of a dual-career family and perform disproportionately more housework and caregiving duties than male physicians, resulting in a higher overall personal and professional workload.[7] The COVID-19 pandemic further exacerbated these inequalities, with physician-mothers being 30-fold more likely to manage childcare and schooling responsibilities compared to physician-fathers.[8] Among dual-physician couples, this disparity was even greater, with not a single male physician in a 2021 study[8] taking a primary role in managing the increased pandemic caregiving demands. This increasing work-family conflict, driven by a combination of growing work responsibilities and the second shift (ie, unpaid labor in households and childcare, which disproportionately impacts women) at home, has contributed to higher rates of depression, burnout, and emotional exhaustion.[8] The competing and incompatible demands of work and family among female physicians are so severe that data show that almost three-quarters of female physicians reduce their work hours to part-time or consider part-time work within just 6 years after completion of training to mitigate work-family conflict.[9]

Gender disparities in work-family conflict and mental health are further compounded by the disproportionately high rates of sexual harassment in medicine and persistent gender inequities in promotion and pay, both of which are associated with poorer well-being and attrition from the workforce.[10] With these primary drivers of mental health disparities among female and male physicians clearly driven by institutional rather than individual factors, the field of medicine must move beyond awareness to the implementation of proactive, preventive measures that address the identified causes. Upholding policies that support diversity, equity, and inclusion and target sexism and racism in medicine are necessary.[1] Organizations must also create flexible practice environments that recognize that most physicians are in dual-career relationships with shared family duties, enabling physicians of all genders to meet their personal and professional obligations while minimizing risk of burnout, depression, or suicide.

Prioritizing system-level interventions that reduce individual work hours and workload is critical for improving the mental health of all physicians and would particularly benefit physician-mothers due to their increased overall workload and work-family conflict. The lack of flexibility in physician work schedules significantly contributes to childcare challenges, particularly when unplanned parenting demands arise (eg, child illness, school closure). Improved access to quality childcare options that align with physicians' work schedules and implementation of a formal coverage system for last-minute schedule changes could significantly reduce the burden on physician-mothers and their colleagues. In addition to childcare, access to services that can help reduce female physicians' overall workload, such as meal delivery and home cleaning, could be helpful.

Improved parental leave policies are also crucial. The American Academy of Pediatrics recommends at least 12 weeks paid leave for the benefit of the mother and child's physical and mental health. However, according to a 2018 study,[11] the average paid childbearing leave for US faculty physicians is only 8.6 weeks. As the field of medicine is tasked with safeguarding the health of others, it must also take responsibility for the well-being of its own workforce, ensuring that female physicians have the resources and support needed to thrive personally and professionally.

Moving beyond the development and implementation of supportive policies, a shift in culture around work and family within medicine is critical to improving workplace condi-

tions and mental health for female physicians. To reduce fears around flexibility stigma (ie, a cultural bias that can make it difficult for people to utilize family-supportive policies for fear they will be seen as less committed or dedicated to their work), leadership must not only enact supportive policies but also actively promote and model their use. For example, normalizing the use of parental and sick leave for male physicians and taking time off for caregiving needs more broadly can help challenge gendered parenting expectations within medicine and foster a more supportive culture wherein physicians of all genders feel they can take time off for caregiving needs without penalty.

These findings from Makhija and colleagues[2] underscore the urgent need for US health care systems and leaders to address the root causes of increased depression and suicide risk among physicians in general, with a specific focus on the factors that disproportionately affect women. To address the elevated suicide risk observed in female physicians, it is crucial to implement approaches proven to reduce suicide risk in the general population, including ensuring accessing to timely care, means restrictions and safety planning for those at risk, as well as targeted efforts to mitigate work-family conflict. As women now represent the majority of medical school graduates and a growing proportion of the physician workforce, the institution of medicine must recognize the unique combination of stressors that female physicians face and endeavor to make real change moving forward. Strategic action to address the longstanding systemic gender inequities in medicine is critical to improving workplace conditions—for the benefit of all physicians and the communities they serve.

ARTICLE INFORMATION

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