Elsewhere in *JAMA Network Open*, Kohrt and colleagues reported findings from a pilot cluster randomized trial testing clinician training to reduce the stigma experienced by primary care patients with serious mental illness. Stigma experienced during a clinical encounter by patients is problematic because it not only can create barriers to accessing adequate clinical care but also compromises relationships, education, and access to housing, thereby further marginalizing an already at-risk population. Primary care practices from Nepal were randomized to receive 2 different stigma-reducing training programs. Primary care clinicians (n = 43) from 17 practices received the standardized training from the World Health Organization in the control arm, and clinicians (n = 45) from 17 different practices received the same training program with additional social distance-reducing components and cofacilitation by trained patients and master clinicians in the enhanced training arm. This pilot trial aimed to estimate the interventions’ feasibility, acceptability, and fidelity, and this goal was met mainly. But these goals do not capture the interesting features of this trial.

The unique components in the enhanced training group included the following features. First, patients with the lived experience of serious mental illness engaged in a standardized trainer training program. They were rated for their adherence to the core components of the intervention delivery. Second, patients were also guided through the PhotoVoice process created to foster social change and empower socioeconomically disadvantaged communities. Through this process, patients each created a 7-minute photographic recovery narrative about their life before, during, and after successful treatment that were used in the program. These patients were included in training clinicians in the enhanced training group and attended meal breaks, icebreaker sessions, and other informal, social parts of the training program. Finally, clinicians nominated by their supervisors for dedication to and mastery of caring for patients with mental illness also served as cofacilitators. They were asked to provide myth-busting sessions and patient recovery stories from their perspective.

Although not primary outcomes, multiple unique clinical outcomes were assessed in this trial. These outcomes were assessed at 4- and 16-months after training to ensure the changes endured. The first interesting clinical outcome included was the clinician-reported level of social distance from patients with mental illness. Social distance is the willingness to spend time or associate (eg, eat a meal, work alongside, or engage in a close personal friendship) with persons from the stigmatized group. In this trial, clinicians receiving the enhanced training reported a decrease from 16 months to baseline of −10.6 points (95% CI, −14.5 to −6.74 points) compared with −2.79 points (95% CI, −8.29 to 2.70 points) for those in the control group on a 60-point social distancing scale. The second interesting clinical outcome was the accuracy of mental illness diagnoses in standardized role-plays, in which actors presented with symptoms of a serious mental illness, and clinicians provided a provisional diagnosis. At 16-months after training, accuracy was 78.1% (25 of 32) in the enhanced training group and 66.7% (22 of 33) in the control group. Third, after 14 to 22 months, the accuracy of diagnoses of depression, psychosis, or alcohol use disorder in actual patients was validated by a psychiatrist, blind to the primary care clinician diagnosis, who used a structured psychiatric interview with each patient. For actual patient diagnoses confirmed with the psychiatrist-administered interview, 72.5% of patients (29 of 40) receiving care from clinicians in the enhanced training group were correctly diagnosed. In comparison, only 34.5% (10 of 29) were correctly diagnosed from the control group. Assessing actual social distance behavior would have improved this trial’s innovation even further. However, demonstrating changes in diagnostic accuracy in both standardized patient
actors and actual patients is a clinical trial outcome that more trials of clinician training should emulate.

Clinicians can potentially communicate stigmatizing attitudes toward patients with mental illness when these patients seek primary care. These attitudes, in turn, have a potentially deleterious impact on the quality and effectiveness of primary care provided. For example, a recent poll of primary care clinicians and patients with serious mental illness revealed that more than half (n = 131; 53%) of clinicians believed patients with mental illnesses care less about preventive care than the general population. Additionally, most clinicians (n = 216; 88%) expressed a lack of confidence that these patients would follow preventive recommendations. However, 88% (n = 139) of the patients with mental illness surveyed reported interest in improving health, and 82% (n = 129) reported they would try to change lifestyles if their clinician recommended a change. Furthermore, patients with serious mental illness have higher rates of preventable chronic conditions and higher premature death rates than the general population, even after excluding suicide and other unnatural causes. Consequently, it is possible that reducing stigmatizing attitudes by primary care clinicians through educational training could ultimately improve other aspects of care received by this large subpopulation of patients.

Empathy and compassion for patients—admittedly more than just the absence of a stigmatizing attitude—are sought after as crucial qualities in primary care clinicians. However, recent movements, news stories, and publicity around health care inequity suggest that these qualities are most easily evoked by patients most like us and may not be present for patients who conventionally experience stigmatization. Recent books, movies, and grand rounds from primary care clinicians also remind us how profoundly the realization comes to individual clinicians who discover the realities of impoverished clinical care they receive when they find themselves as the patient who is stigmatized. Therefore, standardized clinician training to reduce stigma may have pleiotropic therapeutic effects. This training may not only reduce stigma and increase the likelihood that patients receive accurate diagnoses, but maybe it will increase empathy and compassion experienced during the clinical encounter. Perhaps after further replications of the trial by Kohrt et al1 and others, wide dissemination of this type of training may start to combat just one of the many root causes of health inequities in access to and receipt of high-quality clinical care experienced by so many patients who have been traditionally stigmatized.
