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Mr. Smith was ready to be discharged home after his laryngectomy, an extensive operation that removes a patient's throat due to cancer. In the opinion of Dr. Lu-Myers, he was a capable man who had passed

his physical and occupational therapy evaluations with flying colors. Mr. Smith had fulfilled the doctor's list of clinical discharge criteria, and she was eager to send him home. She planned to entrust him and his family to manage his dressing changes, as well as his tracheostomy and drain care, with the support of frequent outpatient nursing visits — all very routine protocol, especially for someone who seemed alert and capable.

The day before Mr. Smith was to be discharged, Dolores, his nurse, approached Dr. Lu-Myers with some concerns: "Mr. Smith seems depressed to me, and you know, his wife has never come by to visit. I'm worried about us discharging him." Dolores explained that Mr. Smith was undergoing a divorce, his children were not around, and he would likely be living alone. With the responsibility for his care now a concern, it was unsafe to discharge him. The care team ultimately found him a temporary rehabilitation facility where he recovered for two weeks until he was ready to go home.

This fictionalized vignette highlights an important aspect of health care: Providers often have vastly different ways of seeing and treating patients, as differences in profession, specialty, experience, or background lead them to pay attention to particular signals or cues and influence how they approach problems. For instance, one person might assess a patient through a clinical lens, focusing on whether the patient meets clinical criteria for discharge, while another might see the patient through a personal or social lens, considering the patient's broader support system at home.

How these lenses are brought together to inform decision making can have profound implications for patients. While diverse perspectives and approaches to care are important, if they are not managed appropriately, they can cause misunderstandings, bias decision making, and get in the way of the best care. For instance, had the providers in Mr. Smith's case not communicated effectively, he may have been sent home too soon, which could have led to complications or readmission.

Unfortunately, this collaboration tends to be the exception rather than the norm in many health care organizations. Communication failures are a common cause of patient harm. They are often due to a culture that does not promote the systematic sharing of differing perspectives, instead supporting a hierarchy of power and one-way transmissions of information — both of which hinder effective communication.

Differences in the lenses providers use to see and make sense of patients' needs extend beyond physicians and nurses. For instance, when emergency department physicians handed off patients to hospital wards, they agreed with hospital physicians about the patient's primary problem in fewer than 50% of handoffs. This is closely linked with ineffective communication and frequently leads to increases in medical errors and malpractice claims.

Even within the same specialty, providers can have varying perspectives and approaches to care, due to their different backgrounds and experiences. Female physicians, for example, are more likely than male physicians to follow evidence-based practice and to engage in more preventive services (e.g., cancer screening) and communication (e.g., information giving, partnership building). Research has

also demonstrated that male cardiologists are more likely to conduct invasive cardiac procedures on the average patient than their female counterparts are (which may be warranted for some patients but less so for others). Similarly, other health care professionals, such as system administrators and managers, also bring varying perspectives to their work that can influence the care patients receive, as highlighted in research by one of us (Jemima) on the racial backgrounds of opioid treatment program managers.

Each way of seeing a particular issue has its pros and cons; what matters is that providers learn to consider each other's perspectives and communicate effectively when working together. This is the only way teams can reach a shared understanding of a patient's diagnosis, identify and resolve any blind spots around an issue, and develop more-robust, well-rounded treatment approaches.

Similarly, individuals must learn to appreciate the limits of their own perspective and seek to adopt other lenses when complex problems demand it. We all adopt a default way of seeing any given issue, which can bias our choices and cause us to overlook other important details. This has been demonstrated in the classic "invisible gorilla" experiment, where participants were so focused on counting basketball passes in a video that they failed to notice someone in a gorilla suit walk by. And this tendency has been shown to impact health care providers as well. For example, in one study (inspired by the gorilla experiment), researchers asked radiologists to examine a set of CT scans of lungs for anomalous nodules. What the researchers didn't disclose was that they had placed an image of a gorilla (larger than the average nodule) on one set of the lung images. The result: 83% of the radiologists missed the gorilla.

In our work to promote more-effective decision making and evidence-based practice, we have come across at least two ways that health professionals can get better at communicating with each other and adopting multiple lenses themselves.

Create an environment that supports perspective sharing and effective communication among team members. The multidisciplinary care team model, championed in modern health care, brings together different providers (e.g., physicians, nurses, social workers, and other specialists) to treat patients. This works best when teams communicate effectively and integrate their diverse perspectives.

Our colleagues at the Johns Hopkins Armstrong Institute for Patient Safety and Quality have shown how utilizing multidisciplinary teams in emergency departments can decrease the risk of misdiagnosis — a costly error that can result in patients being undertreated or overtreated. For instance, many patients come to the ER complaining of dizziness, a symptom that can indicate a variety of possible diagnoses. They found that including a physical therapist in the emergency department care team helped them more accurately diagnose causes of dizziness among ER patients, resulting in better treatment, better patient satisfaction, and faster discharge. This is because the physical therapist had specialized knowledge of a vestibular assessment technique that can help diagnose cause of dizziness.

But in order to leverage the benefits of others' expertise, teams need to prioritize open communication. This requires a strong cultural shift toward voicing opinions and concerns and away from the often siloed, hierarchical, and blaming culture that can predominate in health care settings. Building this culture requires both top-down and bottom-up efforts, but leaders can set the tone through their actions and the behavior they reward among care team members.

One way to create this culture is to have teams practice sharing and adopting different lenses using simulations. We have begun implementing a case-based teaching exercise among surgeons, anesthesiologists, nurses, and technicians who work together to deliver surgical care to patients at Johns Hopkins. The goal is to help them recognize, surface, and integrate different lenses. In our simulation they must decide how to deal with a problematic surgeon who is receiving many complaints from coworkers. The exercise reveals team members' different default ways of seeing the situation and allows them to practice adopting different lenses and combining each other's different perspectives. In doing so, they can hone the effective communication needed to make better decisions during patient care.

Importantly, improving patient care doesn't always mean bringing in different specialties, but it does involve team members being willing to acknowledge different perspectives and learn from one another. Sharing lenses with other people in one's field — such as male and female surgeons sharing how they'd approach a particular patient — can give providers a more comprehensive view of a patient and a more robust plan for action. This is critical for improving care.

Build individual providers' capacity to adopt multiple perspectives. Not all patient care decisions are made in a team setting, so individuals must also practice applying different lenses to overcome the limitations of their default lens and improve their decision making. For example, they can ask, "If I was viewing this as my colleague would, would I see something else?"

Leaders in health care organizations can help by creating more opportunities for different professions to "shadow" one another. For instance, having a physician spend a few days working closely with and observing a nurse in a hospital might help them better understand how nurses respond to patient requests or challenges. Likewise, physicians, nurses, and others who work in one particular specialty might gain new lenses by rotating through a different specialty. While this rotation is common in clinicians' early careers (e.g., during residency), ongoing exposure throughout their careers may help broaden their expertise and improve their problem solving. For instance, surgeon Atul Gawande recently wrote about his own transformative experience visiting primary care headache clinics and learning from their unique approach to diagnosing and treating patients.

Research by one of us (Kathleen) has demonstrated how individuals with experiences in different work domains, called having "intrapersonal functional diversity," can improve team performance by promoting greater sharing of information among team members. This boosts performance more than simply bringing together different subject matter experts.

Building this intrapersonal diversity requires not only exposing providers to different experiences but also continually creating opportunities for them to apply what they learn so that they develop a habit of viewing challenging decisions through multiple lenses. For example, hospitals can create simulation, reflection, and mentoring programs to encourage clinicians to review and learn from their experiences.

Transformations in the U.S. health care system, along with the complex needs of patients, demand more-effective communication and collaboration among the various members of care teams. Understanding how to leverage and coordinate different perspectives will help to cut down on miscommunications and improve patient care. Errors can be avoided — and lives saved — by reducing the common tendency to view complex clinical issues through just one lens. Using perspective-expanding approaches to care, at both the team and individual level, will go a long way toward improving patient care and health outcomes.

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