Interdisciplinary versus multidisciplinary care teams: do we understand the difference?

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AS A MANAGER OF allied health staff in a major metropolitan health care service, I am responsible for recruitment to a variety of different disciplines. One of the questions I regularly ask at interview centres around the applicant's understanding of interdisciplinary teams in the health care environment. Anecdotally, I would estimate that only around one in ten individuals can provide an accurate definition of the role of an interdisciplinary team. The remainder default to a description of multidisciplinary teams, and some even utilise the terms interchangeably.

Demands on the Australian health system continue to grow, with an increasingly ageing population juxtaposing underutilisation of current workforce skills. We care for an increasingly educated population of patients, who may be better described nowadays as clients or even consumers (but that is a language debate for another day). We are continuously challenged to find better, evidence-based ways of doing things that will not only improve patient care (our number one priority), but will reduce costs and increase staff satisfaction and retention rates. The move away from multidisciplinary teams toward interdisciplinary teams is a change that may help us to meet these challenges. Therefore it is essential that we have a common understanding of the differences between the terms, and thus the operational differences between the teams.

Multidisciplinary team approaches utilise the skills and experience of individuals from different disciplines, with each discipline approaching the patient from their own perspective. Most often, this approach involves separate individual consultations. These may occur in a "one-stop-shop" fashion with all consultations occurring as part of a single appointment on a single day. It is common for multidisciplinary teams to meet regularly, in the absence of the patient, to "case conference" findings and discuss future directions for the patient's care. Multidisciplinary teams provide more knowledge and experience than disciplines operating in isolation.

Interdisciplinary team approaches, as the word itself suggests, integrate separate discipline approaches into a single consultation. That is, the patient-history taking, assessment, diagnosis, intervention and short- and long-term management goals are conducted by the team, together with the patient, at the one time. The patient is intimately involved in any discussions regarding their condition or prognosis and the plans about their care. A common understanding and holistic view of all aspects of the patient's care ensues, with the patient empowered to form part of the decision-making process, including the setting of long- and short-term goals. Individuals from different disciplines, as well as the patient themself, are encouraged to question each other and explore alternate avenues, stepping out of discipline silos to work toward the best outcome for the patient.

One of the risks of interdisciplinary teams is that traditional hierarchies, or dominant personality types (or both), may interfere with the process. For example, quieter or less experienced team members may feel intimidated or less worthy, and thus not speak up about their opinions around a patient's care. These individuals would be protected in a multidisciplinary environment, where assessments and interventions are carried out with the patient individually. However, this

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being said, these risks can be managed through well defined and respectful communication protocols within the team.

Interdisciplinary teams have some obvious advantages over multidisciplinary, the most obvious being the patient-centred approach. Furthermore, it provides a stimulating work environment within which staff can learn about, and even conduct, some of the assessments and interventions traditionally carried out by other disciplines (where it is safe and appropriate for them to do so). When done well, it is an extremely efficient method of operating, with both time and cost savings from the lack of duplication and need for follow-up case conferencing. One of the unexpected advantages of the interdisciplinary teams may be the evolution of new workforce roles, developed through identification of service system gaps not always visible in multidisciplinary teams. An example of this may be an advanced allied health assistant role, where the assistant takes on some of the tasks traditionally held by medical, nursing and/or allied health staff.

I am not suggesting that we "do away" with multidisciplinary and single discipline interventions, as these are still valuable and valid methods of providing patient care. However, what I am suggesting is that we need to develop a common language and understanding of what these two terms mean, and what this translates to in practice. Upon reviewing the literature around interdisciplinary and multidisciplinary teams, and through discussions with colleagues, it is clear that we are still debating the definitions — presented here is my interpretation. We clearly need more debate about the terms, and a great deal more clinical research evaluating the different methods in the health care environment. We are only at the beginning.

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