Multidisciplinary Collaboration: The Core of Integrated Healthcare Delivery

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9 September 2025

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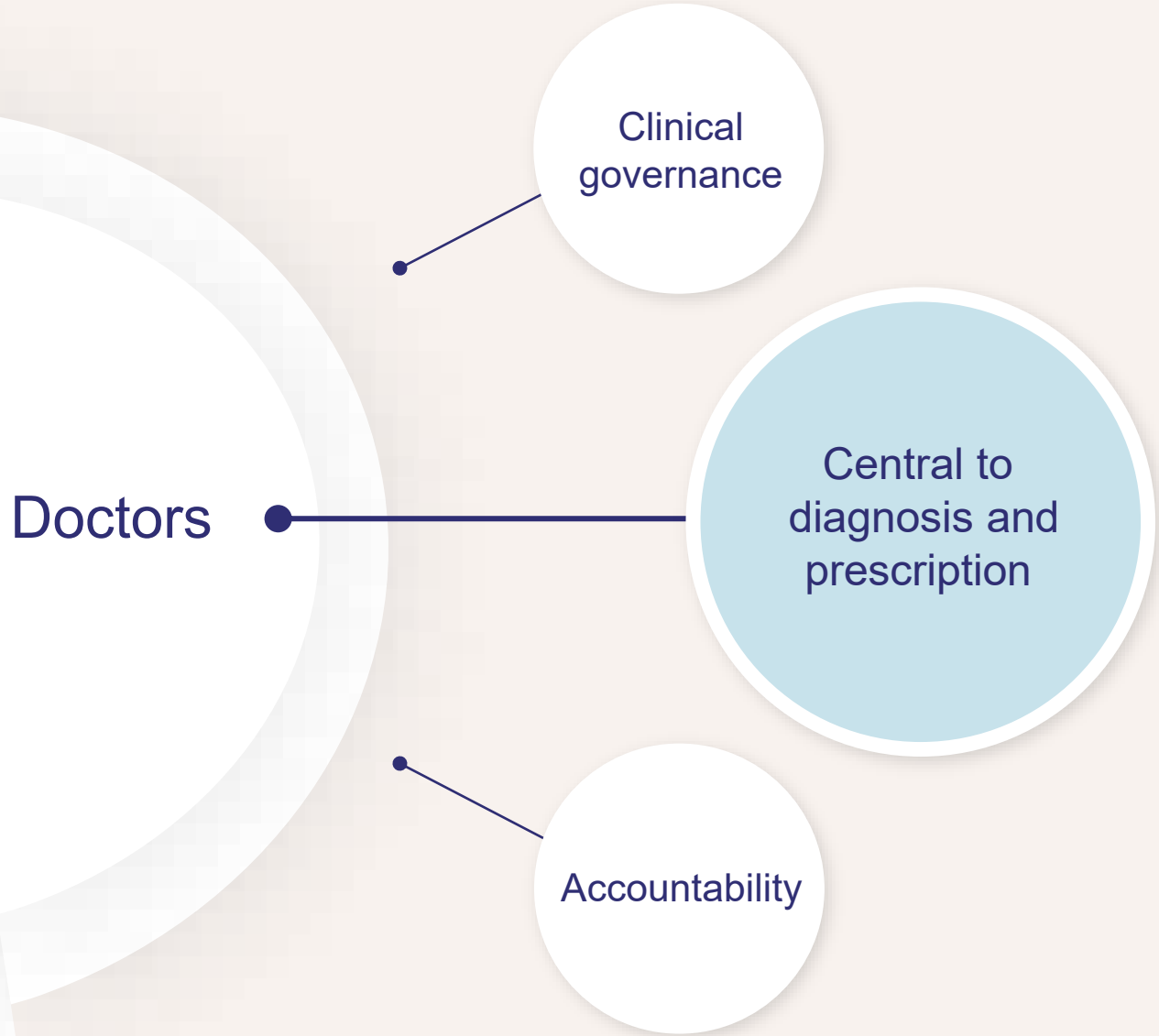
Reality today

But,

diagnosis and prescription do not change lives;

adherence, recovery, function and lifestyle do.



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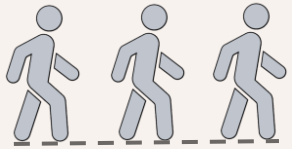
Malaysian snapshot

Chronic diseases demand continuous, team-based support



Patients move across settings: hospital → clinic → community → home

Fragmented handoffs cause readmissions, complications, cost

Integration

is not “nice to have”.

It is the operating system for modern care.

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From doctor-led to team-led

Doctors
Diagnose, prescribe, set direction

Allied health
Translate plans into daily recovery – function, behaviour, independence

Nurses
Optimisation, continuity

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Empowering allied health

Physiotherapists	Medical geneticists	Pharmacists	Clinical psychologists	Radiographers
Medical lab scientists	Micriobiologists	Occupational therapists	Audiologists	Dental technologists
Biochemists	Health education officers	Dietitions	Speech & language therapists	Medical physicists
Environmental health officers	Nutritionists	Medical lab technologists	Embryologists	Exercise physiologists

From add-ons to **co-designers of care**

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Speak up **early and often**

- Invite dissent
- Surface risks
- Propose alternatives

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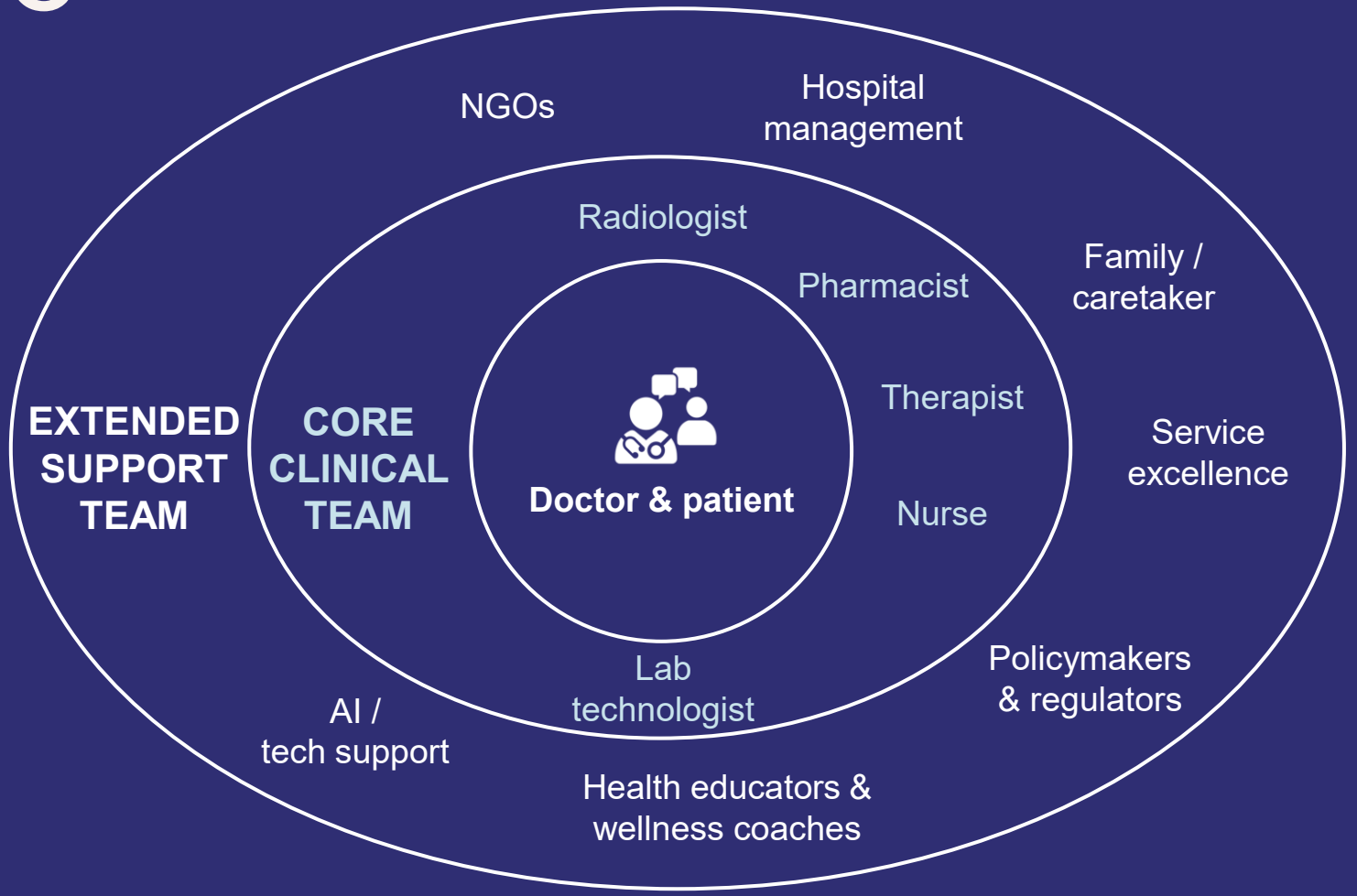
The holistic approach



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Common gaps

Cardiology / Heart failure

Dietitians and physios engaged late; limited community follow-up on salt/fluid, exercise tolerance

Oncology

Routine tumour boards, but inconsistent dietetics/speech therapy/psychology involvement (eg: head & neck, GI)

Orthopaedics

Prehab seldom standardised; OT home-safety input often after discharge

Stroke / Neuro

Early speech/ OT/ physio delayed by bed flow; caregiver training not systematic

Takeaway:
If allied health arrives late, function and adherence suffer.

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What ‘good’ looks like

01

Joint clinics
Diabetes
(endocrine + dietetics + podiatry + pharmacist)

02

Prehab & ERAS for major surgery
Surgeon + anaesthesia + physio + dietitian
+ pharmacist (standard order sets)

03

Bedside huddles
Daily, time-boxed, with AHPs present;
decisions recorded in a shared care plan

04

Discharge-to-home bundles
OT home safety, physio plan,
pharmacist reconciliation,
community referral before discharge

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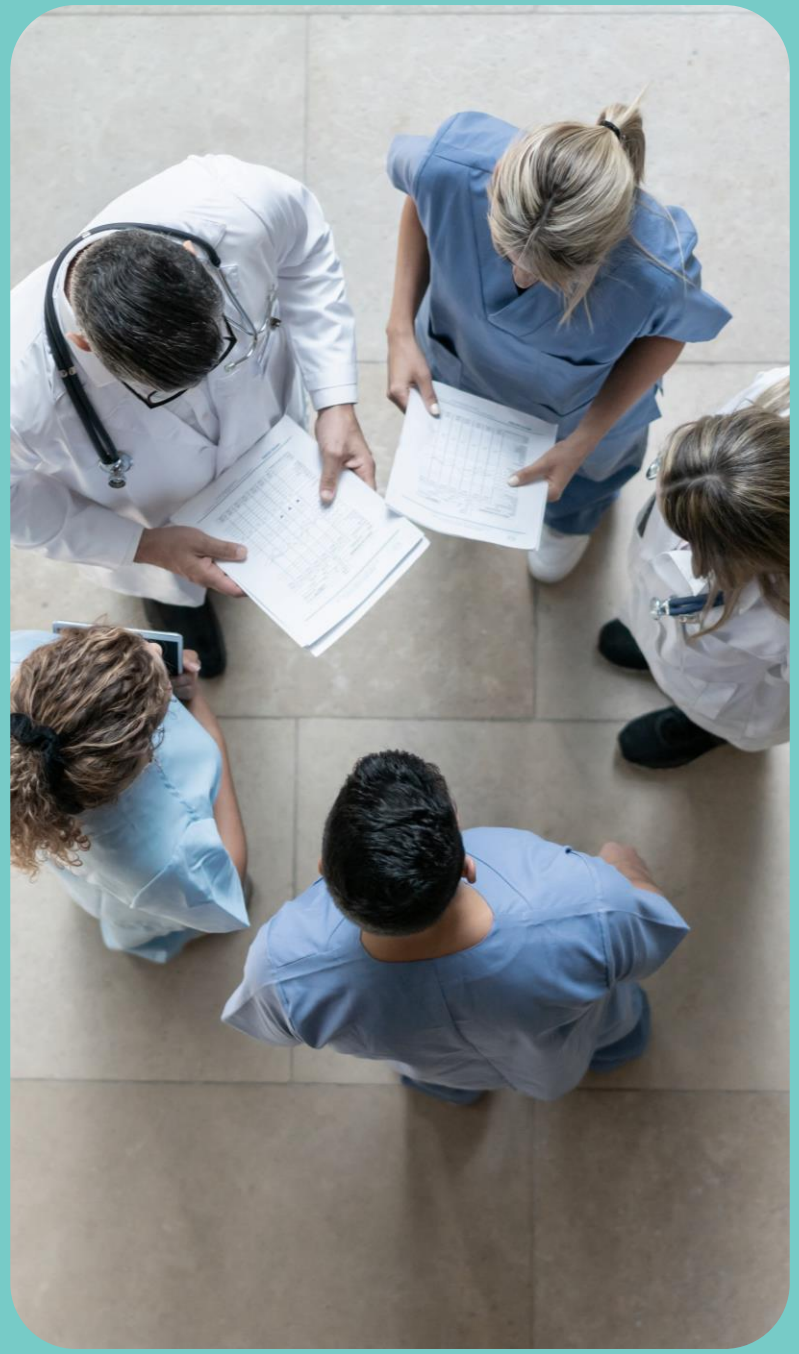
Hub-and-spoke model



Hospitals as **hubs**.

Primary care, virtual care and community partners as **spokes**.

RIGHT CARE, CLOSEST TO HOME.

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Discussion starters

Discussion 1	How will multidisciplinary collaboration work across specialties as single-focus hospitals grow?
Discussion 2	How should we balance business interests with patient/public health, and who decides?
Discussion 3	Will there be national policies or incentives to support MDT models, AHP roles, and community follow-up?

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Thank you