Managing multidisciplinarity: organisation as a driver of safety and clinical quality

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ABSTRACT

The transition from multidisciplinarity as a 'spontaneous' practice to a governed organisational process is one of the central challenges of modern Clinical Governance. Through the analysis of the evolution of Multidisciplinary Meetings (MDM) at the Cantonal Hospital Authority, the article illustrates how the standardisation of flows and digital integration make it possible to transform collegiality into a traceable safety device. The contribution analyses the benefits in terms of clinical risk reduction and quality monitoring, highlighting the role of leadership in preventing bureaucratic drift.

Introduction: quality as system output

The quality of care is not a static attribute, nor does it depend exclusively on the clinical competence of the individual. It is a system output: the result certainly of competence, but also of the organisation's ability to structure coherent, evidence-based and monitorable decision-making processes.

In this perspective, talking about clinical governance does not mean evoking administrative control or bureaucratic superstructures. It means designing the environment in which clinical decisions take shape. Governance is the invisible architecture that makes a choice not only possible, but consistent, verifiable and shared. It is the transition from individual responsibility to systemic responsibility.

Clinical governance systems and quality models are therefore not formal fulfilments, but concrete tools to raise the standards of care and guarantee patient safety. If contemporary medicine is too complex to be practised alone, then governance is not an organisational option: it is an evolution of the profession.

The experience of the Multidisciplinary Meetings (MDM) of the specialist cancer centres of the Ente Ospedaliero Cantonale (EOC) offers a significant example. The challenge was not the introduction of collegiality, which was already present as a practice, but its transformation into a structured and certifiable quality process.

From the “clinical moment” to the governed process

If governance è design of the decision-making environment, then collegiality must also become a process and not remain just a spontaneous practice.

Before the integration in the digital management systems – specifically in the computerised patient file – the MDM presented criticalities typical of non-formalised

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practices:

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Dataset heterogeneity: non-homogeneous way of presenting cases among different teams and professionals;

- **Documentary**fragmented record of therapeutic decision;
- **Opacityà of the path**: difficulty in reconstructing ex-post the decision rationale in the audit;
- **Lack of KPIs**: lack of structured data on coverage of eligible cases.

The management engineering intervention aimed at structuring the process through three fundamental pillars:

1. **Standardisation of input**: structured registration of the case on the clinical platform before the meeting, with definition of input timing, in order to ensure completeness, uniformity and consistency of the information.
2. **Formalisation of output**: documentation of the outcome directly in the electronic medical record, making explicit the rationale of the therapeutic choice.
3. **Traceability and tracking**: transformation of clinical activity into analysable data for aggregate evaluations and periodic pathway reviews (clinical audits).

Uniform language for data integration
To further strengthen the standardisation of input, the integration of international clinical nomenclature standards, such as SNOMED-CT, is a strategic step to improve data comparability. The adoption of codified languages makes it possible to reduce the heterogeneity of datasets and to transform clinical documentation from a collection of fragmentary information to a structured data set, which can be interrogated and analysed on an aggregate scale.

Impact Indicators: Quality and Safety

The effectiveness of the model is measured by organisational coverage indicators. In 2024, 96% of oncology cases (new cases and relapses) è were discussed in an MDM, out of a total of 1181 cases.

The figure is significant not so much for its numerical magnitude as for what it represents: an almost total number of therapeutic decisions that pass through a structured and documented comparison between specialists. It is therefore not an episodic gesture, but a systemic practice.

From a clinical risk management perspective, systematic collegial discussion acts as a

defensive barrier, reducing the risk of isolated decisions in highly complex settings.

From a quality point of view, the system guarantees:

- greater adherence to guidelines;
- uniformity of therapeutic indications between different specialists;
- possibility of retrospective analysis for continuous improvement.

In other words, quality stops being an individual intention and becomes a shared and observable responsibility.

Governance beyond the tool: from control to enablement

The integration of MDM into the quality system marked the crucial transition from "declared quality" (based on individual intentions and good practices) to "observable quality" (based on structured data and replicable processes). However, experience shows that standardisation can degenerate into "bureaucratic drift" if perceived as an external imposition. To prevent the system from becoming an empty shell, governance must act on three strategic levers:

- **Clinical leadership: co-design as a factor in adherence**

Clinical governance cannot be top-down. The active involvement of professionals in process design is essential to ensure that standardisation respects the complexity of medical practice. Strong clinical leadership transforms the protocol from "administrative task" to "shared professional standard". In this model, the clinician is not a mere executor of digital flows, but the architect of a system that enhances his or her judgement within a protected multidisciplinary context.

- **Flow review: the PDCA approach for process efficiency**
  Continuous improvement requires strict application of the Deming cycle (Plan-Do-Check-Act). In particular:

    - **Check:** analysis of the data collected via the MDMs allows for the identification of unwarranted variability or bottlenecks in the paths
    - **Act**: the review of flows is not to "control" but to streamline procedures, eliminating the *steps* that do not bring added value to the patient (*Lean approach).*

The aim is a dynamic system, capable of self-correcting and adapting to the evolution of scientific evidence and the operational needs of cancer centres.

- **Culture of transparency: traceability as protection and guarantee**
  È a cultural paradigm shift is necessary: traceability must not be experienced as an act of surveillance, but rather as the maximum form of protection for the physician and guarantee for the patient. Documenting the clinical rationale in a collegial and structured manner “crystallises” the quality of medical work. For the practitioner, it means operating within a framework of shared and documented responsibility; for the patient, it means having the certainty that his or her therapeutic course of action is the result of a consensus between specialists, verifiable at every stage of the treatment pathway.

Conclusions: when the organisation becomes the guarantor of care

The experience of the Cantonal Hospital Authority shows that organisation really does affect the quality of care when it intervenes in a structured way in decision-making processes. It is not enough that multidisciplinarity exists; it must be governed to be safe.

The digitisation of Multidisciplinary Meetings (MDM) transforms what often starts out as a “good intention” clinical into a systematic, repeatable and analysable quality tool. In this crucial transition – from isolated professional practice to consciously governed process – lies the most concrete contribution of organisational systems to improving care. No system automatically guarantees quality. But a well-designed system makes mistakes more difficult, reviews easier and decisions more solid.

In the final analysis, the integration of MDM in the quality system is not a mere technical fulfilment, but the expression of an organisational maturity that puts patient safety at the centre. Through traceability, KPI monitoring and clinical leadership, the organisation takes charge of oncological complexity, ensuring that every therapeutic decision is the result of a robust, transparent and continuous improvement-oriented system. And it is in this invisible architecture – made up of processes, leadership and culture – that clinical governance finds its most authentic meaning.

Governance is not è neutral

We often talk about clinical governance as if it were a natural progression. But every organisational model brings with it a cultural choice.

The MDM structure implicitly states that:

individual decision-making is no longer sufficient in highly complex contexts

clinical variability is not always synonymous with personalisation;

professional autonomy must coexist with systemic responsibility.

Not everyone is ready to accept this. The truth is that governance redistributes decision-making power. It shifts it from the individual to the process. From individual charisma to traceability.

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È a step that enhances patient safety — but requires a profound revision of the professional identity.

The question is not è whether governance is useful. The question is whether we are ready to accept its implications.

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