**The Whisper**

Interprofesional communication takes place whenever health students or providers communicate with one another, with patients and their families as well as with their communities in a manner that collaborative, open as well as responsible. Such communication allows both parties to exchange information that may be crucial to their delivery of service (Kelly & Tazbir, 2014).

In *the whisper*, Dan was transferred through numerous health workers before he suddenly passed away. When Dan first fell sick, his parents contacted Ontario’s TeleHealth and were subsequently advised to take him to the local hospital’s emergency room. At the hospital, the Nurse and Doctor took note of his higher than normal heart rate which was 140 beats per minute. This first evaluation was subsequently followed by several visits to other. However, it was unfortunate that the patient ended up passing away.

This was a classic case of poor interprofessional communication leading to the deterioration of a patient’s condition. There was an inefficient or at times complete absence of information exchange between the different medical practitioners that had the opportunity to attend to Dan. Towards the end of June 2003, the deceased patient’s parents submitted a request for review of his case to the Ontario’s Pediatric Review Committee. They also went ahead and registered complaints with the CPSO and the CNO within Ontario.

The final report prepared by the death review committee verified most of the concerns held by the parents. The report asserted that given the blood test results, the diagnoses of Dan’s dehydration and enteritis on the 6th of January was seen to be questionable. After the release of the report, all the medical personnel that reviewed it were of the view that they would not have gone ahead and discharged the patient on the 6th of January without conducting more investigations. The report also stated that the hepatitis diagnosis that was done on 8th January was inconsistent with the lab results. It also confirmed that Dan had been provided with a significant amount of IV fluid within 24 hours without any supporting rationale for its usage. Due to poor communication between the practitioners, the findings of a case of incomplete acidosis were under-appreciated and there also appeared to have been an inadequate input into the possible treatments and diagnoses at the level of staff physician. This was a clear indication of there being inadequate supervision of the resident doctor. In hindsight the review found out that his administration of sedation medicine not to be appropriate.

As witnessed in this case, interprofessional communication breaks down information silos within the medical fraternity. Such silos are not beneficial to all the stakeholders in the medical sector from the patients to the practitioners (Smith, 2010). Sharing of patient information allows physicians to reduce the amount of time taken to diagnose a patient (Eisler & Potter, 2014). It also helps them to prescribe the required medication at the right dosage an avoid cases such as Dan’s where he was given unexplained amounts of IV fluid within a single period of twenty four hours.

**References**

   Eisler, R. T., Potter, T. M., & Sigma Theta Tau International,. (2014). Transforming interprofessional partnerships: A new Framework for nursing and partnership-based health care.

    Indianapolis, IN: Sigma Theta Tau International Kelly, P., & Tazbir, J. (2014). Essentials of nursing leadership & management. Clifton Park, NY