International Journal of Africa Nursing Sciences 10 (2019) 38–42

Contents lists available at ScienceDirect

International Journal of Africa Nursing Sciences

journal homepage: www.elsevier.com/locate/ijans

Is there a Theory – Practice – Ethics gap? A Patient Safety Case Study

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ARTICLE INFO

Keywords:
Ethics
Medical error
Non-compliance
Patient identification
Practice
Theory

ABSTRACT

This exposé employs a case study to illuminate an ongoing medical dilemma which places a patient's safety at risk. The medical dilemma is one of non-compliance by healthcare professionals and is associated with correct patient identification. Typically, the healthcare academics declare that when clinical practice is inadequate, a "*theory-practice gap*" is usually responsible. Within this paradigm there is often a gap between theoretical knowledge and its application in practice. Most of the evidence relating to the non-integration of theory and practice makes the assumption that environmental factors are responsible and will affect learning and practice outcomes, hence the "*gap*". However, it is the author's belief, that to "*bridge the gap*" between theory and practice an additional component must be considered, called "*Ethics*". In order to effectively implement practices, such as identifying a patient correctly, the user must deem these practices to be important and relevant to provide safe patient care in their role as healthcare providers. This introduces a new concept which the author refers to as the "*theory-practice-ethics gap*" and must be considered when reviewing some of the unacceptable outcomes in healthcare practice, such as wrong patient identification.

1. Introduction

The purpose of this exposé is to elicit consideration by healthcare professionals of the possibility of a new paradigm which the author has termed the *"theory-practice-ethics gap"*. The article employs a case study to demonstrate this new paradigm; which is tentatively deemed to be a patient advocacy and patient safety concern (Mortell, 2009, 2012, 2013). The case study that will be reviewed to exhibit this suggested paradigm; involves an authentic patient with coronary artery disease [CAD]; who required an urgent surgical intervention in the form of coronary artery bypass graft surgery [CABGS]. The dilemma which will be reviewed illustrates a situation that placed a patient at risk. It focuses on the fact that health-care professionals are provided with knowledge; organizational policies and procedures [Theory], and are also required to demonstrate competence and organizational compliance [Practice]. Yet, healthcare professionals and providers continue to sponsor an attitude of non-compliance or unethical practices which create medical errors and place the patients' safety at risk (Dixon-Woods, Baker, Charles, et al., 2014; Leape, 1994, 2002, 2015).

2. Background

Patient safety and high quality of care are essential aspects of all healthcare practices. When people are admitted to hospital, they expect to have their illness or disease treated effectively, and to receive safe, high quality care. They do not expect to be put at risk or be harmed. The primary goal of healthcare is to maximize safety and wellbeing, and so optimize the quality of people's lives (Wilson, 2009; Leape, 1994, 2002, 2015). The Institute of Medicine's [IOM] report *'To Err Is Human: Building a Safer Health System'* stated that 98,000 deaths occurred annually in the United States of America [USA] as a result of medical errors (IOM, 2000). Not unique to the USA, European nations also have concerns associated with ongoing medical errors which place patients at risk (Fowler et al., 2008; Classen et al., 2011; Hinno, Partanen, & Vehviläinen-Julkunen, 2011). In the United Kingdom as many as 10% of hospitalized patients may experience a medical error and some may experience multiple errors (Sari et al., 2007). A subsequent study from the USA declared that, 400,000 medical errors and 210,000 deaths were associated with preventable harm in hospitals (James, 2013). A more recent study, estimated that medical errors in England were a contributory factor to approximately 22, 000 deaths a year (Wise, 2018).

The IOM report (2000) generated questions about patient safety and an obligation for healthcare providers to deliver high quality, safe healthcare (IOM, 2001, 2012). Over the last 18 years, this commitment has been a strategy and policy target for healthcare organizations around the world. The Joint Commission International (JCI) is one such organization that labors to improve patient safety and quality of health care in the international community. In 2003, the JCI designated accurate patient identification as a National Patient Safety Goal. Each

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https://doi.org/10.1016/j.ijans.2018.12.002
Received 20 July 2018; Received in revised form 3 December 2018; Accepted 12 December 2018
Available online 13 December 2018
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