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A CASE STUDY: WRONG PATIENT; WRONG BLOOD TRANSFUSION: IS THERE A THEORY – PRACTICE – ETHICS GAP?

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ABSTRACT

This case study illustrates an ongoing therapeutic dilemma which continues to place the patient's welfare at risk. The safety predicament is associated with the transfusion of blood or their products to the correct patient. Predictably, healthcare scholars declare that when clinical practice is ineffective, a *"theory-practice gap"* is typically responsible. Within this paradigm there is often a gap between theoretical knowledge and its application in clinical practice. Most of the evidence relating to the non-integration of theory and practice makes the premise that environmental factors will influence 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 called *"Ethics"* must be appreciated. This introduces a new concept *"theory-practice-ethics gap"* which must be considered when reviewing some of the unacceptable appalling outcomes in health care practice.

Keywords: Blood transfusion, Ethics, Error, Identification, Patient, Practice, Case study

INTRODUCTION

This article uses a case study to demonstrate a predicament which the author has termed the *"theory-practice-ethics gap"*; and is deemed to be a patient advocacy and patient safety concern (Mortell *et al*., 2013). The case study that will be examined to demonstrate this *"theory-practice-ethics gap"*; involves a critically ill adult patient in the intensive care unit [ICU] who required an urgent blood transfusion. The dilemma which will be reviewed illustrates a situation that placed the patient at risk. It focuses on the fact that health-care professionals are provided with organizational policies and procedures [Theory], and are required to validate competence and organizational compliance [Practice]. However, some health-care professionals continue to support an attitude of unethical practices which generate medical errors and place the patients' safety at risk (Dixon-Woods *et al.*, 2014; Leape, 1994, 2002, 2015).

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 appropriately, and 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] because of medical errors (IOM, 2000). European countries also have concerns associated with ongoing medical errors (Fowler *et al*., 2008; Classen, *et al*., 2011; Hinno, Partanen & Vehviläinen-Julkunen, 2011). In the United Kingdom (UK) as many as 10% of patients may encounter a medical error and some may encounter multiple errors (Sari *et al*., 2007). A subsequent study from the United states of America (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 related to approximately 22, 000 deaths annually (Wise, 2018).