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 & Veihviläinen-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).