Towards understanding the nature of conflict of interest and its application to the discipline of nursing

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Abstract
Most incidences of dishonesty in research, financial investments that promote personal financial gain, and kickback scandals begin as conflicts of interest (COI). Research indicates that healthcare professionals who maintain COI relationships make less optimal and more expensive patient care choices. The discovery of COI relationships also negatively impact patient and public trust. Many disciplines are addressing this professional issue, but little work has been done towards understanding and applying this moral category within a nursing context. Do COIs occur in nursing and are they problematic? What are the morally appropriate responses to COI for our discipline and for individual practicing nurses? In this paper I examine the nature of ‘conflict of interest’ as a general ethical category, its characteristics and its application to our discipline. Conflict of interest is an odd moral category that may actually or potentially result in immoral decisions. The moral justification for COI is grounded prime facie by the moral value of respect for persons and principle of fidelity from which trust is developed and maintained. In review of the historical development, there appears to be consensus on some qualities of COI that are presented. I conclude that making judgements about COI are challenging and often difficult to determine from a nursing perspective. Improving nurses’ and professional organizations’ awareness of COI and sharpening our ability to respond appropriately when COI arise can reduce potential harm and promote trust in those whom we serve.

Keywords: professional ethics, conflict of interest, trust, loyalty, nursing ethics.

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What this paper adds to what is already known: Conflict of interest is conceptualized as a moral significant term that relates to other values and principles. This paper sharpens the definition, and applies it to nursing.
Commercialization of the healthcare industry in the USA, together with other social and political forces, has led to a proliferation of questionable relationships between healthcare professionals and health care for profit organizations. Seventy per cent of clinical drug trial research in the USA is funded by the pharmaceutical companies and studies indicate that drug efficacy is reported significantly more frequently in pharma-funded research than other non-pharma funded research (Holmes et al., 2004; Angell, 2004). Physicians or other providers frequently maintain conflicting roles as investors in the healthcare industry and as decision makers about service utilization. It is not unusual for physicians to ‘own’ a hospital or healthcare facility to which, in turn, they admit the patients, or to sell pharmaceuticals agents from their offices. Each of these questionably ethical activities began with a prior conflict of interest (COI) that contributed to the professional’s acting out of self-interest. Although commercialization may not be as great a concern in countries with socialized health care, the literature on COI indicates that the problem is not limited to commercial based enterprises but rather common in professional and ethical circles worldwide. Conflicts of interest are known, in many cases, to lead to higher costs for patients and taxpayers, less than optimal decisions by healthcare professionals who maintain these types of relationships, and often reduces patient and public trust (Brennan et al., 2006).

Conflict of interest, like many moral categories, has universal applicability as well as particular aspects that are specific to each discipline (Stark, 2001). In healthcare disciplines, medicine has a more obvious involvement with COI and has led the way for reform of their discipline. Other healthcare disciplines, like social work, physical therapy, and nursing have been slow to address the issue of COI. According to Martin & Gabard (2001), the lack of discipline-specific response is explained in part by the view of the discipline itself by the public and by misconceptions of the practitioners. Most healthcare disciplines are viewed as service and not high profile like medicine or law. In addition, discipline members misperceive their fiduciary relationships and their professional members’ impact on patient care decisions.

Although recognized in nursing, COI does not appear to be a central moral concern. Literature that specifically addresses the fundamental questions about COI is limited (Crigger & Holcomb, 2008) but strongly related values of human respect and ethically based principles, of loyalty, and beneficence, are clearly evident and lead to right relationships. Right relationships are ones in which patients and society trust in nursing and its practitioners. Trust in a nurse or in the discipline is maintained solely by the people who are recipients or potential recipients of nursing care and is the cornerstone of the nurse–patient relationship (Johns, 1996). There is significant evidence that trust leads to better outcomes for patients (Johns, 1996) and higher public satisfaction suggesting that nursing as a profession should place a high priority on maintaining it. Individual professional nurses should also maintain right relationships with patients and the public that includes responding appropriately to relationships that represent COIs.

Through this paper, I hope to adequately address the nature of COI, its characteristics, and how to apply this moral category to professional nursing. This discussion informs from the perspective of professional nursing in the USA, but I believe that these ethical issues transcend national orientation and are generalizable. First ‘trust’, a central component of right nurse–patient relationships, is examined in regard to nursing’s special concern and duty to patients’ COI. The subsequent sections attempt to address three practical questions: (1) What is a COI? (2) When and how do COIs occur in nurse professionals? (3) How should nurses respond if a COI arises?

**Trusting in nurse–patient relationships**

Although a full account of ‘trust’ is beyond the scope of this work, there are four qualities of trust that are salient to the discussion of COI. From the etymological perspective, ‘trust’ originates from Middle English and has had a multiplicity of uses in noun and verb forms. The explicit meaning is ‘protection’ and ‘firmness’ such that the word ‘trussel’, is a derivation from ‘trust’, and this word refers to the strong metal
supports for bridges (Webster, 1983; http://www.askoxford.com/).

**Distinctions**

Recently, excellent explicatory work of trust in nursing has appeared in nursing literature (de Raeve, 2002; Sellman, 2006, 2007). de Raeve (2002) drawing upon work by Baier and Govier, distinguished two ways to conceptualize trust. Trust in refers to a relationship, situation, person or role in which one has confidence. I may trust my nurse for many different reasons: because of my faith in professional nurses’ role, through my experience with her as my provider in past years, or through knowing her and the strength of her character. Trust, in these situations, appears to be dependent upon present beliefs about a particular person or thing or to be acquired through past experience.

One trusts differently when one trusts to or relies on an ability to predict behaviour for future events and is firmly rooted in expectation rather than in past experience Trust as reliance occurs when an individual does not have confidence in what one might do. For example, Nurse C forgets my medication, then gives me the wrong medication and fails to teach me about them. I may lose my trust in her competency in nursing practice over a series of events, but still trust her to complete the forms I need for discharge.

Although de Raeve (2002) claimed this distinction may be too simplistic, the experience related sensitive to trust as a confidence is of particular importance in COI situations; it illustrates the historical nature and the cumulative impact of trust as confidence. Should one have both types of trust? de Raeve does not state if they relate to a more global conceptualization but it might appear that if both types were actually present in a trusting relationship that the quality of the trust one has could be more resilient if a trusting relationship were inclusive of both.

**Reflexivity**

A second interesting quality of trust is offered in Sellman’s (2006) discussion that I will call ‘reflexivity’. One trusts because one believes that the other has goodwill towards him. To use a partial example from Horton (Sellman, 2007), the warrior lays down a sword and raises a white flag trusting that the enemy will respect the established convention of defeat. In other words, I trust because I believe that the other agent will respond in a certain way towards me. Conversely, I run or fight because I believe that the enemy will fight or run as well. Although this aspect of trust may not characterize all trust relationships, it illustrates that reflexivity has a place in the conceptualization of trust. What one person believes about the other is significant in building, maintaining or eroding trust in someone or something. This aspect of trust is significant when one ethically responds to COI. Trust is gained when one’s standards are set by the perceptions of the other, by the patient and the public rather than by a professional’s perception of what is appropriate.

**Good will**

Sellman (2007) argues for Baier’s position that the central nature or defining feature of trust is good will. Although Sellman does not define good will, it appears to be used as lack of ill will (Sellman, 2006, p. 30) and appears to relate to the principle of beneficence. The article has much more discussion about the features of ‘good will’, and with limited space, I take issue with only one aspect of the discussion. I argue that ‘good will’ may be sufficient as the central feature for some types of relationships and one’s relationship to any human being to whom moral respect is given but that it is not adequate as essential grounding for many other relationships. There are special relationships that have, what a principled approach to ethics, are termed obligations. I content that the nurse–patient relationship is fiduciary and that the agent has an obligation to be loyal. Loyalty or fidelity goes beyond beneficence and good will through setting some special relationships apart from other types of relationships. To further characterize, a healthcare professional faithfully fulfils a role of special concern for other that also respects the vulnerability of the recipient of care (Pellegrino & Thomasma, 1993).
Nature of COI: historical and conceptual frame

Conflict of interest in the professions

Situations that give rise to COIs are as old as human relationships, but its use as a specific explicit moral category has been recognized only in the last 60 years (Luebke, 1987). ‘Conflict of interest’ was initially a moral and legal term used in the discipline of law, business and public officials (Luebke, 1987; Davis, 2001). Over time COI became a pervasive problem; concern for participating in it at individual and institutional levels grew and the evidence for disciplines to self-regulate mounted. Physicians were the first of the disciplines to address COI problems. Professionals from other disciplines less obviously affected by COI (including educators, dietitians, physical therapists and even ethicists) began addressing COI in general and discipline-specific ways (Davis, 2001).

Conceptualizing COI

There is disagreement about the definition of COI as well as its nature as a moral term. Margolis, who is credited as an important early writer on the topic, characterized a COI as essentially a conflict of role (Davis, 1982; Davis, 2002). Davis (2001) claimed that Margolis’ characterization of a COI as role conflict was insufficient and added that COI be a situation of compromised judgement in a person who has a fiduciary relationship that results from self-interests. The question remained of the nature of COI (Carson, 2004). Is a COI a principle, or does it relate to virtues? Luebke (1987) who provides a clear and persuasive argument for accepting COI as a moral category acknowledges the peculiarity of the term and argues that COIs are distinct from a principle or duty, virtue, and from a moral dilemma. As a moral category it is a descriptor of a situation and is useful for guiding actions.

Although consensus of the nature of COI is lacking, it is generally accepted that a COI is peculiar in that it is not in and of itself unethical; but it can result in a situation that increases the potential for unethical decision making or judgement to be made, just as smoking increases one’s chance of developing lung cancer. With that said, not all COI relationships lead to unethical decisions, but rather they set up an environment of risk in which unethical decisions or judgements are more likely to occur. Luebke (1987) uses the metaphor of pregnancy to explain COI.

...conflict of interest is like being pregnant... there is nothing morally wrong with being pregnant but it may be morally wrong knowingly to become pregnant, to fail to avoid pregnancy, to act in disregard of one’s pregnant condition, ... and to refuse to inform affected parties about the pregnancy. (p. 70)

Consensus appears to have been reached on three critical qualities of a COI (Carson, 2004; Davis, 2001). This claim appears to be substantiated by my review of the literature that included: engineering, medicine, law, business, accounting, anthropology, dietary science, research literature, physical therapy, education, and ethics.

1 A fiduciary relationship exists. A fiduciary role or relationship is a situation in which a person assumes a special relationship within which the fiduciary agent also has the obligation to act for the benefit of the one with whom this special relationship exists.

2 Self-interests exist on the part of the fiduciary agent. Self-interests of the agent can be influenced and potentially override the agent’s primary concern and obligation to maintain the interest of the recipient of the fiduciary relationship first.

The term ‘self-interest’ requires additional clarification. Early work by Davis defines ‘self-interest’ or ‘interest’ as ‘...any influence loyalty, or other concern capable of compromising... (the agent’s) ability to act for the benefit of his client’ (Davis, 1982, p. 18). This definition is useful and appropriate in a general way for most disciplines.

3 A relationship with another agency, individual, or group exists that has the capacity to influence the fiduciary agent to shift primacy of concern from the recipient of the fiduciary relationship to one that is motivated by direct and/or indirect self-interest.
The moral chain

Conflict of interest is distinctly unique element of moral discourse. In this section ‘moral chain’ is a useful metaphor for COI relationships because COI also relates to a number of morally relevant terms, but only two of which are included herein. Like a chain the moral elements connect as justification and explanation for how COI relationships are viewed.

Dignity and respect for persons and the belief that every human being has certain inalienable rights is one link in the moral chain of COI. From a religious perspective, humans are valued and owed moral regard because they are created by God. From a secular orientation, a number of reasons have been advanced to justify dignity and respect. Kant grounded dignity in human beings’ ability to use moral reasoning to make decisions in a kingdom of ends (Kant, 1785/1964).

In the kingdom of ends everything has either a price or a dignity… (435/77, p. 102)
Therefore, morality and humanity so far as it is capable of morality, is the only thing which has dignity. (435/77, p. 102)

More recently Nussbaum (1998) and Sen (2004) have proposed a capacity framework as the justifying reason for morally regard. From any justification, dignity and respect for persons is considered a right, according to Gallagher (2004), that, although not universally recognized, is the belief that human beings should, because they are human and are moral agents, be valued and treated with respect (Veatch, 2002).

Three principles used in bioethics that are particularly significant to respect for persons are: fidelity, beneficence, and veracity. Of the three moral principles, fidelity is most directly applicable to COI, nurse–patient relationships and is the only one of the three discussed. The principle of fidelity establishes the agent’s responsibility to carry out duties carefully and completely (Pellegrino & Thomasma, 1993; Veatch, 2002). A person who is faithful to her duty to another is often called ‘loyal’. In applying fidelity in nursing, the special role of the nurse is fiduciary with the patient because the patient, who is not as knowledgeable as the nurse, places her faith and trust in the nurse’s special knowledge and advise to make decisions for her health that are in her best interests. Nurses are given special privileges by patients and society. For example, nurses can administer medications, obtain extensive personal information and examine private body parts as part of our discipline’s scope of practice as given by the society. Therefore, fidelity is deeply related to all activities that the nurse performs in her professional role, one of which is the proper response to COI.

Certain actions or statements by the nurse may erode the trust of a patient and endanger the fiduciary relationship that the nurse has with the patient. The less that the patient knows about the professional provider and what constitutes good or bad practice, the more vulnerable she is to, the more likely the fiduciary agent’s infidelity will not be detected. Therefore, transparency in all affairs with the patient is essential. Disclosure of COI is apparently an important part of appropriately dealing with situations of COI as will be discussed in the final section.

Interpreting the moral significance of COI

Relationships in professional life that represent problematic COI are common and many are unavoidable. Once a COI is known and if it is unrealistic to avoid or eliminate it, one must determine to what extent the COI is morally problematic for the professional and for the public. Some unethical behaviours are clear and evident to all but others may be more ambiguous complex and indeterminate. It is helpful to consider problematic situations from differing perspectives. There are considered to be four ways from which one can view the moral appropriateness of a decision or act (Veatch, 2002).

1 One can use her own personal moral compass to determine if issues are of moral concern but this view in COI appears to be in itself problematic. Extensive research of COI and the pharmaceutical industry, personal judgements about self-interest and COI consistently demonstrate that providers – physicians and
Nurses – are able to see the problematic nature and bias of decision making in their colleagues but not in themselves (Allman, 2003; Blunt, 2004; Ashmore et al., 2007; Ashmore & Carver, 2001). In cases of COI, self-interest, rationalization, denial, and response to consensus (everybody is doing it) play a role in the inability of nurses to critically view their personal moral compromising situations (Crigger et al., 2009). Therefore, using personal moral orientation may be flawed and is not sufficient to ethically respond to COI in practice.

2 The specific profession’s response can be seen in peer review or in professional standards, using codified formal criteria or principles. Professional organizations use broad statements or principles that must be applied to specific situations so that judgments can be determined. Formal codes are helpful guides but are not in and of themselves a sure method for judging moral appropriateness in given situations.

3 Reasonable Person Standard is used in courts of law as with jurors. In these instances the individual has no special education or knowledge, but responses in an assumed thoughtful and unbiased or as some say, disinterested way. Limitations for the reasonable person are the assumptions made about the reasonableness of the person.

4 Subjective Standards are ones in which the people who would be or are affected by a particular decision or act that is made by the agent speak to the moral appropriateness of it.

Taking all four standards into account, nurses may use any and all of the standards, but should use the subjective standard because it appears to be the most sensitive as the primary measure of moral appropriateness with COI. Subjective standards indicate that people who make judgments of moral appropriateness of actions or decisions are the same ones who will suffer if problems arise from providers or professionals participating in COI relationships. Further support using this standard comes from the generally accepted position that ‘fiduciary agents are to avoid even the appearance of involvement in situations that are COIs’ (Luebke, 1987; Crigger, 2009).

Conflict of interest in nursing

Currently in the USA almost every profession addresses COI as morally problematic through codified in ethical statements, and in some cases, legally established mandates (Stark, 2001; Waymack, 2003; Holmes et al., 2004). In nursing, acknowledgement of COI in professional organizations, in education, and in the literature as well as in established codified ethics statements is often uneven or altogether missing in the USA. The oldest and most noted professional organization, the American Nurses Association, has historically addressed ethical expectations through the ANA Code of Ethics for Nurses addresses COI in the provision interpretations (Fowler, 2008). The ANA Code is composed of Nine Provisions, the second of which states that a nurses’ primary commitment is to the recipient of care. Sub-provision 2.2 of this document affirms that COI arise among many relationships and also with personal interests but that the patient’s best interest and professional integrity of the nurse should be maintained. This provision goes further to direct the nurse to disclose and withdraw in some instances (Crigger, 2009). Some organizations have codes of ethics or may defer to the ANA Code like the Association of Operating Room Nurses (Crigger, 2009). Still other elements of nursing practice fail to address COI issues or only through indirect or related concepts. As an example, a recently published ethics text for nurse practitioners (Grace, 2009) omitted discussion of COI in the book and professional ethics is very minimally address with the author focusing instead the lion’s share of the book on patient related issues. This is omission of direct and clear discussion of professional ethics and role related issues is unfortunate because these areas are currently the ones that are most in need of definition, clarity, and guidance.

What Is a COI?

A common misconception of nurses is that COIs are problematic only for nurses who prescribe medication in advanced practice settings. The belief that COIs are of little concern in nursing and apply only to a few discounts the influence that nurses have on patient
choices and on how they may be influenced about their patient care choices (Ashmore et al., 2007; Jutel & Menkes, 2009). Consider the following example cases that illustrate COI in nursing practice:

Nurse X manages and is responsible for the budget for her unit. She is also anticipating a promotion and knows that cost reduction is viewed favourably by administration. Patients with a particular surgery are sent home after 3 days, but Nurse X knows that earlier discharges will result in additional funding for the unit as well as place her in a favourable light for promotion. Nurse X approaches Nurse C about her patient on the second post-operative day. Nurse C says that she thinks her patient is not ready for discharge and needs at least one more day of hospitalization. Nurse X disagrees with her assessment and instructs Nurse C to contact the physician to suggest an early discharge.

Nurse Y receives grant funding for her doctoral research from Medical Supply Company B. She recommends that patients purchase their home care from Supply Company B’s services even though Company B is known to charge a higher price for the same product. She gives patients the names of other Medical Supply Companies, but always mentions Company B first and gives a card with the address and telephone to each patient so that contacting Company B is made easier. She also tells the patients to give her name, saying ‘Tell them I sent you’.

Nurse Z works in a neurology clinic and frequently attends the promotional programmes because of the meals, gifts and supposed educational programmes. She has gotten to know and like a number of different pharmaceutical representatives. Nurse Z finds patients often asked her for advice about the best treatment for seizures. Nurse Z believes that the information she gains from the pharmaceutical companies is true and passes this information on to the patients. She recommends that they ask their doctor about the newest (which are often also the most expensive) medications. She fails to assess the patient’s situation, or rarely discusses other non-pharmaceutical measures for improving seizure control like moderation of lifestyle, and seizure onset triggers.

These types of situations should raise a nurse reader’s ethical ire as well as illustrate the variety of ways that self-interest can override fiduciary obligations of the nurse. In all three cases the relationship establishes a COI between the nurse and the healthcare industry that altered the nurse’s ability to make decisions that are in the patient’s best interests. In the first instance, Nurse X knowingly exerts her influence to gain power. Nurse Y, in the second case, also knowingly encourages patients to use Company B so that the company recognizes her endorsement; perhaps this is a thank you for their financial help and/or a ploy for additional funding. Nurse Z, however, has fallen prey, unknowingly, to the persuasion of marketing and in doing so will not providing optimal care for the patient through giving her expert advice. She is ignorant of the manipulation that is subverting her thinking through aggressive pharmaceutical marketing.

All three nurses in these cases have chosen to act on self-interests by first establishing and maintaining the relationships that place them at risk for unethical behaviours. In such cases, whether knowingly or unknowingly, the judgements of the fiduciary agent are less reliable and objective than they would otherwise be and may lead to less than optimal care as well as, if discovered by the patient or public, erode trust in the healthcare provider (Luebke, 1987; Davis, 2001).

The ethical response to COI in practice

What guidance is given on how to respond to situations that may represent COIs? There are generally two ways to respond: avoid, or disclose and ameliorate. Although avoidance at times can be impractical and even impossible there are many situations of COI that can be avoided altogether (Davis, 2001). Allman (2003) claims that ‘. . . they (providers) should refrain from those activities which are self-serving indulgences offered by a wealthy, powerful industry’ (p. 165). In the instance of the pharmaceutical industry, nurses need to just say no to educational and promotional involvement and seek out unbiased information that is not tainted by the drug industry. Additionally not all COI situations lead to potentially negative outcomes. There are some situations in which the potential for negative outcomes is so small as to be negligible. Therefore, avoidance is preferred but an absolute answer for every COI.

Second, in situations in which a COI cannot be avoided, it should be disclosed and interventions adopted to reduce the chances for a bad outcome or
compromising trust in the recipients of nursing care. Most publishers require that authors disclose potential COI relationships for conferences, and published work. Less disclosure is given to the public. One suggestion to ameliorate COI is for healthcare providers to list their personal involvement with pharmaceutical companies or interests in services or referrals that they may use. There is little doubt that knowledge of professional participation in pharmaceutical sponsored lunches, dinners, and gifts would raise concerns about COIs (Crigger et al., 2009). Unfortunately, the people that are most affected by COIs are the people least informed of the potential harm. The unethical behaviour resulting from COI is often perpetrated on the group or persons who are the least knowledgeable and who also suffer the greatest harm. The act of failure to inform the harmed is similar to the pathological way that professionals have managed mistakes made in clinical practice. Often an error made in the clinical setting is given, what one author calls, ‘cheap grace’ (Berlinger, 2003). The provider who makes an error that results in patient harm tells other colleagues, the institution, and completes an incident report. The patient, most vulnerable and least aware, is never told and never receives an apology for the harm done. In the case of the professional nurse, the COI relationship is unknown to the patients and public, and the professional does nothing to inform the patient of their COI involvement.

**Professional practice**

Nurses alone are individually responsible to maintain competency and continue to grow professionally. One of the most obvious COI exists among nurses and the pharmaceutical supply industry that supplies educational programming literature, samples, and gifts (Allman, 2003; Blunt, 2004). Gifts are not given from the altruism of pharmaceutical companies but are designed to sell their products. The best response of the nurse is to avoid participating in promotional activities and to be professionally responsible enough to seek out unbiased information about products from objective sources. The most morally praiseworthy response to the roar of marketing is to be a non-participant. Just say no (see http://www.justsayno.org/). If a nurse chooses to participate she should consider the source, speakers, and the topic (programmes that are titled advances in treatment or identifying a disease state earlier for treatment are often promotional), thus avoiding nice meals, gifts, and promotional items even if one does choose to attend.

Although conflict of roles may not be a COI in our definition of the term, nurses should examine their roles carefully to determine if some of these roles compromise others. In determining ethical appropriateness the nurse should use the Reasonable Person Standard or the Subjective Standard since research indicates that Personal Moral Compass Standard is less critical on how COIs are viewed (Angell, 2004; Brennan et al., 2006). For example, being a researcher and a caregiver for a patient represents a COI in the roles that the nurse is attempting to satisfy. The nurse educator’s primary role is nurse educator and not one of patient care. Another potential problem arises in the educational role of the nurse should still be aware of the conflict between roles and work with nurse providers so that patient care is not compromised.

Nurse educators have a particular duty to educate their students at all levels about their professional responsibility to fidelity of the nurse–patient relationship, and trust. They are also responsible to teach their students to become critical consumers and to share this knowledge with their patients. Nurse educators are at the front lines for eliminating the participation of students in promotional and educational activities that are offered and often ubiquitous in professional education.

**Institutional and professional organization changes**

The problems of COI extend beyond education and individual practice. Institutions and professional organizations are responsible for making rules, policies, codes, and structural changes that will impact on the degree to which any individual or group can participate or affiliate with COI agencies. Conferences sponsored by pharmaceutical or supply companies are suspect for marketing and promotion rather than education. Speakers should disclose and course
content be screened and directed towards balanced presentations. Publications in nursing literature also have a responsibility to disclose individual professional groups should continue to shape professional expectations and to recognize the discipline-specific issues raised by COI.

Summary

The greatest threats to trustworthiness occur when nurses are perceived as failing in their commitment to make decisions that are based on the best interests of the patient and the common good of society. Conflict of interest is prime facie a breach in adherence to the moral principle of fidelity, through which trust is developed. This paper has addressed the nature of COI and how to apply this concept contextually to nursing.

Making judgements about COI is challenging and often difficult to determine. Improving nurses’ commitment to their professional role, structuring policy and ethical codes to specifically and clearly address COI, and sharpening our understanding of them will reduce the potential harm of COI and promote trust in those who we serve.

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