National Consultative Ethics Committee for Health and Life Sciences

OPINION N° 114

Consumption of alcohol and drugs, and drug addiction in the workplace. Ethical issues connected to substance-related risks and screening.

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List of main abbreviations (*in text and footnotes)*:
BTS: *Brevet de technicien supérieur.* (Higher-education vocational training certificate)
CAP: *Certificat d'aptitude professionnelle.* (Certificate of professional competence)
CCNE: National Consultative Ethics Committee for Health and Life Sciences
CHSCT: *Comité hygiène, sécurité et conditions de travail.* (Committee on hygiene, security and working conditions, composed of employee representatives).
DGT: *Direction générale du travail.* (French Labour Ministry)
DRH: *Direction des ressources humaines.* (Human Resources Managers)

DUT: *Diplôme universitaire de technologie.* (University degree of technology)
MILDT: *Mission interministérielle de lutte contre la drogue et la toxicomanie.* (Interdepartmental Mission against drugs and drug addiction)

I. Introduction

The *Mission Interministérielle de Lutte contre la Drogue et la Toxicomanie* (MILDT - Interdepartmental Mission against drugs and drug addiction) referred to the National Consultative Ethics Committee for Health and Life Sciences (CCNE) on the possibility of screening for drugs in the workplace, with reference to the CCNE's 1989 Opinion.

MILDT considers that since this Opinion was published, new events of consequence have taken place: there has been significant progress as regards the diversity and reliability of tests and the legal framework has evolved as evidenced by, in particular, reinforced road safety test procedures and counter-narcotic inspections which can be implemented in transport companies. It also notes that concern for drug addiction issues involves not just the private sector, but all sectors of activity, including the civil service. The MILDT is therefore asking CCNE to review the "possibility of screening for illicit substances in the workplace".

CCNE has expressed its opinion on issues arising out of the use of drugs and drug addiction in the workplace on three occasions, and has also considered the matter from a more general point of view[1]:

- Opinion N° 15, dated October 16, 1989 on Screening for drug addiction at the workplace, following a referral by Mme C. Trautman, at the time President of the Interministerial Mission to Combat Drug Addiction (Mission Interministérielle de lutte contre la toxicomanie). It is this Opinion that the current referral by MILDT calls attention to;
- Report N° 43 on drug addiction, dated November 23, 1994 (self-referral);
- Opinion N° 80, dated December 4, 2003 on the Role and responsibilities of occupational physicians in the definition of worker aptitude.

In this Opinion, CCNE reaffirms the principles set out in its previous Opinions on:

- the specificity of occupational physicians' missions in their appreciation of worker aptitude for a specific employment, upon recruitment and periodically for the entire workforce,

- on the existence of certain workstations for which there may be justification for a systematic screening policy since the use of illicit substances

[1] Annex I contains a brief analysis of these documents.

in these occupations could cause particular risk to the workers themselves or to third parties,

- the need for total respect of the principle of medical confidentiality and more generally, of professional confidentiality (doctor-patient privilege) as regards communication to any third party, in particular to company management. Occupational physicians declare worker aptitude, or inaptitude, be it temporary or permanent, for a given occupation, but do not provide medical grounds for their appreciation.

- the invitation extended to occupational physicians to seek involvement — but with strict regard for their own independence — in risk prevention and management.

That being said, CCNE takes note of the two following observations:

- consumption of alcohol, of illicit drugs and of psychotropic medications, and the community's awareness of their dangers have significantly evolved, which is reason enough for the Committee to reflect further on these subjects;

- the legal and competitive environment in which companies, large and small, are operating, has changed. This is also true of other sectors, both public and private.

There is, therefore, a need for further thought.

II. Objectives of the Opinion

● Preliminary considerations

Humans have always sought out in their environment the products of nature that we now know to be capable of interfering with and modifying our neurological functions, our emotions and perceptions, our vision of the world we live in and our individual position within human society. The quest for well-being is an anthropological constant. Traces of it can be found in the writings of the first philosophers of antiquity and every civilisation seems to have some evidence of it. The strength of this desire for well-being varies with different individuals and contexts, in both private and professional settings. But as a phenomenon in its own right, dependence on narcotics is by no means new.

The human race is not alone in seeking out pleasure and avoiding pain; other animal species do likewise. In isolation, the desire for well-being does not suffice to explain the existence of the various addictions which are dependence diseases. To explain the phenomenon, sociocultural parameters (habits connected to alcohol, etc.) and social values (increasing one’s efficiency, transcending oneself, etc.) must also be taken into account.

The natural component of the addiction phenomenon explains to some

degree the human tendency to use substances which give pleasure and lighten the weight of life's afflictions. Today's society should take care to refrain from making excessive demands on its members and should be content with expectations which are realistically adjusted to their capacities and vulnerabilities. A reflection on addiction cannot ignore the components of desire and withdrawal which are characteristic features of this disease. Excessively interventionist policies would be fruitless and even counterproductive.

● **Usage and drug addiction**

Consideration of this subject must cover the entire range: alcohol and illicit substances as well as psychotropic medication abuse. The distinction between alcohol and illicit substances is, it is true, essential as far as legal and criminal law considerations apply. But this is mainly due to historical and sociological factors and, as CCNE had already pointed out in 1994, is not founded on any scientific principle. The dangers that their consumption may lead to are identical: addiction which is a disease and the withdrawal syndrome. Regarding their use in a work environment, the general view is that, in the majority, risks are connected to the consumption of alcohol. Special attention should be given to the concurrent use of alcohol and psychotropic medications.

● **Working environments**

Both the Committee and MILDT are of the opinion that all forms of work and the full array of employment sectors: businesses, be they large or small, agriculture, crafts and the civil service as a whole, must be considered in this reflection.

For some years, new constraints, both external and internal, have complicated intra-company relations. Simultaneously, the authorities and public opinion have become more and more demanding as regards risks and safety.

A / The effects of international market trading rules

In a growing number of sectors (aeronautical construction and civil engineering, for instance) global competition is forcing business leaders in search of a significant position on world markets to guarantee that no drugs (legal or illegal) will be consumed by employees working on the production or maintenance of the products they are under contract to manufacture. In the event of infringement of such clauses, a contract may be terminated.

Increasingly frequently, international contracts contain this kind of clause which raises ethical issues, not the least of which are effective implementation of such commitments, adequate supervision of the implementation and ensuring that companies are treated equitably in this respect.

B / The ethical and legal responsibilities of business leaders

The responsibility of a company director to employees is primarily an ethical one, taking precedence even over legal considerations.

A director's duties include providing employees with appropriate working conditions and, therefore, to guard them against any dangers which their work may expose them to. This refers to the hazards inherent to the workstation and the precautions that need to be taken to avoid risks or protect workers from them (cf. the asbestos tragedy, etc.). It is up to management to make sure that employees' behaviour is not dangerous, to themselves or to others. This is indeed strong justification for a policy designed to prevent and detect the consumption of alcohol or illicit substances in the workplace. This is also true for the misuse of psychoactive medications capable of altering mental states, alertness in particular.

This ethical requirement is materialised in substantive law by the legal liability incurred by company directors in the event of injury sustained by employees or third parties as a consequence of the company's activities, in particular when accidents of any kind are involved.

Both European and French case law tend to consider that as regards risks, even if the obligation to achieve a result need not apply to replace a "best endeavour" obligation, this latter should be given legal reinforcement via a requirement for the company director to prove non responsibility (these legal considerations are detailed in Annex 2).

- **Risk awareness**

Awareness of the risks and dangers to oneself and to others in connection with alcohol and illicit substance consumption seems to be progressing. The whole body of contemporary thinking on risk analysis and accidentology confirms the predominance of human error (error of appreciation and/or of actions) in the majority of catastrophic accidents (Bhopal, the North sea oil rig, serious railway accidents) that came under study, and the same is true of more trivial accidents. Consumption of alcohol and of illicit substances that may alter alertness, reduce vigilance and cloud judgment obviously increase the risk of error. These various levels of impairment appear in internal company

regulations, or equivalent documents, where high-risk workstations are specially designated, as are functions involving security and safety.

A broader definition of responsibility towards others is emerging. This point, reflecting a general trend in our society, is probably essential in the current phase of thinking on the consumption of alcohol and illicit substances, and on drug addiction. The concept of responsibility towards others and the obligation not to harm others, on which CCNE insisted in the 1994 Report, has undeniably moved forward in recent times, in its perception by public opinion. On a more practical basis, it has been referred to increasingly in the last few years in prevention campaigns aimed at the general public on the dangers of consuming alcohol or illicit substances when driving, or on the consequences of excessive smoking. These trends in public thinking are certainly the main reason why people have been ready to accept the enforcement of strict rules which, only fifty years ago, would probably have been viewed as a serious encroachment on individual liberties. Similarly, the now legally allowable possibility of preventive testing for the supervision of road transport employees is a demonstration of the importance authorities attach to such matters in a sensitive sector of the economy.

III. Data on consumption in the workplace.

In the wake of the implementation of the government's 2004 - 2008 plan to combat the dangers that the consumption of illicit products, tobacco and alcohol are the cause of, expert working groups[2], symposiums[3], reports by institutions[4], a growing number of multidisciplinary research studies (occupational healthcare, clinical psychology, pharmacology, etc.) are contributing highly diversified data on the specific aspects of substance abuse and addiction in the workplace. The contributors all agree that alcohol (a licit drug) and chronic alcoholism have pride of place among the array of addictive behaviours in the working environment.

Nevertheless, particularly as regards other illicit substances, experts agree on the regrettable fact that available data on abuse is, more often than not, fragmentary, in particular as regards evaluations of prevalence and consequences at work. This may be seen as a clear indication of the social taboo on the subject.

CCNE's task does not include an analysis of the multiple causes, socio-

[2] *Conduites addictives et milieu professionnel*. (Addictive behaviours and the working environment) MILDT, report to the Prime Minister, 18.12.2006

[3] *Assises nationales : Drogues illicites et risques professionnels.* (National consultation on illicit drugs and drug-related risks in the workplace). MILDT-DGT, Paris 25.06.2010

[4] *Observatoire Français des Drogues et Toxicomanies : Consommation de drogues en milieu professionnel, état des lieux des connaissances et des recherches menées en France.* (French observatory on drugs and drug addiction: drug consumption in the workplace, survey on available data and research in France). B. Redonnet, note 2010-9

economic causes in particular, attending the expanding use of illicit products. Work-related circumstances may play an important role in the growing incidence of alcohol, illicit substance and psychotropic medication usage: demanding conditions in some workstations, work-related stress, the "dehumanisation" of work relations in some large companies where the be-all and end-all is the balance sheet. However, there is no denying that personal, family and social factors play just as decisive a role in the consumption of illicit substances and in addiction to these substances or to alcohol and here we are entering the realm of private and personal matters and of individual vulnerability.

- **Alcohol use and abuse.**

Most of the available data concerns alcohol consumption[5]. In France, there are some ten million regular consumers (at least three times a week). Five million people suffer from medical, psychological and social complaints connected to alcohol abuse. Two million are classified as addicted. One million consult doctors about the problem.

The average annual alcohol consumption of French citizens has been reduced by half in the last thirty years, dropping from 26 litres to 12.5 litres today. But although the consumption of wine has dropped considerably, that of spirits and so-called "premix" drinks has increased no less considerably, particularly by the young, which raises questions on the growth of compulsive alcoholic behaviour known as "binge drinking". In view of such developments, the prohibition of advertising on the internet for all alcoholic beverages should be reinforced and in particular, legislation currently under discussion to allow advertisements for alcohol should be opposed.

On the subject of risks in the workplace, it is generally considered that alcohol is involved in 10 to 20% of accidents which are reported. According to statistics given in 2008 by the road traffic authorities on their website for fatal traffic accidents, alcohol was involved in 34% of cases, in as much as 45% for accidents involving a single vehicle and no pedestrians, and 52% for fatal accidents over the weekend.

When people are intoxicated, a large number of symptoms and abnormal behaviours are obvious to one and all, in particular colleagues, superiors, clients or users. As regards driving and road safety, the community has accepted "surprise" tests for blood alcohol contents and the setting of a threshold, above which penalties apply. The accepted objective is to protect others and offenders themselves and punishment. Breathalysers, if correctly used, are well accepted, both in a private capacity and in a working environment. They are part of daily

[5] www.ofdt.fr, *alcool, consommation niveau et fréquence* (alcohol, consumption level and frequency).

life, self testing devices are on offer to the public, in particular near establishments open at night and selling alcoholic beverages. National and European legislation is well developed and fully integrated in the internal regulations of companies, large and small. Furthermore, some major companies (for instance SNCF, EDF, Air France, etc.) have drafted "Charters for the prevention of alcohol-related risks" to which managements, trade unions, Hygiene, Safety and Working Conditions Committees (CHSCT - *Comités Hygiène, Sécurité et Conditions de Travail)* and occupational medicine authorities have all subscribed. Bringing alcoholic beverages to work, or consuming them at work is prohibited, and furthermore the Charter excludes the presence of alcohol on the occasion of any internal and external events companies may be organising. Subcontractors are likewise concerned by these procedures.

● **Illicit substances.**

The auditions and interviews held by CCNE, in particular those involving company managers and specialist doctors, confirmed the scope of behavioural changes. There seems to be a large measure of agreement that there is:

- a significant increase in illicit substance use by young people, cannabis in particular,
- and a diversification of substances, these two factors supported by the development of global criminal enterprises which supply the market and organise distribution;
- a sharp drop in consumption frequency by young people once they are in stable employment; however, when consumption becomes more than occasional, although this is not easily measured, this should point in the direction of diagnosing addiction, which is a disease.

This situation is not particular to France; it prevails in all developed countries.

Data is scant, as we noted above, on the various kinds of illicit substances used at work, and as it is based on statements volunteered by employees, it lacks the objectivity and the semi-quantitative features of alcohol abuse reports.

Occupational physicians, heads of human resources in companies and MILDT agree that there is a growing and increasingly alarming use of illicit substances: cannabis, cocaine, Ecstasy, amphetamines, etc. both in and out of the workplace.

According to MILDT, there are 1,200,000 cannabis users in France, 550,000 of which on a daily basis, and 250,000 cocaine users.

At work, about 10% of employees regularly or occasionally consume illicit substances. In first place and well ahead of other substances, comes cannabis (around 8%), followed by cocaine, amphetamines and very little

heroin. Among the actively employed population, consumption varies considerably with socio-occupational categories: very low for farmers (2.7%), very high for artists and in show business (17%) and, to a lesser degree in the hotel and catering trades. The figure is around 9% for craftsmen, tradesmen and business leaders, and 7% for executives and middle-level employees. The most regular consumers of cannabis and cocaine are the unemployed and young apprentices (respectively 15% and 19%) *vs.* 5.7% for students in higher education.

Generally, on obtaining gainful employment, cannabis and cocaine users tend to stop the habit. On the whole, women do not consume as much as men, but when they attain a higher degree of education and employment, they consume more, in contrast to men whose consumption drops in similar circumstances, so that gender-related differences are smoothed out at this point.

More objective data is available from road safety statistics due to the fact that screening for illicit substances and alcohol is systematic in the event of road accidents and traffic offenses. These *a posteriori* checks are well accepted as they come in the wake of violations which are potentially dangerous for the person concerned or for others. Cannabis use multiplies by 1.8, and alcohol plus cannabis by 8.5 the risk of being responsible for a fatal accident. The same data holds true for the public at large, for drivers at work and for people using their vehicles to get to work. However, for this latter category, the frequency of alcohol and illicit substance-related responsibility for accidents is markedly lower.

● Abuse of psychopharmaceuticals

Many factors affecting people's psychological balance and performance motivate a visit to a doctor and frequently medication is prescribed. Depending on the symptoms, the pharmaceutical drugs prescribed may be anxiolytics, hypnotics, antidepressants, psychostimulants, or even neuroleptics. All of these neurotropic agents have their own specific effects aiming to correct the symptoms of the various pathologies for which they are prescribed; they act on the behavioural and performance disorders brought on by these pathologies. They may enable a return to psychological and relational well-being which is often and partly the reason for misguided continuation of consumption once the symptoms have disappeared. Such misuse is frequently the start of pharmaceutical addiction[6]. A 20-year longitudinal study of a cohort of 2213 employees[7] revealed that 6.1% of them used a psychoactive drug, that over half

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[6] Afssaps, *Médicaments et conduite automobile, actualisation 2009.* (Pharmaceuticals and driving, 2009 update). Nathalie Richard, audition.

[7] Boeuf-Caron O., Lapeyre-Mestre M., Niezborala M., Montastruc J-L. Evolution of drug consumption in a sample of French workers since 1986 :" the Drugs and Work" study. Pharmacoepidemiology and Drug Saf. 2009 ; 18, 335-343.

were also regular alcohol users and that 10% were occasional cannabis users. All the doctors specialising in addiction medicine who were heard by the Committee drew attention to the harmful and dangerous effects of using alcohol and psychoactive drugs — both of which are licit — in combination. Another study[8] shows that 20% of employees take some medication to "enhance their performance at work", that 12% use a drug while they are working to "attenuate a bothersome symptom" and that 18% are users "to relax on a difficult day".

- **Methods for screening of illicit products**

Behavioural and clinical signs of illicit drug use, abuse of neuroleptics or doping at work are either discreet or invisible, so that screening requires medical competence. But, as is the case for alcohol, there are commercially available tests.

Illicit substances are ingested, absorbed and then break down in the body. They leave traces which first disappear from saliva (24 hours), and subsequently from the blood stream, urine and finally the hair (after several years). In urine, traces of opioids (morphine and heroin) persist 3 days, amphetamines (Ecstasy) for 4 days, cocaine (crack) for 9 days and cannabis traces (marijuana, hashish) for 1 to 30 days depending on how much is consumed.

The screening process for the detection of traces of all these illicit substances is immunochromatography, which tests for an antigen, i.e. the product, with as specific an antibody as possible.

However, a number of antibodies recognise not only the drug, but also kindred molecules present in particular in licit psychoactive drugs or even in some foodstuffs (poppy seeds). As a result, there are false positives, the proportion of which varies between 11 and 16% depending on the antigen-antibody combination. In view of the limitations of the screening tests and the complex catabolism of the illicit substances, testing and reading test results is a job for professional healthcarers, while interpreting results and follow-up action should be left to occupational physicians.

We are now accustomed to being informed on tests for doping in the sports' environment and to discussion on cross-effects between authorised pharmaceuticals, food pollutants and prohibited doping agents. In the corporate environment, it is clear that its specific constraints, the performance levels required, the inevitable interdependence between private and corporate behaviours, respect for individual liberties and non discrimination at work, combine to make ethical considerations more complex.

IV. Health services in the workplace and companies, depending on size.

[8] Niezborala M. et al. *Conduite dopante en milieu professionnel : étude auprès de 2106 travailleurs de la région toulousaine. Journées nationales de médecine et de santé au travail.* (Drug use in the workplace: study involving 2106 workers in the Toulouse area). 2006 Lyon. Oral communication.

Screening for substances and alcohol abuse in the working environment falls into three main categories:

(1) pre-recruitment medical examinations and determination of fitness for posts involving security and safety,

(2) medical examinations following security and safety incidents in the workplace,

(3) public health campaigns for drug addiction prevention in the working environment.

Occupational physicians, in liaison with health services in the workplace, are responsible for the management of these three procedures, for referring employees to their attending doctor if they need treatment, for reintegrating them, with due respect for deontology as prescribed for occupational medicine and in compliance with CHSCT-validated procedures, or their equivalent, in particular in small and very small sized businesses.

More generally and as concerns the dual mission of occupational medicine and physicians, i.e. (1) supervision of employees' health and (2) be the company's medical officer, preventive measures must be taken after joint discussion and decision. Supervision of abstinence from the consumption of illicit substances, or even of alcohol, can be achieved on the basis of individual detection of presenting symptoms, or through unscheduled or systematic screening for personnel working in clearly identified safety and security workstations, or holding well-defined positions of responsibility or involving safety.

● The current situation

At this time, when its role in combating alcohol and illicit substance consumption and addiction in working environments is very obviously essential, occupational medicine finds itself in an uncomfortable position.

A number of studies have provided an analysis of the situation in recent times, in particular the *Inspection générale des affaires sociales* and the *Inspection générale de l'administration de l'éducation nationale et de la recherche* (Inspectorates for social affairs, education and research) report in October 2007, on the "*Bilan de réforme de la médecine du travail"* (Results of the occupational medicine reform), and the *Conseil économique et social* (Economic and Social Council) Opinion on "*L'avenir de la médecine du travail*" (The future of occupational medicine) dated February 27, 2008.

In recent years, the authorities have embarked on a deep seated reform of occupational medicine, directed in the main to giving priority to primary prevention. A number of documents have marked these developments, in

particular a law on social modernisation dated January 17, 2002 which emphasised the need to focus on multidisciplinary participation in the reform of occupational medicine, now to become occupational health services. There was also a decree dated July 28 2008, the aim of which was to reinforce the preventive role of medical services in the workplace, with occupational physicians devoting one third of their time to this activity.

Recent reports found that the results of these reforms were disappointing. As regards their implementation, there is a great deal of disparity between regions and departments and even, within a department, sometimes from one doctor to the next. Altogether, the time needed for individual examinations, in particular for assessing fitness, was considerable so that there was very little time left over for other tasks incumbent on the occupational health services.

In the circumstances, occupational medicine seemed poorly prepared to face up to changes in the production system, i.e. the development of part time work and teleworking, increased worker mobility — making medical follow-up and monitoring of harmful exposure more difficult — and finally, the ageing of the active population with all the problems that entails.

Moreover, the profession is in the throes of a serious demographic crisis. In 2009, the number of occupational physicians totalled 7000, of which 55% were over 55. In five years' time, 4,000 of them will have reached or be over retirement age[9], but only 370 newcomers will have emerged from internship training. This numbers crisis is reinforced by an image problem: occupational medicine is not highly regarded by medical students and comes last in their preferences for specialisation. There is already a shortage of professors in this discipline so that some medical schools no longer have anyone teaching it.

● The need for new impetus

The authorities are aware of this crisis and, in 2009, launched a broad consultation on how to remedy the situation, with the participation of occupational physicians, representatives of the corporate world and workers' organisations. No unanimous agreement was reached, but the most important measures to be taken were included in a draft law which is currently being submitted to Parliament[10].

The draft law recalls that the "exclusive mission of occupational health services is to avoid any damage to workers' health as result of the work they do". It reaffirms the independence of occupational physicians who act "in coordination with employers, members of CHSCTs or staff representatives and people involved in occupational hazards prevention" and, more generally,

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[9] *La santé au travail. Vision nouvelle et profession d'avenir.* (Health in the workplace. A new outlook and a profession with a future) C. Dellacherie, P. Frimat and G. Leclercq. April 2010

[10] Draft law adopted by the *Sénat* on the organisation of occupational medicine, sent to the lower house on January 28, 2011.

danger to third parties.

The document furthers confirms that occupational health services must be supplied by a multidisciplinary team composed of doctors, nurses, occupational hazards prevention operators (psycho-ergonomists), under the leadership and coordination of the occupational physician.

In the event that the occupational health services are provided on an "intercompany" basis (the most frequent case, in particular for small, very small or medium-sized companies) this is managed by a council composed of an equal number of employer and employee representatives.

These arrangements are currently being discussed by Parliament and are not within CCNE's purview. However, CCNE considers that the reminder concerning the independence of occupational physicians is essential, but that they would be undertaking new and increased responsibilities as leaders of this multidisciplinary team. The overall efficiency of the occupational health service would be improved as a result, including the fight against addiction, but obviously on the condition that material and personnel requirements are effectively met.

It is also hoped that this reform could contribute to enhancing the image of a mission which is in the public interest. For new occupational physicians to join the workforce, which is a matter of increasing urgency, it is important that the university hospital status of the discipline should be retained. A further need is to organise effective training courses in this discipline for the benefit of interns.

● Current practices for the prevention of alcohol and illicit substance consumption and detection in the corporate environment

For want of anything but fragmentary data on matters that companies moreover do not care to discuss voluntarily, a general overview of the situation is not easily gained. CCNE's impression from the hearings and interviews it conducted, however, was that a very broad variety of situations co-exist.

1/ The big companies, particularly those for which security is particularly important, generally have their own occupational health service and do their own recruitment for it. But the service operates totally independently of management, and of the Human Resources directorate in particular.

They also have policies for risk prevention which include raising awareness on alcohol and illicit substance-related risks. The policies are discussed in the CHSCTs, of which there may be a number in companies with a collection of different sites, e.g.: 160 for the SNCF (French railways) and 200

for EDF (French electricity). The debate may lead to the signature of agreements or charters designed to define and harmonise prevention policies. However, the intensity of social dialogue on addiction risks seems to vary considerably from one company to the next and the documents we have seen seem mainly focused on alcohol, which is not a new problem so that participants are more familiar with the subject and therefore less reluctant to discuss it.

"High risk positions" may justify, in the light of currently applicable legal regulations, adding to company by-laws articles authorising occupational physicians to screen unannounced for alcohol and illicit substances.

All the people we interviewed agreed that the designation "high risk positions" was inadequate because of its ambiguity. It seems fitting for positions where the worker is exposed to a specific risk due to the nature of the work or the conditions in which it is performed, and which should be alleviated by the implementation of a prevention policy. But the dangers associated with the use of alcohol or illicit substances in fact exist for any post where safety is a factor which requires particular attention in order to protect not just the worker, but also co-workers and clients or users. Poor maintenance of a sensitive aircraft component when it is being overhauled could have the most serious consequences for crews and passengers... CCNE considers that referring to "posts or functions involving security and safety", which would appear to be one of the most frequently used expressions, would be more appropriate.

Defining such posts is clearly a difficult task. Companies adopt a variety of methods. SNCF, for example, because of the specificity of railroad security and sensitivity on the subject, has a long-established list of security postings. This list is enshrined in a ministerial decree (Decree dated July 30, 2003 - official publication on August 24, 2003). However, a regulatory text of this nature is the exception; in this particular case, the reason was that identical security regulations are applicable to other operators using the French railway network. About half of the company's employees are involved, ranging from train drivers and inspectors to maintenance staff in the workshops dealing with sensitive rolling stock components.

At the opposite end of the scale, although they emphasise the importance of security, EDF refuses to list specifically the jobs involving security for the company as a whole. They have, however, in the last few years, made an exception for all the employees working in nuclear power stations, irrespective of individual qualifications. Since 2005, the head of each power station can arrange for unannounced blood alcohol content screenings (not so however for illicit substances). The ruling was included in the by-laws of each site, after discussion with the CHSCTs.

Special attention is given to prevention policies in companies which have in-house training programmes for newly hired workers, such as centres for

apprentices. There is also a broad consensus in finding that the habit of consuming alcohol or illicit substances on a regular basis is formed much earlier than used to be the case, by youngsters just embarking on their careers, be they apprentices or university students.

Some big companies have also set up counselling services for employees who have been diagnosed as addicted to alcohol or illicit substances (confidentiality is preserved) as well as reclassification procedures within the company once their health is restored. This is an essential part of such policies so as to ensure that prevention, social dialogue and intra-company communication goals are achieved, since emphasis is placed on the concept of "pathology" (which does in fact correspond to the reality of addiction), instead of on "fault". Another factor is that, in this way, the risk of dismissal is eliminated.

2/ CCNE does not have a great deal of information on the consumption of alcohol, illicit substances and psychoactive medications in small or very small companies. Most of them call on external occupational health services.

It is probably in this context that the consequences of the scarcity of occupational physicians are most conspicuous and this is also true as regards efforts to combat addiction. The doctors' workload is overwhelmingly concerned with recruitment and periodic examinations. Setting up multidisciplinary teams should probably bring some relief. Some people, however, are of the opinion that employees in small companies can enjoy closer and more human relations than is possible in very large companies. Since people know each other better, it may be easier to detect problems experienced by a colleague in connection with the use of alcohol or illicit substances and help him or her fight the addiction, for example by suggesting medical advice. Others consider that this proximity may in fact make the situation more, rather than less, difficult for the person concerned and that it is no substitute for vigilant and confidential professional assistance.

In small companies coping without a CHSCT, whose tasks include specifically communication on employees' health-related problems, the issue of drug addiction and alcohol abuse may be more difficult to include in a discussion with staff representatives. The coordinating task of occupational physicians in this case would be of paramount importance, but in the current situation it seems unlikely that they could carry it out adequately everywhere. However, it must be remembered in this context that the company director's ethical responsibilities are implicated.

3/ As mentioned in the introduction above, CCNE considers that the issue of risks in connection with the consumption of alcohol and illicit substances in

the workplace are of concern, not only in corporations, but in all working environments, in particular in the civil service.

Available data in this context is even more patchy than in the business world, and CCNE's mission does not include carrying out its own enquiries, nor does it have the resources to do so. However, it does seem clear that some systematic research and evaluation would be very necessary, all the more so since some sectors seem particularly exposed. For example, this is the case in hospitals where at every level, ranging from department heads to trainee nurses, staff have to cope with tasks involving patients' health, with stress inherent in their line of work and possibly opportunities for access to illicit substances and psychoactive medications. The Paris public hospitals (*Assistance Publique — AP-HP*) have recently rolled out a systematic campaign aimed at all the people they employ to raise awareness of these dangers. It is too soon, however, to draw any conclusions.

It is also true that, in the IT community, which operates in both the private and the public sectors, in view of the immediacy of decisions taken via the internet and their sometimes far-reaching consequences, there is good reason to be particularly watchful of the people taking such decisions.

IV. A summary of the ethical issues

In France, the efficacy of prevention campaigns regarding road safety, as well as regrettable cases of doping in sports[11] have had the effect of sensitizing public opinion to the need for weighing respect for individual liberties against responsible behaviour towards others. One of the most significant developments marking this change of outlook on the part of the community has been the acceptance of non-smoking rules in corporate environments and public places to combat passive smoking.

However, although society has taken the route of more responsible behaviour when there is a risk to the life and/or health of other people, some cultural obstacles persist. The consumption of alcohol or of illicit substances is seen as a factor for social cohesion, which may constitute a stumbling block in the action taken to prevent their use.

There are several major ethical values to which our society subscribes: respect for the body of each individual, respect for autonomy, concern for others and for not doing them harm, and a demand that justice be done. What follows is a brief outline of these values.

● Respect for the body of each individual

[11] Opinion n°81 CCNE: "Performance and Health", www.ccne-ethique.fr

Screening is not an innocuous action. In the collective imagery of society, an action with an effect on someone's body in the name of the community's interest is seen as intrusive. Our society is sensitive to values relating to privacy: modesty, unavailability and integrity of the human body. Collective memory is still mindful of the ideological, coercive and hygienist characteristics of the early screening campaigns in the workplace during the first half of the 20th century. Social control policies, invoking the "higher national interest" to justify screening so-called "high risk" populations. Some employees were set apart from others to prevent them from "contaminating" the social body. For instance, as regards tuberculosis, screening in the work place has often been mixed in with policies involving supervision, identification and tight control over people through legislative, sanitary and social coercion (visiting nurses, factory supervisors, etc.) although the reliability of tests was open to question for quite a long time. As an example, studies have now demonstrated that almost all adults reacted positively to the tuberculin test[12,] signifying that there had been prior contact with *mycobacterium tuberculosis*, but not that the person concerned was necessarily ill or contagious[13]; in fact he or she was already immunised. Discrimination based on this kind of screening was devoid of any prophylactic virtue.

One has to admit that article 2 of the Code of Medical Deontology: "A physician acts in the service of the individual and of public health. A physician's task must be accomplished with due respect for human life, individuals and their dignity..." is not easy to implement. Generally speaking, the instances of instrumentalisation of healthcarers that occurred in the last century can explain and justify their inclination to be wary at the present time. Vigilance on their part is not simply a right, it is also a duty. Screening in the working environment needs robust justification for it to be allowed.

- **Respect for autonomy**

In the ordinary exercise of practice, a doctor acts in response to a health problem that patients or their next of kin have already become aware of, with a view to the patient adopting preventive and/or curative measures. The concept of autonomy includes a commitment on the part of the person consulting a doctor. A measure is "autonomous", literally, when it is "self" (*autos*) initiated. It is not simply acquiescence to the will expressed by third parties.

Because of our attachment to autonomy, society would not in the long run tolerate a proliferation of coercive measures in the workplace. People being screened do not have any health complaints, frequently do not feel at all unwell

[12] Intradermoreaction test.

[13] 86% of people aged over fifteen in Calmette's first major survey of a population in the north of France: cf on this point Pinell P. *Dictionnaire de la pensée médicale* directed by D. Lecourt, PUF, Paris, 2004, pp. 320-324.

and were not asking for help. For these reasons, medical intervention affecting the body of a person without that person's consent and performed solely at the behest of a third party, may be perceived as contrary to the demands of respect for autonomy. This could explain the islands of resistance encountered in various sectors of the working world.

It is true that individual liberty is not incompatible with the notion of collective interest. Properly understood, autonomy implies acting *with* others and not *against* others. However, it is in the public interest that the greatest autonomy be left to the greatest number of people. The argument that "people need protection against themselves" is to be taken with caution. For example, "assisting people in danger" can lead to the kind of abuse CCNE warned of in its Opinion n° 87 in 2005 on Treatment refusal[14].

To act against people's wishes and without their consent cannot, therefore, be justified solely in the name of the supposed duty they owe to themselves and can only acquire legitimacy if the health or life of a third party is at risk. It can be socially acceptable but only as a last resort, in the absence of any other alternative or initiative on the part of the person concerned. It must be noted that such a derogation must be clearly stated in by-laws and employment contracts.

● Concern for others and for "not doing harm"

To be compatible with medical humanism, a screening test must comply with the principle of individual beneficence. In other words, it must have diagnostic, preventive and/or curative aims. The discovery that illicit substances are being consumed can be experienced as a kind of invasion of someone's privacy and bring about feelings of shame and humiliation.

Doctors perceive the vulnerability of "suspects" in the context of an exclusive dialogue. When they reveal a condition of "inaptitude" to an external authority, they may feel that they are stepping away to some extent from the confidential care relationship, that they are adding a feeling of isolation to the fragility of the person suffering from an addiction and, finally, that they are aggravating that person's personal problems. Even when medical confidentiality is preserved, persons screened may come under suspicion and encounter difficulties simply by reason that they are known to be temporarily incapable of going to work.

● The demand that justice be done

A sense of justice calls for taking account of the needs and rights of all the

[14] Opinion n°87, CCNE "Treatment refusal and personal autonomy". www.ccne-ethique.fr

members of society. Collective indignation always runs high when the death of one or several people is connected to the consumption of illicit substances or of alcohol by the author of a tragedy. The feelings of repulsion and injustice aroused by the negligence of the perpetrator bear witness to the importance society attaches to protecting human life. No one should have to suffer harm caused by others, whatever the reason.

Security is an essential condition if the values which make life in society worth living are to be protected. It is for this reason that if a person's employment exposes him or her to putting others in danger, then justice demands and legitimises preventive measures to attenuate the risk. Unscheduled screening for illicit substances is justified by these requirements which involve primarily safety and security positions where a high degree of vigilance is essential, but on the condition that those concerned are informed of this possibility in the by-laws or the employment contract.

V. Conclusion — Recommendations — Avenues to be explored

- In response to the question raised by MILDT's referral on the "possibility of screening for illicit substances in the workplace", CCNE **is replying as follows:**

On the condition that society's action in this respect is solely in derogation from the exercise of individual liberties, medical screening for the use of illicit substances in the workplace is ethically acceptable. Screening is advisable and justified for posts involving security and safety; it should be extended for these same posts to screening for alcohol abuse, and even for alcohol use. Nevertheless, CCNE considers that if screening were generalised, the transgression of the duty to respect individual liberties would be trivialised.

- This reply implies, and must necessarily be associated with, **the following recommendations**:

- **Weighing up the ethical values involved**, taking care that none of them are sacrificed in favour of another: respect for individual liberties, preserving the medical confidentiality of personal data, the collective interest of public health, the protection of third parties.

- **Giving society, in general terms, the right to compel its members to the duty of protecting themselves (supposing that such a duty does exist) should take into consideration the risk against which it wants to safeguard them.**

- **Only exercising society's right to oversee personal decisions when they lead to risk which affect *directly* the health or life of others.** Unannounced or otherwise, detection and screening is only founded on the existence of dangers incurred by third parties who are exposed to suffer serious injury in connection with the consumption of illicit substances, alcohol abuse or possibly use, drug addiction and abuse of psychoactive medications.

- **Making sure that all those who are employed in posts involving safety and security, requiring a high degree of vigilance at all times, are effectively and previously informed that they may be the subject of screening for the consumption of alcohol or of illicit substances. The reasons justifying this action must be clearly explained to them.**

  - CCNE is suggesting **five avenues that could be explored** on the subject of public health (information and education), the setting up of "Health at Work" services, regulatory approaches tailored to the various professions and, in conclusion, exploring the possibility of improving working relations.

1. **Promoting an extensive campaign of information**
on the effects of alcohol and illicit substance consumption, and of psychoactive medication abuse, on vigilance, sensory mechanisms and learning processes, focusing on scenarios involving the working environment. The campaign should also be aimed at doctors, i.e. the prescribers of psychoactive medications so that they seek out information on the working conditions of their patients. It should also draw attention to the responsibility incurred by users of such products. Strong commitment on the part of the authorities is all the more essential because there will be no lack of reluctance to "drag into the open" this sensitive, and up till now, almost taboo subject.

2. **Introducing new educational processes**
into the curricula of occupational training courses, with modules specially adjusted for each level of education: vocational training certificates, secondary school certificates, school-leaving certificates, intermediate and higher university degrees, BAs and MAs, technical and engineering degrees, doctorates in all disciplines in the exact, experimental, normative, legal, human and social sciences.
It is furthermore necessary to stimulate scientific and medical research on the negative, but also on the positive, effects of the occasional use of certain illicit substances or psychoactive medications on performance in certain working environments.

3. **Conducting the creation of "Health Services at Work"**:

- by making certain that multidisciplinary qualifications are fully integrated and the code of medical deontology is respected as regards medical confidentiality and not revealing secret information; for this to happen, there is an urgent need to include specific educational modules on "health in the workplace" to the training courses provided for nurses, ergonomists, security engineers, clinical psychologists, etc. Occupational physicians, whether already trained or in the process, must be given an opportunity to gain know-how in team coordination and management,
- by furthering the occupational physician's dual mission, i.e. protecting the health of employees and improving safety at work, in all the various occupational medicine configurations (services performed for one single company, shared between several companies, group practices, etc.) throughout the private sector, irrespective of the size of companies, and the various public sector departments,
- by making certain that are maintained and reinforced the human and material resources needed for occupational medicine, which is a service in the public interest, at a time when reforms are under way,
- by devoting attention to the reinforcement of the attractiveness of the "Occupational Medicine" specialty.

4. **Respecting the ethics of the division between the private and the professional spheres by granting greater importance to collective negotiations:**

- It is necessary:
  - to complement the by-laws and working contracts in each company and each civil service unit with a detailed census of posts and functions in security and safety where human error, or even simple failure of attention could have serious consequences for the person concerned or for others;
  - to describe the constraints and obligations attached to these security and safety posts and functions, in particular as regards abstinence from alcoholic beverages and illicit substances.
- This census must be mandatory and its principle enshrined in law.
- As regards procedures, it is absolutely essential to give preference to collective bargaining (branch, company or collective labour agreements, etc.), rather than to legislation or regulation in view of the diversity of the professional activities concerned, of their sizes and of their legal status. Such negotiations need to be discussed in detail by all the actors in the company, i.e. those representing management, the employees and the occupational health services so that the complements to the by-laws can be duly validated and incorporated in the

working contract.
- For posts involving security and safety, screening for alcohol and illicit substance consumption is advisable and justified as CCNE's Opinion n° 15 already noted in 1989 (Annex 2). If screening is required, it must be specifically stated in internal regulations and labour contracts, including whether it is to be performed systematically and/or unannounced. This is one of the essential items on the collective bargaining agenda.
- Such screening must only be organised under the sole responsibility of the occupational health service. In the light of current scientific knowledge, only saliva tests should be used (providing evidence of consumption in the previous 24 hours). The interpretation of biological and clinical data and recommendations regarding follow-up care must remain within the exclusive competence of the occupational physician. These various procedures are protected by the rules of medical confidentiality and the data recorded in the Personal Medical File — a system in the process of being implemented — only with the patient's agreement.

5. **Giving positive emphasis to the social dimensions of work.**

Measures to fight alcohol and illicit substance consumption, and to prevent psychoactive medication abuse, cannot be dissociated from a more general consideration of the quality, the appeal and the significance of work in today's society. A person whose working life is a source of self-esteem will be all the more motivated to honour commitments, so that due importance should be attached to an appreciation of involvement, both individual and collective, in success at work, while avoiding the conditions which lead to workaholic behaviour and burn out. A successful company is not described solely in quantitative terms; it is also assessed by the degree of well being of its employees.

In the course of their lives, all employees may be confronted with misfortunes (bereavement, separation, ill health, etc.) which act as a challenge to their commitments at work. Depending on the degree of trust and solidarity experienced in their place of employment, they may be able to express these temporary setbacks and take the initiative of asking for help in overcoming an incipient addiction problem. Companies, whatever their size, are fulfilling their social role within the community if they develop a caring approach and see to it that people working for them, when some private mishap has made them vulnerable, can express themselves, feel that they are being heard and be provided with counselling and moral support in their place of work.

Paris, May 5, 2011

Annex 1

1/ The National Consultative Ethics Committee has produced three successive documents on issues raised by drug addiction, of which the first and earliest is the one MILDT referred to, Opinion n°15 dated October 16, 1989 on Screening for drug addiction at the workplace, in response to a referral by Mme C. Trautmann, at the time President of the *Mission Interministérielle de lutte contre les toxicomanies* (Interministerial Mission to Combat Drug Addiction), following a request addressed to the Mission itself by a pharmaceutical laboratory who wanted to make available a urine screening test for drug abuse to companies wishing to protect themselves from risk generated by drug abuse (illicit substances).

CCNE's Opinion, in summary:

- underlined the importance of commercial considerations which seemed to be at the origin of the initiative,
- recalled that within each company, occupational physicians are required to examine an employee upon recruitment and later, periodically, to make sure that he is able to perform the task for which he is or was hired and whether "he could be a danger to himself or to others when he is accomplishing that task". At this time, "the doctor's duties include finding out whether the person (...) is exposed to any such danger by abuse of illicit toxic substances". For that purpose, the doctor is at liberty to prescribe any test that may be needed...";
- recalled that ethically and legally, it is not permitted, however, to make systematic examinations at the time of recruitment or periodically once an individual is employed if they are not relevant to the work to be done;
- noted that, there are or there can be in certain companies, activities for which the use of drugs could be dangerous, either for those in that activity or for their fellow workers, or for others. Systematic testing with a view to detecting substance abuse which would be incompatible with the work concerned is "to that extent, but to that extent only" advisable and justified.
- finally recalled that screening results come under the rule of medical confidentiality. "The occupational physician must confine himself to stating that the applicant or employee is fit, or partly or completely unfit, to accomplish the work in question". Irrespective of the circumstances, he cannot disclose, to the employer in particular, the existence of substance abuse as such.

2/ Report n° 43 dated November 23, 1994 on Drug Addiction.

This report was the result of a self-referral on the part of CCNE and aimed to review generally the problems caused by drug addiction. From the outset in

the preamble, the report emphasised that recent progress in neurobiology and pharmacology had made it clear that the distinction between licit and illicit drugs is not based on any coherent scientific principle; it returned to this point on several occasions in the rest of the document.

The report made a detailed analysis of the various classifications used to categorise pharmacological substances affecting the central nervous system and which may lead to dependence. It also reviewed the available data on the mode of action of the various substances, in particular those leading to addiction.

It also analysed relevant French law as it applies to licit drugs (tobacco and alcohol) and illicit drugs. In passing, the report points out that in French substantive law, there is no legal definition for drugs and drug abuse.

In conclusion, the report considered drug-related ethical issues at some length, but did not express categorical views on the subject and there was no specific reference to the working environment.

As regards the issue we are discussing in this document, the report put special emphasis, in particular, on the distinction to be made between "harm done to oneself" and "harm done to others", the latter calling for sanction. "He who loses control of his consumption and thereby is a threat to life, limb or merely the interests of others, must be sanctioned. And so must he who urges another to consume drugs or encourages abuse".

3/ Opinion n° 80 dated December 4, 2003: "Guidance of workers to risk-bearing occupations". This Opinion does not refer specifically to occasional drug taking or addiction, but considers in depth some of the ethical issues involved in occupational medicine: "... is it allowable – without being at fault – to expose a worker to a known or potential risk as a function of his/her individual characteristics, and with whom must rest responsibility for doing so?" It is these personal characteristics, in particular addiction to a drug or chronic consumption of psychoactive substances, which are of concern in this paper. In view of the ethical conflicts raised by the concept of "aptitude", the Opinion suggests that a consensus conference could aim to:

1) identify more clearly, scientifically and medically, situations involving a known risk;
2) establish an up-dating procedure for the above;
3) encourage Occupational Physicians to become involved, with due regard to maintaining their autonomy, in the current risk management problems;
4) to consider a desirable reinforcement of their responsibilities and of their mission, within the framework of values which have always prevailed in France.

Annex 2

Legal aspects

As regards companies, both European and French case law have detailed some of the legal aspects:

1. An employee's liberties are naturally subjected, during the period of time covered by the working contract, to restrictions which are the result of the employee's obligation, under the authority of the company's management, to obey orders and instructions received. Some of these orders and instructions, however, are the result of the employer's own obligation to comply with law. This is, for example, the case for legal hygiene and safety regulations (wearing protective garments and headgear, etc.).

Community law has further extended these regulations, producing a general directive on the safety of workers (Directive EEC 89/391, dated June 12, 1989). The directive was transposed to French law (articles L.4121-1 and L.4121-2 of the *Code du Travail*). Employers are under obligation, inter alia, to 1° Avoid risks, 2° Evaluate risks which cannot be avoided, 3) Combat risk at source... 8° Take steps to ensure collective protection... 9° give appropriate instructions to employees".

It should be added that the 1989 directive as transposed to French Law, also puts an obligation on individual employees to pay particular attention to safety: "*It shall be the responsibility of each worker... to take care of his own safety and health and that of other persons affected by his acts or omissions at work in accordance with his training and the instructions given by his employer*" (article L.4122-1).

The *Cour de Cassation* (the French Supreme Court of Judicature) extended the scope of these articles, judging on the one hand that employers had "*an obligation to secure results*" (soc. February 28, 2002, Dalloz 2002, p. 2696 ; Civ. 2ème, October 14, 2003, B. n° 300). However, doctrine notes with some justification that reference to an obligation "to obtain results" is inappropriate and that it is in fact an obligation to reinforce best endeavours, i.e. that it implies

a reversal of the burden of proof.

Furthermore, the *Cour de Cassation* also places an obligation of safety on the employee; failure to comply could be a qualifier of serious misconduct (Soc. February 28, 2002, Dr. Social 2002, p. 533).

Clearly, crucial requirements must be justification for restricting employees' individual liberties. The safety obligation, which is incumbent on both company and those it employs, is of sufficient importance to warrant testing for alcohol use or for the presence of illicit substances (either in employees' personal belongings or in their bloodstream; in the current state of our knowledge, with breathalysers for alcohol and saliva tests (to detect consumption in the previous 24 hours) for illicit substances, by reason of the serious risk for those who are using them and for other people that consumption of these substances can lead to.

Taken in combination, the rule set out in article L.1121-1 of the *Code du Travail* and those arising out of articles L.4121-1, L.4121-2 and L.4122-1 of the same Code, in principle confer legitimacy on measures to verify compliance with the safety obligation, on the condition that they remain proportionate to the aim being pursued.

Obviously, tests cannot be systematically extended to all employees. Case law, be it that of the *Conseil d'Etat* (Council of State) or of the *Cour de Cassation*, rules in the direction of limiting tests to only those employees who may have occasion to generate risks.

2. It should also be emphasised that the authority, which is in principle held by the employer, to take steps regarding health and safety, may be delegated to a subordinate.

Case law has clearly defined delegation of authority.

If such delegation is an attempt on the part of the employer to shirk responsibility by delegating to poorly qualified and ill-equipped employees, it is considered to be totally invalid. Five different decisions of the Criminal Division of the *Court of Cassation* clearly set out the rules of validity for delegation of authority: "*Unless the law otherwise stipulates, the employer, who did not personally participate in the violation, may be exempted from criminal liability if he is able to prove that delegation of authority was in the hands of a person in possession of the required competence, authority and means of action".*(Crim., March 11, 1993).

In other words, delegation of authority, exempting the employer of any personal liability in the event of an accident, is a means of enhancing safety by placing protection in the hands of a competent worker, close to the site of possible risk and in possession of appropriate financial and technical means of action.

3**.** In conclusion, the part played by workers' representative bodies as regards safety needs to be highlighted.

Workers' representatives (art. L.2313-1 of the *Code du Travail*), the Works Council (art. L2323-27 of the *Code du Travail*) and the Committee on hygiene, security and working conditions (CHSCT) (art. L.4612-1 of the *Code du Travail*) are all involved in ensuring worker safety. CHSCTs play an ever increasingly important role: among other things, they must analyse the risks to which workers are exposed in the workplace (art. L.4612-2) and participate in the prevention of these risks (art. L.4612-3). Numerous means of information and investigation are available to them to carry out these tasks, in particular they may use the services of an expert (art. L.4614-12).

Setting up procedures to test for possible employee intoxication at the workplace requires that these representative bodies be informed and consulted. When they are well aware of the risks to all the personnel, to the company itself and to third parties generated by some employees' illicit substance and alcohol addiction, they are likely to be able to provide useful insight as to measures to be taken.

Although the working environment is not the only forum where the issue of a satisfactory balance between individual liberty and the collective public health interest in fact arises, regarding the use and abuse of alcohol and the consumption of illicit substances, but it is emblematic of ethical decisions to be taken or rather, of the quest for a problematic ethical equilibrium. In attempting to define this delicate balance, CCNE is fully within the scope of its mission.