CLINICAL ETHICS

Should physicians be allowed to use alcohol while on call?

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Although physician alcohol use that leads to impairment has been extensively discussed, few statements address the issue of alcohol use of physicians who are on call. In this paper the authors review recent information on physicians' perceptions of alcohol use by themselves and their colleagues while on call. It is argued that conflicts in physicians' perceptions are due to the fact that the larger society has not addressed the question of whether drinking on call is public or private behaviour. The authors argue that when medicine is understood as a practice defined partly in terms of standards of excellence, the present approach of the American Medical Association to prohibit practicing medicine under the influence of alcohol requires a prohibition of drinking alcohol while on call, unless studies determine a clear threshold for drinking alcohol without placing patients at risk.

There has been much discussion in the medical literature about physician impairment by alcohol,[1–8] and medical organisations address the issue in their ethical statements. For example, the American Medical Association (AMA) *Code of Medical Ethics*[9] section E-8.15 entitled ''Substance Abuse'' states that ''It is unethical for a physician to practice medicine while under the influence of a controlled substance, alcohol, or other chemical agents which impair the ability to practice medicine.'' The AMA House of Delegates has also offered a policy (H-30.960)[10] that ''(1) urges that physicians engaging in patient care have no significant body content of alcohol and (2) urges that all physicians, prior to being available for patient care, refrain from ingesting an amount of alcohol that has the potential to cause impairment of performance or create a 'hangover' effect.'' The former statement does not define what ''under the influence'' means and the latter does not define what ''a significant body content of alcohol'' or ''an amount of alcohol that has the potential to cause impairment of performance'' is. Neither explicitly states whether any alcohol can be used while on call, but both statements imply that some alcohol can be used. Indeed, the use of the term ''urges'' implies that physicians have the discretion to make the final decision.

In a recent ethics grand rounds, one of us asked whether physicians should drink any amount of alcohol while on call.[11] A number of ethical concerns were raised, including potential harm that could be done; colleagues' and patients' perceptions of alcohol use by physicians; the professional standard for alcohol consumption while on call; what medical students and residents are told of the proper approach to drinking while on call, and whether patients should be informed if a physician has consumed alcohol while on call. Although we found some literature about whether physicians should attend to an emergency if they have been drinking when not on call,[12 13] we found little discussion about whether physicians could drink while they are on call.

We decided to investigate physicians' perceptions of alcohol use on call.[11] We hoped that this information might provide some basis for determining the actual practice of physicians and assist in determining if there exists within the practice of medicine a standard governing drinking while on call. Our findings are reproduced in table 1.

The three survey questions that related to physicians' perceptions about alcohol use showed that a majority of physicians is against taking any amount of alcohol while on call. The rest expressed their disagreement with the majority view: 14% felt that social drinking was acceptable while on call; 27% disagreed with the statement that ''physicians should not have a single drink while on call'', and 24% admitted to ever having drunk alcohol while on call. Two questions related to physicians' observations of colleagues: 64% reported having encountered colleagues whom they suspected used alcohol while on call, and 27% reported encountering colleagues whom they suspected were impaired by alcohol while on call. One question related to physicians' perceptions of their patients' perceptions of their use of alcohol while on call. Almost all of the physicians believed that patients do care about this, but physicians were divided about whether physicians are obliged to inform their patients of alcohol use before caring for them. Even though 53% felt that doctors have an obligation to tell their patients that they use alcohol while on call, only 12% reported that they do so when using alcohol on call. A final question (not in the table) related to physicians' perceptions of a safe alcohol use threshold while on call in their specialty. About 27% of the physicians think that some alcohol use is safe in their specialty and 10% felt that even four or more drinks could be safely imbibed in their subspecialty in a 24 hour period. Physicians with more remote graduation dates were more likely to respond positively that they had encountered physicians whom they suspected had used and were impaired by alcohol while on call.

Abbreviations: AMA, American Medical Association.

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Table 1 Doctors' perceptions of using alcohol while on call.

Statement	Agree (%; 95% CI)	Disagree (%; 95% CI)
Social drinking is acceptable while on call	19/134 (14; 9 to 21)	115/134 (86; 79 to 91)
I have encountered doctors whom I suspect have used alcohol while on call	86/135 (64; 56 to 72)	47/134 (36; 28 to 44)
I have encountered doctors whom I suspect were impaired by alcohol when they were on call	36/135 (27; 21 to 36)	99/135 (73; 65 to 79)
Doctors should not have even a single drink while on call	99/135 (73; 65 to 80)	36/135 (27; 20 to 35)
Patients do not care if I drink alcohol while on call	3/135 (2; 1 to 6)	132/135 (98; 94 to 99)
When using alcohol on call, I report that I have done so to any patient I advise or treat	15/129 (12; 7 to 18)	114/129 (88; 82 to 93)
Doctors have an obligation to inform patients that they have consumed an alcoholic beverage before advising or treating them	69/131 (53; 45 to 62)	62/131 (47; 38 to 55)
Alcohol use while on call is a private matter	35/134 (26; 19 to 34)	99/134 (74; 66 to 81)
I have consumed alcohol while on call	32/135 (24; 17 to 32)	103/135 (76; 69 to 83)

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The results of this survey raise three important questions:

1. Is there any safe amount of alcohol that a physician can take while on call, when he or she is supposed to advise and treat patients?
2. How are we to understand the tension between the widespread agreement that patients care if a physician has been drinking while on call and the perception of a significant number of physicians that drinking on call is private behaviour?
3. On what basis can we determine if physicians are free to drink alcohol while on call?

We will address all of these questions. We believe that although more study needs to occur before it is possible to answer the first question definitively, we argue that, given what we know about alcohol impairment, the ethical situation of physicians requires that they do not drink alcohol while on call until and unless some definitive study of impairment of physicians under the influence of alcohol defines safe parameters for such drinking.

IS DRINKING ALCOHOL ON CALL A RISK TO PATIENTS?

Although there is no definitive study of physician behaviour under the influence of alcohol that correlates blood alcohol level with risk to patients under different practice circumstances, there is sufficient evidence for a prima facie case against drinking while on call. Some authors suggest that if a physician cannot drive a car, then he or she should not advise a patient.[13 14] If the standards for safe driving and safe practice of medicine correlate in this way, we might also look for other conclusions to draw from studies of alcohol impairment while driving. Other studies have shown that the risk of being in a crash while driving increases with blood alcohol content level. There is, as well, widespread public support (66%) for placing a 0.08 blood alcohol content limit on drivers when they learn that it takes two to three drinks per hour to reach this limit. This level of public support shows a general belief that this amount of alcohol can impair a driver.[15] By parity of reasoning, physicians would also be impaired by these amounts of alcohol, and we should expect similar levels of public support for placing alcohol content limits on physicians.

Policies for other activities—some medical, some not—where safety concerns are paramount contain strict prohibitions of practicing under the influence of alcohol. Emergency medical technicians are subject to license revocation if they provide patient care under the influence of alcohol.[16] But an even more striking policy is the requirement that airplane pilots abstain from drinking within eight hours of the time they are to fly.[17] This policy is even less tolerant than that regarding driving. In both cases, these prohibitions rest on worries about impairment of motor skills as well as impairments in judgment. If we take these well established policies into account, it is reasonable to conclude that physicians put patients at some risk, increasing with the number of drinks per hour, if they drink on call.

Complications arise, however, when trying to determine at what point any individual in any of these activities will become impaired. The exact amount of alcohol that creates a risk is probably influenced by many factors including sex, body size, accompanying food or medication, and difficulty of the manual task or perceptual problem. In fact, the multiplicity of factors that affect the determination of a threshold may make the explicit determination, in an individual instance, highly improbable.

It may be that these worries about putting patients at risk by being under the influence of alcohol are, in some respects, culturally determined. Indeed, reactions to the study we are describing, by some British and one Australian respondent, indicating a strong reaction against any prohibition of physician drinking while on call suggest just this.[18] But if the arguments in this section are reasonable, such cultural differences are largely irrelevant. If practicing medicine under the influence of alcohol increases risks to patients, then this increase would occur in any culture. Of course, tolerance to such risks might differ from culture to culture, but any culture tolerating such risks will still be under the requirement to defend its level of tolerance if it is to show that its tolerance is justifiable.

There is at least a prima facie reason to think that, given what we know both about alcohol impairment and existing policies governing the influence of alcohol on various high risk activities, drinking while on call should either be prohibited altogether or should be severely limited. Indeed, if physicians wish to exercise the same level of prudence required of airplane pilots, there should be a prohibition of drinking alcohol while on call. Not only is this argument, prima facie, persuasive, there is also a widespread understanding that drinking alcohol impairs judgment and motor skills. Why, then, did the physicians in our study show a remarkable ambivalence about such a prohibition?

IS DRINKING ALCOHOL ON CALL PRIVATE OR PUBLIC BEHAVIOUR?

Physicians in our study overwhelmingly believe that patients care whether a physician has been drinking alcohol before advising them. Physicians are widely divided, however, on whether they are obligated to tell patients if they have taken alcohol before treating them. Despite the fact that 53% think they have an obligation to tell, in actuality a very small minority of physicians (8% of those who reported ever having used alcohol while on call) reported telling their patients if they had taken alcohol before advising or treating them. Here the question is whether the fact that patients care that their doctor has been drinking alcohol before advising them

generates an obligation for doctors to inform their patients that they have been drinking, and a correlative right on the part of the patient to be informed. Data from this survey alone cannot answer these questions.

We are, nevertheless, struck by the disagreement among physicians in their claims that they have an obligation to inform patients that they have been drinking, but most of them do not report to patients their drinking. Although we believe that one explanation is fear of malpractice lawsuits, the discrepancy may have another source as well: confusion over whether drinking on call is the private behaviour of the physician or a behaviour that occurs while on the job. For some of the physicians we surveyed, drinking alcohol while on call may seem to be both private (''I am not at work'') and public (''patients care about whether I have been drinking''). This confusion might also explain how some physicians might be perplexed over whether they have an obligation to inform patients that they have been drinking—if it is private behaviour, they do not; if it is public, work related behaviour, they do.

It should be no surprise that there might be a confusion of this sort. Drinking while on call has all of the hallmarks of a mixed case. The action is private in the sense of occurring at home when the physician is not actually working, but is public in so far as the physician must be prepared to practice medicine at a moment's notice. The question of whether drinking on call is private or public behaviour has, moreover, so far gone unaddressed by society and the medical profession. This question is one instance of a central problem of liberal institutions: which behaviours are private and protected from public interference and which are public and subject to regulation?

Modern liberalism, which has played a significant role in the formation of life in the United States and other Western, industrial nations, is founded on the ideal of individual liberty. John Stuart Mill's classic formulation holds that we should be free from social coercion as long as our behaviour harms no one else. Furthermore, he, like all classical liberals, argued that private, self regarding actions—actions that have no negative impact on others—ought to be free from public sanction.[19]

Practicing liberals understand Mill's principle of private liberty in terms of paradigmatic examples of free behaviour. Most people would agree that private sexual activities between consenting adults are nobody else's concern. Indeed, many people who find some sexual activities personally repugnant are sufficiently steeped in the ethos of liberalism to realise that their repugnance has no moral weight.

Mill, and those liberals who follow him, argue that the creation or the discovery of the zone of privacy has been beneficial. A protected sphere of private behaviour provides individuals an opportunity to be themselves and find satisfactory modes of conduct freed from undue public scrutiny. The more each of us is able to do that, the happier we are. The more people take advantage of privacy protection, the greater is the happiness of the whole community.[20]

A perennial problem for liberal theory and practice is what to include in, and exclude from, the realm of privacy. In fact, how we draw the distinction shifts over time in part as a result of moral and legal reflection. For example, the famous US Supreme Court decision *Roe v Wade* based its argument for a woman's right to an abortion on the view that a person's treatment of her body is a private concern. Similarly, the right to informed consent is based on the view that one has a privacy right to prevent invasion of one's body. These ways of looking at one's body, however, have changed over time. This change was the result of reflection on the privacy right to control what happens to one's body. What was thought permissible (treatment against a patient's wishes, compelling a woman to take a pregnancy to term) changed because pregnancy and medical treatment came to be seen as a private matter. As such, these matters became protected from public interference.[21]

Physicians are not removed from the benefits or conflicts endemic to liberalism. Physicians, maybe even more than other professionals, because of their role as healers and counsellors and the high stress quality of their jobs, need to find time to relax unburdened by the pressures of public scrutiny, free to enjoy themselves in whatever ways they will. In addition, some use of alcohol may be beneficial to their health.[22] Nevertheless, which behaviours of a physician should be protected as private and which should not is subject to question. Although it is perfectly clear that, on the one hand, drinking socially on holiday when one is not on call is a private act, and therefore perfectly acceptable and, on the other hand, that drinking at a hospital while on duty is completely unacceptable, there is a continuum between these extremes: being on call is part of this continuum. The question is which state of affairs does it most clearly resemble?

It might seem perfectly clear, given the arguments we presented in the previous section, that physicians ought not to drink while on call but so far the medical profession has left this decision up to the discretion of individual physicians. Because there has been no public debate, drinking on call has been—by default and without adequate examination—treated as private behaviour. Indeed, this approach may not be wrong. We need to remember that Mill's zone of privacy provides important benefits—ones worthy of protection because of their role in giving us as wide a range as possible to express who we are as individuals. The data indicate, however, that physicians appear to be confused about how to categorise drinking while on call. The question society and the medical profession need to face directly, in order to resolve this confusion, is: ''Can physicians have their privacy, in drinking while on call, and protect their patients too?''

Even though we have presented a prima facie argument for prohibition of drinking while on call, there is no simple inference one can make from the fact that some action harms others to a prohibition on such actions. Indeed, liberalism requires that the harms to others be weighed against the benefits to the actor that arise from their engaging in risky behaviour. Not only does liberalism require this, a very powerful argument can be offered from within liberalism for permitting drinking while on call. In the next section we outline this argument, and in the subsequent section we subject this argument to critical scrutiny.

THE LIBERAL CASE FOR MODERATE DRINKING OF ALCOHOL WHILE ON CALL

Joel Feinberg, in his four volume work developing Mill's harm principle, presents an analytical apparatus for applying this principle. The harm principle in the abstract, as Mill expresses it, is ''Do as you wish as long as you harm no one else'', or as Feinberg reads it, cannot by itself be applied to specific cases. So Feinberg offers a set of maxims necessary for determining how to apply the principle to specific cases. We use Feinberg's analysis to construct what we take to be the most plausible liberal argument for permitting drinking alcohol while on call.

On Feinberg's analysis, *A* harms *B* when

1. *A* acts
2. in a manner which is defective or faulty with respect to the risks it creates to *B*—that is, with the intention of producing the consequences for *B* that follow, or

similarly adverse ones, or with negligence or recklessness in respect to consequences.
3. *A* is acting in that manner is morally indefensible—that is, neither excusable nor justifiable.
4. *A*'s action is the cause of a setback to *B*'s interests, which is also
5. a violation of *B*'s rights.[23]

As Feinberg indicates, this analysis captures the notion that the relevant sense of harm, where we are talking about morally justifying limits on behaviour, is not just the setback of another person's interest but a setback that wrongs the person. Conditions 1, 2, 3, and 5 capture the notion that *A* wrongs *B* and condition 4 captures the notion that *A* sets back an interest of *B*.

Feinberg argues that even this amplification of Mill's principle needs to be supplemented by ''maxims'' that guide its application. Feinberg lists 11 maxims, but we will mention those relevant to our inquiry (see reference 23 at page 214) When there is a chance that an act will harm another person, but where this fact is not certain, Feinberg offers five rules for determining if the action can be justifiably prohibited:

1. The greater the *gravity* of a possible harm, the less probable its occurrence need be to justify the prohibition of the conduct that threatens to produce it.
2. The greater the *probability* of harm, the less grave the harm need be to justify coercion.
3. The greater the *magnitude of the risk* of harm, itself compounded out of gravity and probability, the less reasonable it is to accept the risk.
4. The more *valuable* (useful) the dangerous conduct, both to the actor and to others, the more reasonable it is to take the risk of harmful consequences, and for extremely valuable conduct it is reasonable to run risks up to the point of clear and present danger.
5. The more *reasonable* the risk of harm (the danger) the weaker is the case of prohibiting conduct that creates it (see reference 23 at page 216).

These rules for prohibiting actions in the face of the uncertainty of danger help to clarify any debate about the permissibility of drinking while on call.

Consider the following two cases. Patient *A*, taking new medicine *X*, believes that his stomach pains are a result of the change in medicine. In one case, he sees his doctor in the office, but in the other case, he speaks with the on call substitute for his doctor. By hypothesis, the gravity of the possible harm of treating this patient is the same. There is, however, a clear difference between the decision making situation about drinking alcohol of the doctor who knows he will see this patient after lunch and that of the doctor on call. The doctor on call does not know in advance that he will attend to this or any other patient. So even though the gravity of the possible harm to both patents is the same, the probability, from the on call doctor's point of view, of attending this or any other on call patient is less than the chance (close to 100%) for the doctor in the office of attending to this patient with the regular appointment.

Suppose that the present policy of the AMA against practicing under the influence of alcohol prohibits doctors from drinking moderately during their lunch break. The justification for the prohibition, appealing to the rules specified above, is that the *magnitude* of the risk of harm to patients is sufficient to prohibit drinking during lunch. If this interpretation of the justification is correct, then what can we say about the magnitude of the risk to patients from a physicians' moderate drinking while on call?

Given that the on call physician does not even know that he or she will attend to any patients during his on call service, the risk that his or her drinking will endanger patients will be ''significantly less'' than the risk of a physician working during regular work hours. Here is why: other things being equal (such as lack of sleep when on call, other activities being attended to, and so on) the chance of harm to a patient while under the influence of alcohol is proportional to the rate of patient seeing activity. Assume that the rate of the on call physician in question attending to any patients in one 24 hour period is one patient each day out of four days on average or 0.25 patients per day. The rate per hour will be 0.25 patients per day/24 = 0.01 patients/hour. In contrast, the rate of a doctor on duty, who sees 10 patients per afternoon (four hours) will see 10/4 hours = 2.5 patients per hour. The relative rate of patient seeing activity of the on call doctor in relation to the on duty doctor will be 0.01/2.5 = 1/250. So the magnitude of the overall risk to on call patients is, other things being equal, significantly less (1/250) than the risk to patients seen during regular office hours. As a result, there is a reason to treat on call alcohol drinking differently than alcohol drinking during lunch breaks while on duty.

Furthermore, one might argue that if alcohol drinking on call is *valuable* enough to those interested in doing it, drinking moderately while on call is, even if a real, but remote risk, a reasonable one. We will call this argument the best possible liberal argument for drinking alcohol while on call.

THE UNSOUNDNESS OF THE LIBERAL ARGUMENT

Even though this argument is the strongest one could make within liberal principles for the permissibility of drinking while on call, this argument certainly fails, for this framework, by design, ignores the role related obligations that physicians have to their patients, which arise out of the practice of medicine itself.

When treating patients, physicians are required to put their own personal self interest aside and give priority to the treatment of their patients. They must, if asked, be able to certify to the best of their understanding that their approach to the patient in no way compromises their professional integrity. The practice of drinking while on call, despite its reasonableness on liberal principles, would place physicians in situations in which they would be, contrary to professional standards, treating patients under the influence of alcohol.

The problem with the liberal argument is clear: if there is a prohibition against practicing medicine under the influence of alcohol, then there appears to be no good reason to make exceptions to this absolute prohibition. That is, in real cases of medical practice while on call, physicians will put the actual patients they see in a situation that would be found unacceptable were it not for the fact that the doctor treats these patients while on call. There would appear to be no good reason for adopting a double standard about patient care.

If this criticism of the liberal argument is correct, then where does the liberal argument go wrong? The liberal argument is designed to show how the benefit to doctors of having the liberty to drink while on call overrides the magnitude of risks to patients. The demand that doctors put their personal interest behind the medical interest of their patients defines in part what it is for a doctor to have a good professional medical relationship with his or her patients. The demand to place the medical interests of patients before their own personal interests is a role related obligation that physicians have to their patients. Once a person becomes a doctor, he or she takes on this obligation.

Policies like the prohibition of practicing medicine under the influence of alcohol are zero tolerance policies designed to articulate what is demanded of physicians to ensure that they

do not compromise their professional standards. That is, there is zero tolerance for practicing while under the influence *even if* it is not clear what amount of alcohol is being prohibited. Similar rules would hold for other professions. It would be equally unacceptable for college professors to teach or lawyers to conduct a trial under the influence of alcohol. Indeed, to practice a profession under the influence of alcohol demeans the profession and does so even if the quality of the work one does not significantly suffer. For it is definitive of being a professional that one engages in the work of the profession with the sort of full attention made more difficult by drinking alcohol. Furthermore, practicing with alcohol on one's breath, even if not under the influence of alcohol, causes problems. For the medical profession to permit such behaviour and were this policy to be known by the public, the integrity of the profession would be questioned. In addition, smelling of alcohol would be problematic for particular practitioners, whose patients would question—rightly or wrongly—their capacity to treat them and their seriousness as physicians.

Professions like medicine, teaching, or law are what Alasdair MacIntyre calls ''practices'': A practice is ''any coherent and complex form of socially established cooperative human activity through which goods internal to that form of activity are realized in the course of trying to achieve those standards of excellence which are appropriate to, and partially definitive of, that form of activity, with the result that human powers to achieve excellence, and human conceptions of the ends and goods involved, are systematically extended.''[24] For something to be a practice it must be a complex form of activity with ''goods internal'' to it. The goods internal to medicine would be the maintenance and restoration of health, reduction of pain and suffering, among others. Internal goods contrast with external goods. An external good of practicing medicine would include making a specified amount of money, having a comfortable life, and so forth. The internal goods, in a well organised practice, always trump the external goods. If medicine were to be structured primarily by the goal of making money, the practice would be corrupted. Standards of excellence for medical practice derive instead from how best to achieve the goals internal to medicine and define, in part, what it is to practice medicine. The best way possible to diagnose illnesses in a subspecialty and the most effective communication skills in taking patient histories embody standards of excellence that serve the goods internal to medicine. By pursuing the internal goods of medicine, through trying to achieve the standards of excellence embodied in its present practice, it becomes possible for practitioners to understand both the benefits and limits of present practices and the goods they support. As a result, this sort of understanding puts the present generation of physicians in a position to find ways to improve the practice, by proposing new standards or new internal goods.

Two more features of practices are crucial for the argument we are giving: (1) to take up a practice is to ''accept the authority of those standards'' that partially define the practice. When taking up chess, I do not take it upon myself to redefine the practice of chess. My key task is to learn to master the practice as given. The same would be true for the practice of medicine; (2) to master a practice requires virtue. MacIntyre defines virtue as ''an acquired human quality the possession and exercise of which tends to enable us to achieve those goods which are internal to practices and the lack of which effectively prevents us from achieving any such goods'' (see reference 24 at page 178). A vice, in contrast, would be an acquired human quality which thwarts achievement of the goods internal to a practice. For example, if I play chess *dishonestly*, then I will never play it well. That is, I will violate standards of excellence internal to chess by substituting cheating for learning improved strategy, concentration, and analytical skill. Similarly, if I am prepared to lie about medical errors I have made or a colleague has made, I will not maximise chances of eliminating errors in the future. The virtue of *honesty* in such a case also requires *courage*, since I risk loss of job or damage to professional relationships by revealing these mistakes.

The problem with the liberal argument for permitting drinking while on call is that it abstracts from medicine as a practice. The liberal argument presupposes that the situation of the physicians, in which their interest in consuming alcohol while on call is balanced against possible harms to patients, is no different from the situation of any given citizen in relationship to other citizens. The liberal argument provides a set of principles for justifying prohibition on freedoms that appeal only to the magnitude of risk of harm to others. But if medicine is a practice, as MacIntyre defines it, then standards of excellence and virtues appropriate to the practice of medicine already limit the freedoms physicians have. Even if the liberal argument could show that the risk of harm to patients while drinking on call is low in comparison to the personal benefit physicians might receive from drinking moderately while on call, that argument would not address the question of what the standards of excellence and virtues that sustain those standards require of physicians.

Sobriety is a virtue. *The Oxford English Dictionary* identifies it with moderation and with becoming less wild and reckless. Sobriety is a requirement for success at practices generally, but also for medicine. Even if we do not think of it as a virtue, the demand for practicing medicine while not under the influence of alcohol would be a minimal standard required to realise standards of excellence internal to medicine. It is clear that the AMA thinks of it as such.

CONCLUSION

We have shown that although there is no direct investigation of the way in which alcohol, at different blood levels, impairs physicians there is prima facie evidence for prohibition of consumption of alcohol while on call. The best argument for a more permissive policy about physician drinking while on call—the liberal argument—is unsuccessful. The criticisms we offer of the liberal argument—that it ignores the role related obligations of physicians to put their own interests second to their patients' interests and the need to practice medicine with sobriety—show that a liberal defence of drinking while on call will not succeed. Our argument does not, however, finally settle these issues. Indeed, as with other ethical issues that rest on an empirical argument, we must draw conclusions based on available evidence. That available evidence shows that, pending further empirical evidence on the safety of alcohol use while practicing medicine, it would be prudent and ethical for physicians not to consume alcohol while on call.

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ECHO

Study questions use of placebos

Please visit the *Journal of Medical Ethics* website [www.jmedethics.com] for a link to the full text of this article.

Researchers are calling for appraisal of the clinical use of placebos and debate about the ethics of using them, after finding that patients are given placebos more commonly than supposed.

Three out of every five hospital or community doctors and hospital head nurses responding to a questionnaire on past use admitted to prescribing placebos, almost two thirds once a month or more for a range of conditions. More than two thirds of them had misled patients, passing off the placebo as medication, and 94% found placebos generally or occasionally effective. Worryingly, more than a quarter saw placebos as a diagnostic tool to separate organic from psychogenic pain. Only 5% (4/79) thought using placebos should be banned, the rest said it depended on circumstances. In 38–43% of cases placebos had been used to satisfy patients' ''unjustified'' demand for treatment, calm patients down, and treat pain. Three quarters of the respondents thought that placebos work solely through psychological mechanisms.

Thirty one doctors and 31 head nurses in two hospitals and 27 family doctors in community clinics in the Jerusalem area took part. The questionnaire covered experience of and attitude to using placebos like saline, paracetamol or vitamin C tablets, sugar or artificial sweetener pills, or prepared placebo tablets.

Using placebos in clinical practice is not approved. Indeed, the previous report on the practice some 25 years ago estimated that use was low—about once a year per doctor. However, anecdotal evidence and first hand observation had suggested to the researchers that the practice continues.

▲ Nitzan U, *et al. BMJ* 2004;**329**:944–946.