From the Editor-in-Chief

Last Call

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THIS PAST FALL, I WALKED TO MY CAMPUS OFFICE FILLED WITH excitement and anticipation. September is, after all, the time of the year when college towns become alive again as the students return from their summer vacation and a new term approaches.

Sadly, my professorial reverie ended abruptly upon crossing “Fraternity Row,” where I was forced to run the gauntlet of hundreds of fraternity and sorority kids bombed out of their skulls on alcohol, clogging the streets and sidewalks in a drunken and often-belligerent stupor. In Ann Arbor, as on many college campuses across the nation, the week before classes start has now become “Drinking Week.” If only this dangerous practice ended there. Unfortunately, many of my students admit to frequent episodes of drinking in a high-risk manner throughout the academic year. And as finals week approaches and ends this December, I have no doubt the partying will only escalate.

What makes this scene so dangerous is that today’s kids drink far differently than their parents did, many who may have fond memories of college keggers and dorm room parties. Forty percent of all college students now “binge drink,” a practice defined as consuming 5 or more drinks in a row. Make no mistake, the goal of these bacchanalian exercises is not to feel buzzed; it is to get flat-out drunk and even black out.^{1,2}

A little less than 5 months ago, in late July, at around 2 o’clock in the morning, a 21-year-old University of Michigan college junior met a young woman at a local bar. He had likely consumed more than 8 drinks over a relatively short time span, and she had had 2 glasses of champagne before going to the bar. Eventually they decided to go to his apartment. At some point on this journey, the couple decided to shimmy up the fire escape of an arcade building and walk across its glass rooftop. On the way back, one of the panes of glass gave way and the young man fell 3 stories to his death.

Long before the results of the young man’s toxicology screen were announced, I would have bet my bottom dollar that alcohol (or some other

inebriant) was involved. In fact, his blood alcohol level was a stunning .20, which in the state of Michigan is classified as “superdrunk.” As a point of perspective, getting pulled over for a blood alcohol level of .08 will result in being arrested for “operating while intoxicated.”

A week after this tragic event, the mother of one of the victim’s “fraternity brothers” told me that the “glass-ceiling walk” was a “thing” among the frats and that this stunt had been going on for some time. Her son had taken on this very same “challenge” a few weeks earlier (also while inebriated) and, miraculously, did not crash through the roof.

To be sure, the highest rates of these decidedly deleterious habits are found among those associated with fraternities and sororities. But lest we blame the “Greek system” alone, it is important to note that relatively few colleges or universities in the United States strictly enforce their own alcohol policies at athletic events and tailgate parties and even in dormitories. Making matters worse, college town bars fuel the fire by promoting events such as “happy hours” and “half-off drink nights.” And then there is the liquor industry, which finds new ways each year to make their products stronger and more palatable to youngsters, from the development of syrupy-sweet concoctions to powdered alcohol products. All these factors, and more, have created an “alcohol epidemic” on American college campuses.³

Each year more than 1,800 college students—that means 5 kids every day—die from alcohol-related causes. More than 600,000 more are injured while drunk; an estimated 400,000 have unprotected sex; and at least 100,000 are victims of alcohol-fueled sexual assaults, a number likely to be low, given the propensity for many to underreport this tragic casualty.⁴ In my own medical practice, I have treated far too many young women who were sexually assaulted on college campuses. In almost every single case, alcohol or drugs played a role.

And yet there is a simple and effective solution to preventing such tragedies: Ban alcohol (and illicit drugs) from college campuses, including every fraternity and sorority house and every residence hall and at every social and athletic event and then back it up with a strict, zero-tolerance policy.

Sadly, almost every time I have made this suggestion at faculty meetings and in administrative boardrooms (and I am hardly alone in doing so), there has been an equal and opposite pushback. One prominent university president told me that he worried about offending parents (read paying consumers) “who like to drink” and insisted that many of

Women turn out in large numbers, some carrying placards reading "We want beer," for the antiprohibition parade and demonstration in Newark, New Jersey, October 28, 1932. (AP Photo)

his students considered drinking to be part of "the college experience." Such circuitous reasoning ignores the fact that we have abandoned many "beloved" collegiate practices, from banning fraternity hazing, "panty raids," and similar juvenile hijinks to denying the admission of women and minority students. Despite the deletion of these practices from the collective "college experience," American universities have not suffered an iota and, instead, have become far stronger, more diverse, and a great deal safer.

Such timidity in definitively rooting out this problem reminds me of the time a dean told me, without a scintilla of data, that banning alcohol would cause his college's application rates (and the school's *US News and World Report* ranking) to plummet.

My hypothesis, based on more than 25 years of practice as a pediatrician, is that many more parents want their children to be learning in a safe environment rather than in one characterized by little or no adult supervision and lots of booze. To go one step further, I predict that

application rates to safe, alcohol- and drug-free colleges would soar and constitute a stunning success of modern education.

Make no mistake; my prescription is hardly a call for a return to Prohibition, the period between 1920 and 1933 when the US Constitution banned the sales, importation, and transportation of alcoholic beverages.

In fact, we already have a law for banning alcohol from college campuses. The National Minimum Drinking Age Act of 1984 “requires that States prohibit persons under 21 years of age from purchasing or publicly possessing alcoholic beverages as a condition of receiving State highway funds” (23 USC §158). Period. This means that on any “football Saturday” or “hangover Sunday,” when too many undergraduates are stone-cold drunk, approximately three-quarters of them have gotten so illegally. The problem is that too few local or campus police forces elect to corral these scofflaws or, at least, call their parents. The excuses range from inadequate budgets and staffs to simplistic conclusions that enforcing these laws is impractical.

Such complicity is especially appalling given the many studies concluding that alcohol-free zones, effective enforcement of the legal drinking-age laws, and campus policies dictating zero tolerance for underage drinking, increases in alcohol taxes, broad screening programs to identify students at risk for drinking problems, counseling programs for those with drinking issues, and community interventions *do* significantly reduce the incidence of college drinking and its many associated harms. At the relatively few American colleges that have adopted all or some of these strategies, there have been transformative changes in students’ behaviors and safety.⁵

The real question is whether more of our university and college presidents, chancellors, and provosts will be brave enough to suffer the slings and arrows (and angry emails) incited by expressly banning alcohol from the premises. The fact is that institutions of higher education are places inhabited by developmentally immature young people who do not always make good decisions, *especially when disinhibited and under the influence*. Hence, they are especially vulnerable to the many health risks associated with drinking.

The right thing to do is to create a culture in which getting blasted every weekend is no longer accepted as a worthy part of going away to college. Such a sea change, of course, will not happen magically by itself. The safety and lives of our daughters, sons, and grandchildren depend

on the adults in the room doing something definitive to arrest this grave public health crisis.

That said, allow me to climb off the editorial soapbox and introduce the December 2015 issue of *The Milbank Quarterly*.

We begin with our Op-Ed section with two distinguished guest contributors. Donald Berwick, the president emeritus of the Institute for Health Innovation and former director of the Center for Medicare and Medicaid Services in the Obama administration, writes about the contributions of health services research to Medicare and Medicaid and how to build on those successes. Former Senator Dave Durenberger (R-MN) discusses the importance of bipartisanship as we move forward in developing health care policies that benefit all Americans.

Our *Milbank* columnists delve into a fascinating set of topics for this quarter as well. Jonathan Cohn tackles the question of what is next in improving the implementation of the Affordable Care Act; Gail Wilensky asks is the ACA meeting its intended goals?; Joshua Sharfstein considers the elusiveness of measuring accountability in health care; Catherine DeAngelis cautions about the culture of conflicts of interests and the pharmaceutical industry; Sara Rosenbaum explores self-insured employers who are legally challenging states' all-payer claims reporting laws; and Lawrence Gostin makes an impassioned plea for contemplating (and correcting) the stunning lack of progress we have made in ameliorating mental illnesses since the 1980s, in contrast with the progress that has been made in containing HIV/AIDS.

We also are pleased to publish 4 original investigations and 1 systematic review of great relevance.

Rebecca Puhl, Janet Latner, Kerry O'Brien, Joerg Luedicke, Sigrun Danielsdottir, and Ximena Ramos Salas present the first multinational examination of public support for potential policies and laws to prohibit weight discrimination in the United States, Canada, Australia and Iceland. At least two-thirds of the participants in all 4 countries expressed support for policies that would make it illegal for employers to refuse to hire, assign lower wages, deny promotions, or terminate qualified employees because of body weight, with women and those participants with a higher body weight expressing more support for antidiscrimination measures. The authors' findings suggest there is strong public

support for legal measures to prohibit weight discrimination in those 4 countries, especially in the employment setting.

Jacqueline Torres, Kathryn Kietzman, and Steven Wallace offer a longitudinal qualitative study of caregivers for older adults and consumers of such services in California between 2010 and 2014. The focus of their study is the blurred line between market and gift economies of care in consumer-directed, home-based care programs for older adults. Policies that cut or restrict formal long-term services and supports for older adults can either push caregivers to provide uncompensated care or leave older adults with unmet needs for care. Given economic and health constraints, caregivers cannot always compensate for cuts in formal supports by providing uncompensated time and resources. Similarly, low-income older adults are not competitive in the caregiving marketplace and, given the inadequacy of compensated hours, often depend on unpaid care. Policies that restrict formal long-term services and supports thus leave the needs of both caregivers and consumers unmet.

Carolyn Treasure, Jerry Avorn, and Aaron Kesselheim present an analysis of the “march-in rights” clause of the “Technology Transfer” or, more formally, the University and Small Business Patent Procedures (Bayh-Dole) Act of 1980. Using document review methods and semistructured interviews of key participants, the authors sought to assess whether government march-in rights ensure access to innovative medical technology in which government-funded research has played an essential role. Since 1980, the National Institutes of Health (NIH) has reviewed 5 petitions to invoke march-in rights for 4 health-related technologies or medical products developed from discoveries resulting from federal funding. Three of these requests were related to reducing high brand-name drug prices, one related to relieving a drug shortage, and one related to a potentially patent-infringing medical device. In each of these cases, the NIH rejected the requests. The experts interviewed were split on the implications of these experiences, finding the NIH’s reluctance to issue march-in rights to be either evidence of a system working as intended or evidence of a flawed system requiring reform. The authors conclude that march-in rights may select for government research licensees more likely to commercialize the results and that they can be used to extract minor concessions from licensees. But as currently designed in the statute, march-in rights are unlikely to serve as a counterweight to reduce the prices of medical products arising from federally funded research.

Michael Shwartz, Joseph Restuccia, and Amy Rosen studied the composite measures of health care providers' performance. As has been known since the 2001 publication of the Institute of Medicine report *Crossing the Quality Chasm*, there has been a rapid proliferation of quality measures used in quality monitoring, provider profiling, and pay-for-performance programs. The challenge is that while individual performance measures are useful in identifying specific processes and outcomes for improvement and tracking progress, they do not easily provide an accessible overview of performance. Shwartz and his colleagues highlight the advantages and disadvantages of different approaches to creating composite measures, and they also summarize the key issues related to the use of the various methods. They conclude that composite measures may, in fact, be a useful complement to individual measures when profiling and creating incentives for improvement but that because of the sensitivity of results associated with the methods used to create composite measures, careful analysis is warranted before decisions to implement a particular method are made.

Charitini Stavropoulou, Carole Doherty, and Paul Tosey provide a systematic literature review of the effectiveness of incident-reporting systems (IRSs) in clinical settings for patient safety. In recent years, IRSs have become a popular and widely adapted, albeit expensive, medical error-reporting method to enable organizational learning. Despite their significant cost, however, little is known about their effectiveness for improving patient safety. In their systematic review, Stavropoulou and her colleagues found no strong evidence that IRSs perform better than other forms of reporting. Although they did find evidence that IRSs can improve clinical settings and processes, they found little evidence that they ultimately improve outcomes or enable cultural changes. Finally, the authors suggest that IRSs might work more effectively if reportable incidents were defined more clearly and there was clinical ownership and integration with wider safety programs.

We conclude the December issue with an appreciation of David Sackett, professor and founder of the Department of Clinical Epidemiology and Biostatistics at McMaster University. Dr. Sackett was one of the leading pioneers in merging population-based research methodologies with clinical judgment for evaluating health care and health care policy. He died this past May. As we celebrate his seminal contributions to our mutual endeavor of improving the public's health, the staff of *The*

Milbank Quarterly wishes our entire community of readers, contributors, scholars, and policymakers a joyous holiday season.

References

1. Hingson RW, Zha W, Weitzman ER. Magnitude of and trends in alcohol-related mortality and morbidity among U.S. college students, ages 18-24, 1998-2005. *J Stud Alcohol Drugs*. 2009;16(Suppl.):12-20.
2. Wechsler H, Nelson TF. Binge drinking and the American college student: what's five drinks? *Psychol Addict Behav*. 2001;15(4):287-291.
3. McMurtrie B. Why colleges haven't stopped binge drinking. *New York Times*. December 14, 2014. http://www.nytimes.com/2014/12/15/us/why-colleges-havent-stopped-binge-drinking.html?_r=0. Accessed September 10, 2015.
4. Turrisi R, Mallett KA, Mastrolo NR. Heavy drinking in college students: who is at risk and what is being done about it? *J Gen Psychol*. 2006;133(4):401-420.
5. White A, Hingson R. The burden of alcohol use: excessive alcohol consumption and related consequences among college students. *Alcohol Res Curr Rev*. 2014;35(2):201-218.