Medical Amnesty Policies: Research is Needed

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This article explores the issues surrounding medical amnesty policies in higher education beginning with the background of such policies, a summary of the current debate regarding the policies, and a discussion of research related to helping behaviors among college students. Due to the negative consequences of alcohol misuse, many student affairs administrators have implemented medical amnesty or Good Samaritan policies. These policies usually consist of an educational campaign in which students are assured that they will not be sanctioned by the university if they seek help for a peer who is intoxicated. The current discussion regarding medical amnesty policies focuses on the debate between harm reduction and enabling. Understanding why students do not seek help is crucial to designing policies or other interventions to increase help-seeking. The article reviews the arguments for and against medical amnesty policies and gives specific recommendations for further research on this topic.

Student affairs administrators are faced with the consequences of problematic student alcohol use on a routine basis. These consequences include injuries, motor vehicle crashes, violence, sexual

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assault, and academic failure and are well documented in the literature (Hingson, Heeren, Winter, & Wechsler, 2005; Perkins, 2002a; U.S. Department of Health and Human Services, 2002; Wechsler, et al., 2002). O’Malley and Johnston (2002) reviewed the major national studies on college student drinking and found the percentage of students that engaged in heavy drinking ranged from 40 to 44%. Heavy drinking was defined as five or more drinks in a row at least once during the 2 weeks prior to completing the survey.

Perkins (2002a) identified three categories of consequences related to high-risk drinking by college students. They included damage to self (e.g., academic failure, blackouts, physical illness, suicide, sexual assault, DUI and legal problems), damage to others (e.g., property damage and vandalism, violence, and disturbances in residence halls), and damage to institutions (e.g., vandalism, loss of revenue due to student drop out, strain on relationship with city, and human resources to deal with consequences).

One of the possible consequences of heavy alcohol use is the potential for death by alcohol poisoning, “an acute toxic condition resulting from exposure to excessive quantities of alcohol within a short period of time” (Yoon, Stinson, Yi, & Dufour, 2003, p. 110). Each year, 1,393 deaths in the United States are attributed to alcohol poisoning (Yoon, et al., 2003). Of those deaths, only 2% of them were younger than 21 (Yoon et al., 2003). No data were found specifically documenting the number of alcohol poisoning deaths for college students. However, the popular press reports such incidents on college campuses on a frequent basis. In addition to the tragic loss of life, deaths such as these have a ripple effect on the campus affecting current students, faculty, and staff. Deaths caused by alcohol poisoning also have the potential to result in expensive lawsuits, negative publicity, and public outcry.

Due to the negative consequences of alcohol misuse and in an attempt to avoid loss of life, many college administrators have focused their efforts on educational and individual intervention strategies (Wechsler, Seibring, Liu, & Ahl, 2004; Larimer & Cronce, 2002). While these interventions are necessary and may have the ability to change individual student behavior, some authors suggest that individual interventions have done little to impact the overall picture of college student drinking (DeJong & Langford, 2002; Wechsler et al.,
In the late 1990s, the U.S. Department of Education’s Higher Education Center for Alcohol and Other Drug Prevention recommended that colleges and universities implement an environmental approach to their prevention strategies (DeJong et al., 1998). The concept is borrowed from public health and suggests a comprehensive approach to preventing alcohol-related problems among college students by focusing individual, campus, and community interventions (DeJong & Langford, 2002). It recognizes that students make decisions within the context of their communities. They are influenced by the media, their parents, their peers, laws, enforcement practices, price, and availability—in essence, their environment. DeJong et al. (1998) summarized the concept with the statement, “College officials cannot expect students to say ‘no’ to binge drinking and other drug use when their environment tells them ‘yes’” (p. 5).

A specific environmental strategy being embraced by many campuses is the implementation of a medical amnesty or Good Samaritan policy. These policies operate under the assumption that when a student is suffering from the symptoms of alcohol poisoning, other students are afraid to seek help for fear of getting into trouble with the university. These policies usually consist of an educational campaign in which students are assured that they will not be sanctioned by the university if they seek help for a peer who is intoxicated. It is important to note that most of these policies do not apply to legal consequences, thus the amnesty offered is specific to a university’s judicial affairs process. Most policies ensure that both the caller (the helper) and the victim (the intoxicated student) will receive amnesty. Some policies also apply to student organizations. For instance, Cornell’s policy states that “organizations hosting a party are expected to promptly call for assistance in an alcohol-related emergency” (Cornell University, 2006). The policy also indicates that organizations that do not call for help will be sanctioned more severely than those that do call for help.

This paper will explore the issues surrounding medical amnesty policies in higher education beginning with the background of such policies, a summary of the current debate regarding the policies, and discussion of medical amnesty policies. Finally, the authors’ reflections will be offered regarding the need for further research on the efficacy of medical amnesty policies in increasing helping behavior among students and decreasing alcohol-related deaths.
Background

While there is no published literature that outlines the history of medical amnesty policies, Meilman cited two examples of such policies in *The Journal of American College Health* in 1992. Meilman (1992) refers to a Dartmouth College policy implemented in 1987 and a College of William and Mary policy created in 1990. The Drug Free Schools and Communities Act of 1989 was amended by congress to require higher education institutions to notify students and employees of the institution’s alcohol policy and sanctions for violating the policy. It is possible that these amendments increased the level of awareness among administrators of the potential conflict for students between helping an intoxicated peer and fear of campus sanctions. In the absence of a published national survey of institutions’ use of medical amnesty policies, it is impossible to know how many exist. However, an Internet search revealed that the policies are not uncommon in higher education.

Another possible factor influencing the implementation of medical amnesty policies is the increasing number of highly publicized alcohol-related deaths among college students. Again, while there is no published research to indicate how many college students die of alcohol poisoning each year, Chapman (2005) cites five highly publicized alcohol-related deaths in Colorado in the academic year 2004–05. In addition to the infamy that such a death brings to a campus, it is possible that institutions will face legal consequences as families file lawsuits against campuses or affiliated organizations such as fraternities (Bickel & Lake, 1999). According to Bickel and Lake (1999), historically, most lawsuits related to college student alcohol did not hold institutions liable for student injuries related to alcohol use. They cite examples of cases in which institutions were not held liable for the alcohol-related injuries of students: “University v. Whitlock, 744 P.2d 54 (Colo.1987); Hartan v. Bethany College, 778 F. Supp. 286 (E.D. Pa. 1992); Millard v. Thiel College, 611 A.2d 715 (Pa.Super.Ct. 1992); and Rhodes v. Illinois Cent. Gulf R.R., 665 N.E.2d 1260 (Ill.1996)” (p. 155). However, as predicted by Bickel and Lake (1998) there is “a pending shift in attitude towards college drinking in the courts” (p. 155). Lake (2005) referred to two recent cases involving alcohol injuries by college students, “Knoll v. Board of Regents of the University of Nebraska and Coghlan v. Beta Phi Fraternity” in which institutions were found by the courts to have a “legal duty to use rea-
sonable care to prevent injuries to students arising out of events where alcohol is served and available” (p. 262). Lake (2005) pointed out that duty did not necessarily lead to liability as the courts have been inconsistent on this matter. With regard to alcohol poisoning deaths and liability, Lake (2005) referred to a case involving Scott Krueger, a student who died of alcohol poisoning at the Massachusetts Institute of Technology (MIT). This case settled out of court for “$6 million, a public apology, and the undertaking to perform various activities and policy changes” (p. 634). According to Lake (2005), the Krueger case “is indicative of a new climate of concern for potential success in courts of law on the issue of the legal duty of colleges to protect students from foreseeable danger in high-risk alcohol situations” (p. 634).

Without adequate data, it is difficult to determine whether alcohol poisoning deaths are on the increase or if they are just more widely publicized. Regardless of the former, it is clear that parents, legislators, courts, and the general public are attempting to hold universities accountable. They are asking what campuses are doing to deter this sort of tragedy. Along with a host of other policy, education, and environmental solutions, many campuses are implementing medical amnesty policies as a way to reduce barriers to help-seeking, and perhaps also, to reduce their liability if a tragedy does occur on their campus.

**Dynamics of Protective and Helping Behaviors**

Prior to proposing alcohol-related policies, it is important for administrators to understand the dynamics of student drinking, including the use of protective strategies and helping behavior in general. Haines, Barker, and Rice (2006) found, in a cross-sectional study of U.S. college students, that “73% of student drinkers in the sample regularly employ at least one protective behavior” to reduce their alcohol-related harm and that the use of a certain cluster of behaviors significantly reduced harm (p. 73). The most commonly used protective behaviors included “using a designated driver, eating before drinking, keeping track of how many drinks are consumed, and avoiding drinking games” (p. 72). The study may have implications for peer-to-peer helping behavior as it is already normative for students to use protec-
tive behavior individually. Calling for help in an alcohol emergency could also be considered a protective behavior if promoted to students in that manner. Administrators interested in implementing medical amnesty policies may find that reducing the barriers to help-seeking may be seen as a natural extension of using personal protective behaviors that students already employ.

Mallett, Lee, Neighbors, Larimer, and Turrisi (2006) examined the ability of students to adapt their behavior based on a negative consequence from a previous drinking experience. It was found that heavy drinking students do not learn from past alcohol-related consequences. Instead, students overestimate the amount of alcohol it would take for them to experience a negative consequence such as vomiting, hangover, blackout, or regretted sex, even after having experienced that consequence in the recent past. The authors pointed out the absence of accurate judgments by students regarding the risk of alcohol consumption. If students cannot accurately judge the number of drinks in order to avoid their own personal risk, they are unlikely to be able to accurately judge whether or not a peer is at risk for alcohol poisoning, especially if the student is under the influence at the time.

General helping behavior is extensively addressed in the psychology literature beginning with Latane and Darley (1968, 1970). Their theory of bystander behavior can be applied to the context of college student drinking. Latane and Darley (1970) identified a five-step series of decisions that individuals must make in order to intervene in an emergency. The individual must decide “whether he [or she] notices an event or not, perceives it as an emergency or not, feels personal responsibility or not, is able to think of the kinds of intervention necessary or not, and has sufficient skill to intervene or not” (Latane & Darley, 1970, p. 36). According to Latane and Darley (1970), these decision points are influenced by many factors including how many people are present, whether or not others seem concerned, the perception that someone else is helping, and if the individual is in a hurry.

Each of these constructs, seem like plausible reasons that students may not engage in helping a peer in an alcohol-related emergency. Rabow, Newcomb, Monto, & Hernandez (1990) studied helping behavior in relation to willingness to intervene with a drunk driver
and suggested that students would be less likely to help in larger groups. They stated, “It may be that the ability to see only six or seven persons who are not helping induces either the diffusion of responsibility or the sense that helping is not required” (p. 210). Student drinking often occurs in a bar or party setting and includes many people, thus diffusing the responsibility that individuals may feel for taking action. In the context of college student drinking, warning signs of alcohol poisoning such as passing out, vomiting, and blackouts are not uncommon (Perkins 2002a). If no one else seemed concerned, it may create a misperception of the norm (Perkins, 2002b). Perkins (2002b) found that “misperceptions of the norm discourage the more responsible students from publicly expressing opposition to heavy drinking and from intervening in potential situations of peer alcohol misuse” (p. 168). In addition, negative consequences, such as passing out, do not always lead to alcohol poisoning and, as a result, a students’ past experiences may lead them to interpret the event as normative, rather than an emergency.

Other possible causes of hesitancy to help students experiencing alcohol poisoning symptoms exist, but none has been presented in the literature. Hesitancy may occur because students perceive that helping a peer would interfere with the pursuit of having a good time at the party. Students may also avoid calling for help for fear of getting in trouble with campus officials and police—especially if the student is engaged in underage drinking.

Harm Reduction Versus Enabling

The current discussion regarding medical amnesty policies focuses on the debate between harm reduction and enabling. The harm reduction model aims to reduce the problems that students experience as a result of substance use. The model views college student drinking as normative and seeks to arm students with strategies to experience fewer consequences when they drink (Colby, Raymond, & Colby, 2000). A free taxi service that provides students transportation home from bars is an example of a harm reduction approach. It does not attempt to reduce students’ drinking, but rather to reduce the harm associated with drinking and driving by offering students an alternative. Medical amnesty policies could be seen as harm reduction. They do not aim to
change the students drinking behavior, but rather to provide them a way to seek help without consequence, thus reducing the potential for physical harm or death.

The argument against harm reduction suggests that failing to address students’ drinking behavior enables them to continue to engage in risky behavior without consequence, thus enabling that behavior. Possible arguments suggest that medical amnesty policies could condone dangerous drinking or provide students with a “get out of jail free card” regardless of their behavior (Chapman, 2005, p. 5). For instance, if students do not have to think about how they will get home from the bar, it is possible that they will drink more than they normally would if that ride were not in place. Or, in the case of medical amnesty policies, students may drink more excessively knowing that they will not get in trouble should something go wrong. Those that subscribe to the enabling perspective propose that medical amnesty policies are treating the symptom of the problem, and may in effect be exacerbating the cause of the problem: excessive drinking.

Impact of Policies

In two recent studies, researchers have investigated the impact of policies on student helping behaviors. Lewis and Marchell (2006) evaluated the impact of a medical amnesty policy at Cornell University. Evaluation of the policy included surveying students before and after the policy implementation to determine whether or not they had called for help in the past 12 months for a student who was severely intoxicated. The students who had not called for help were asked to indicate the reasons why not from a list of possible responses. The final evaluation component included comparing the self report data to actual calls received by the Emergency Medical System at Cornell. Results indicated that in the 2 years following implementation of the policy there was an increase in the percentage of students who reported calling for help on behalf of an intoxicated person. However, Lewis and Marchell (2006) indicated that the increase was not statistically significant. Of those students who did not call for help, the percentage of students citing “I didn’t want to get the person in trouble” declined each of the 2 years following the policy implementation (3.8% in 2000, 2.3% in 2003, and 1.5% in 2001). There was also an
increase in the number of calls for assistance to emergency medical services in the 2 years following the policy implementation (63 calls in 2001–02, 69 calls in 2002–03, and 77 calls in 2003–04). The study provided limited evidence in support of medical amnesty policies. However, it is unclear from this study whether the reduction in fear of getting in trouble or the increased calls to emergency rooms is promoting or deterring actual drinking quantities by students.

Colby, Raymond, and Colby (2000) examined the impact of a policy mandating treatment for students who require hospitalization due to dangerously high blood alcohol levels. The treatment included “referral, evaluation, and treatment for any student that was brought to the area’s trauma hospital ER due to an alcohol-related event” (p. 396). Furthermore, the cost of the mandated treatment was “$995.00 . . . and would be borne by the student who had received the mandated services” (p. 396). Following the implementation of the policy, researchers surveyed students to determine the percentage of students who engaged in helping behavior with their peers and the impact that the treatment policy would have on their future helping behavior. The study revealed that “98% of the survey respondents said that they had provided peer-to-peer help to another student” in an alcohol-related event during the time that they had been enrolled at the college and “on 88% of those occasions, they did so without seeking additional assistance” (p. 399). Finally, “89% of students said that the policy would likely discourage them from seeking police or medical help in the future” (p. 401). The study contributes to understanding the widespread prevalence of peer-to-peer helping behaviors in the college student population. However, the study did not specifically seek to evaluate a medical amnesty policy.

Other studies have examined the protective behaviors that students engage in as individuals (Mallett, Lee, Neighbors, Larimer, & Turrisi, 2006; Delva et al., 2004), but not in the context of helping a peer. While prior research contributes to understanding college student drinking behavior, it does not provide sufficient evidence to support the effectiveness or influence of medical amnesty policies on student behavior. Additional research is needed on a national level to support the efficacy of policies already in existence.
Discussion and Call for Research
to Create Data-driven Policies

While it is admirable that universities are attempting to address the problem of alcohol poisoning among college students by implementing medical amnesty policies, it is disconcerting that little research exists to justify the need for the policies or to examine their efficacy. We believe that medical amnesty policies operate under several assumptions: (a) students can identify the symptoms of alcohol poisoning, (b) students understand the risk associated with the symptoms of alcohol poisoning, (c) students responsible for help-seeking are sober enough to adequately judge the level of risk involved, (d) students are currently not calling for help due to fear of getting in trouble with the university, and (e) students will be more likely to call for help if they are assured that they will not get in trouble. To date, these assumptions are untested and administrators implementing medical amnesty policies may be falsely comforted by what they believe to be a problem solved, when in fact the policy may not have any bearing on behavior.

Understanding why students do not seek help is crucial to designing policies or other interventions to increase help-seeking. A national study is needed to document the number of schools that employ medical amnesty policies and describe the nature of those policies. Future research should also focus on assessing the current nature and prevalence of help-seeking by students and understanding reasons why students do not seek help. It will be important to document both peer-to-peer help-seeking as well as help-seeking from outside entities such as medical or law enforcement personnel.

In addition, institutions with medical amnesty programs in place should consider ways to evaluate the efficacy of those policies and publish the results in peer reviewed journals. Future research should also examine the overall drinking rates prior to and following a medical amnesty policy. This type of evaluation could help to answer the question of whether medical amnesty is harm reduction or enabling in nature. If it is the case that aggregate student drinking increases following the implementation of the policy, an institution would need to assess the risk benefit of that policy in terms of overall student health and safety.
It may be useful to ask the question: How can a medical amnesty policy hurt? Given the lack of research evidence, administrators are implementing medical amnesty policies with little knowledge of whether or not it will help or hurt. It is likely that the policy will help: reducing the ultimate harm of loss of life. However, it could also result in increased drinking rates and negative consequences, causing more aggregate harm. Perhaps the best scenario for institutions and students is to implement the policy, while at the same time supporting research that would bring that decision into the realm of science, rather than guesswork.

References


