TWIST THE CORK, POP THE TOP, AND BOTTOMS UP: SELECTED RECOMMENDATIONS ON ALCOHOL REGULATION FROM SCRATCH

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I. Introduction

Good cocktails usually have recipes. A few ounces of this, a shot of that, and a twist of the other, and a cocktail is born from unrelated ingredients. Cocktails are often generations old. Most were presumably created by trial and error. Some work better in certain situations than others. But all share a common characteristic: they follow a formula, a methodology of combining things that, when taken together, taste good. At least to some people.

This essay maintains that good regulatory schemes – like good cocktails – can be born of good recipes. Some of the ingredients may be changed. Experimentation can occur, and can work. But there is a basic formula with a set of fundamental ingredients. And those ingredients work well together; they taste good. This essay endeavors to identify some of those ingredients, and to explain why it is that they mix well.

II. Policy Implications to Consider

Alcohol regulation shares a close and often rocky bond with the public policy underlying it. Alcohol regulation concerns important questions of public policy. It arouses strong feelings in the people it impacts. And its effects often reach farther than anticipated. As a result, in the area of alcohol regulation, Chief Justice Earl Warren's famous wisdom is particularly applicable: "It is the spirit and not the form of law that keeps justice alive."[1] As such, the following important policy implications, among others, should be kept in mind when implementing a new regulatory framework.

A. The Prevalence of Alcohol Use

Both in the United States and abroad, alcohol is a widely used product. There are approximately two (2) billion "drinkers" worldwide.[2] While attitudes vary, in most countries, alcohol is a product consumed on a consistent and significant basis. This essay concerns the implementation of a regulatory framework from scratch in a hypothetical country. In all likelihood, wherever the hypothetical country may be, at least a noteworthy percentage of the adult citizens of that country will be regular consumers of alcohol.

Of course, social and cultural factors affect the level of alcohol consumption in a given country. Historically, different cultures have displayed different attitudes or degrees of acceptance toward alcohol consumption.[3] In fact, based upon these differences, some researchers have divided cultures into two (2) categories: "wet" and "dry" cultures.[4] In "wet" cultures, "alcohol is integrated into daily life and activities . . . and is widely available and accessible."[5] "European countries bordering the Mediterranean have traditionally exemplified wet cultures."[6] In "dry" cultures, by contrast, "alcohol consumption is not as common during everyday activities . . . and access to alcohol is more restricted."[7] "[T]he Scandinavian countries, the United States, and Canada" all exemplify traditionally "dry" cultures.[8]

Statistics seem to validate these categories. While not at all insignificant, alcohol consumption rates in the United States are relatively modest by comparison to western Europe. According to the 2010 National Health Interview Survey conducted by the Centers for Disease Control and Prevention, in the United States, 51% of adults aged 18 or older identified themselves as "current regular drinkers."[9] In sharp contrast, only 21% of surveyed adults were

"lifetime abstainers," and 14% were "infrequent drinkers."[10] By any measure, those percentages show that at least a significant portion of the American population consumes alcohol on a regular basis.

True to the form described above, studies of European drinking patterns show a much higher propensity for alcohol consumption. One (1) study conducted in 2000 considered the drinking patterns of 15-year-olds in 29 European countries.[11] Again, by any measure, the results showed significant rates of alcohol consumption. In all but one (1) of the surveyed countries (the Republic of Macedonia), more than 70 percent of 15-year-olds were identified as "drinkers."[12] In six (6) of the surveyed countries – including Greece, Lithuania, and the United Kingdom – more than 90 percent of 15-year-olds were considered "drinkers."[13]

The World Health Organization ("WHO") has developed, and maintains, more current "profiles" of the drinking patterns in various countries. Some data contained in the 2011 profiles of several countries is instructive. The data characterizes individuals who had not consumed an alcoholic beverage in the previous 12 months as "abstainers." In the United States, 34.6% of surveyed individuals were "abstainers."[14] The figure in Canada was 22.4%[15], and the figure in the Russian Federation was 41%[16]. Again, unsurprisingly, the figures in Western European countries showed a much lower percentage of "abstainers." Only 4.3% of German citizens were abstainers.[17] Citizens in France and Norway followed a similar pattern, with "abstainers" registering at 8%[18] and 10%[19] respectively.

In sum, cultural variations create different patterns of alcohol consumption. Nonetheless, it is reasonable to suppose that alcohol will be consumed by at least a significant percentage of the citizens of any country. Accordingly, the sheer volume and breadth of alcohol

consumption – and all of the positive and ill effects that may come from it – must be taken into account when considering a new regulatory framework.

B. Health

The negative health implications of alcohol consumption are well-documented, and need not be belabored.[20] Alcohol abuse has identifiable links to various medical ailments, including hypertension, stroke, liver cirrhosis, cardiomyopathy and other heart conditions, cancers, and psychological disorders.[21] "In 2006, there were 22,073 alcohol-induced deaths in the United States, excluding deaths attributed to accidents, injuries, and/or Fetal Alcohol Syndrome."[22]

Global statistics are even more telling. The WHO has reported that alcohol use "causes an estimated 2.5 million deaths every year" worldwide.[23] In addition, "[a]lcohol use is the third leading risk factor for poor health globally," and "is one of the four most common modifiable and preventable risk factors for major noncommunicable diseases."[24] Moreover, "[t]here is also emerging evidence that the harmful use of alcohol contributes to the health burden caused by communicable diseases such as, for example, tuberculosis and HIV/AIDS."[25] These substantial health implications must be considered when enacting a new regulatory framework.

C. Safety

Alcohol consumption has a startling impact upon public safety as well, and one which needs little emphasis to be understood. In 2006, in the United States alone, "there were 13,491 alcohol-impaired driving fatalities."[26] Traffic fatality statistics are staggering enough. But there are various links between alcohol consumption and a host of other safety risks. "Globally, alcohol consumption causes 3.2% of deaths (1.8 million) and 4.0% of the Disability-Adjusted Life Years lost (58.3 million). Overall, there are causal relationships between alcohol

consumption and more than 60 types of disease and injury."[27] Accordingly, safety concerns related to alcohol consumption cannot be ignored.

III. The Suggested Regulatory Framework

Realistically, any framework governing the production, sale, and consumption of alcohol must be multi-faceted. No single regulatory approach could adequately address all of the positive or ill effects of alcohol consumption. Rather, any effective framework should address alcohol consumption from a variety of angles. Sustained research on alcohol policy indicates that effective regulation should target numerous areas, including drunk driving policies, alcohol availability measures (such as licensing and minimum drinking age laws), alcohol marketing regulations, community-based prevention strategies, pricing and taxation regulations, and monitoring or surveillance activities.[28]

This essay will not – and could not adequately – address each of these areas. Instead, this essay will focus upon several of the most consequential, and controversial, aspects of alcohol regulation: minimum drinking age ("MDA") laws ("MDALs"), civil liability (in the form of "dram shop" statutes), and criminal liability (in the form of driving under the influence ("DUI") laws). These areas will be emphasized for a number of reasons. Given their divisiveness, these areas demand at least some analytical depth. Further, these areas clearly require "regulatory" choices, made primarily through legislative action. And finally, these areas are simply important, and should undoubtedly be discussed in any consideration of a new regulatory framework.

A. A Minimum Drinking Age Law

1. The Fairness, Advisability, and Viability of Any MDAL

Enacting an MDAL seems a logical, even inevitable first step in creating a regulatory framework. However, all MDALs are controversial to one extent or another. This is, in part, because MDALs – while intended to curb underage drinking and its negative short-term and long-term effects – may create problems of their own. One commentator identified two (2) potential problems associated with prohibiting alcohol use by young adults: (1) "the impossibility of enforcing the law will engender a lack of respect for the law in general among young adults," and; (2) "for those who choose to violate the law, the necessity of sneaking around to drink may lead to more dangerous drinking patterns and may preclude access to avenues that might imbue healthier drinking habits."[29] Other commentators maintain that MDALs set adolescents apart "for disparate treatment in a way that ultimately creates disrespect for the legal system"; "deter[] underage drinkers from seeking help to deal with problem drinking early on," and; "force[] drinking behind closed doors and encourage[] binge drinking."[30]

Nonetheless, for several reasons, some MDAL is a necessary component of any regulatory framework. First, MDALs serve the admittedly paternalistic, but likely essential purpose, of protecting children and young adults from their own cognitive limitations. In the United States, the first laws prohibiting underage drinking were enacted in the 1880s.[31] These early statutes were arguably "one aspect of the state's intervention into the parent-child relationship," and reflected the newly-formed association between adolescence and "incompetency."[32] The more modern – and arguably, more accurate and less offensive – conception of MDALs is that they represent merely another child protective policy, comparable to policies prohibiting minors from making certain medical decisions, choosing not to attend school, or using tobacco products.[33]

The fundamental legal theory is that, for their own protection and benefit, minors are deprived of certain rights of self-determination, including the right to consume alcohol.[34] In this instance, the practicalities seem to support the theory. Youth drinking patterns have been shown to significantly influence both short-term and long-term health implications associated with alcohol consumption.[35] More particularly, teenage drinkers are more likely to suffer "alcohol-related unintentional injuries (such as motor vehicle injuries, falls, burns, and drownings)" than older drinkers.[36] Likewise, "early onset of regular alcohol consumption has been found to be a significant

predictor of lifetime alcohol-related problems."[37] Given these facts, this author agrees with the basic theory of limiting minors' self-determination rights to avoid certain susceptibilities, and therefore, with the "child protection" justification underlying MDALs.

Second, MDALs save lives. While the number of lives saved is very arguable, the fact remains that MDALs prevent at least some alcohol-related deaths.[38] The American experience is illustrative of this point. Some research indicates that raising the MDA in the United States from 18 to 21 resulted in a significant reduction in the mortal consequences of underage drinking:

> The enactment by Congress of a federal minimum-drinking-age law resulted in many saved lives. In the six months after the state of New York raised its minimum-drinking age, the number of fatal car accidents involving people under twenty-one years of age declined by 41%. Nationally, the higher drinking age was credited with decreasing drunk-driving accidents by persons under age twenty-one by 10-20%. Further, in the twenty years following the increase in the drinking age, researchers estimated that over 20,000 lives were saved by the measure.[39]

Other research has shown that a legal prohibition upon drinking between the ages of 18 and 20 can be linked to a 20-33 percent difference in alcohol consumption, and a 10 percent

difference in fatal accidents for adult males.[40] Of course, a massive body of research exists in this area, and disputes abound. But it seems clear that there is at least some statistical correlation between MDALs and reduced loss of life. That broad conclusion, in and of itself, must count as support for the enactment of an MDAL.

Third, and finally, the vast majority of the world's governments have concluded that at least some MDAL should be enacted. While MDAs vary, the consensus that some MDA is appropriate is relatively settled. As to the sale of beer "on-premise," only 14.8% of the world's countries have no age limit.[41] "Off-premise" figures increase only slightly – 21.4% of countries have no age limit for the "off-premise" sale of beer.[42] The selection of an appropriate MDA is a complex and delicate process, as described below. But worldwide, an MDAL of some kind is the rule, not the exception.

2. <u>How the United States Arrived at a MDA of 21</u>

For decades now, the MDA in the United States has been 21. That, however, was not always the case. The MDA of 21 has always been controversial. The policies and research underlying the selection of 21 as the American MDA have likewise been disputed. And overall, the tactics by which the United States Congress "prompted" states to adopt the MDA of 21 have long been the subject of academic quibbling, political maneuvering, and legal battling.

As noted above, regulation of the sale of alcohol to American minors began in earnest during the 1880s.[43] These early enactments came as part of a wave of government intervention in the family relationship and the development of children.[44] However, these enactments targeted the sale or provision of alcohol to minors.[45] The consumption of alcohol by minors was not made illegal, as minors were viewed as "innocent victims," rather than "persons at

fault."[46]

Moreover, these laws were intertwined with the continuation of the "temperance movement." The American temperance movement originated in the early 19th century.[47] Initially, the temperance movement focused upon avoiding "distilled spirits," but ultimately, advocated total abstinence from all forms of alcohol.[48] The philosophies of the temperance movement, combined with the growing concern of Progressive Era reformers with the problems associated with alcohol consumption in general, brought the issue of youth exposure to alcohol to the forefront of the debate.[49]

In 1919, with the ratification of the 18th Amendment to the United States Constitution, the Prohibition era began.[50] Prohibition made the "manufacture, sale, or transportation of intoxicating liquors within, the importation thereof into, or the exportation thereof from the United States" unlawful.[51] This broad preclusion, of course, impacted the possession of alcohol by minors, as well as adults. But some commentators have observed that Prohibition was not immediately intended to affect underage drinking:

> Prohibition was aimed at eliminating the culture of drinking, particularly male drinking, and was not aimed specifically at youth drinking. Although Prohibition lasted only a few years, it did indeed change American drinking habits. Obviously, the clandestine drinking that occurred while Prohibition was in force could not occur in saloons, as was previously common. However, the secretive drinking that did take place had another new element: men and women imbibed together. Previously, it was considered indecent for men to drink in the presence of women. But, drinking at dances, with women, and to excess had become, by the latter twenties, a new code of permissible behavior among college students because it was sanctioned by peer opinion. When Prohibition finally ended, and individual states resumed regulation of alcohol consumption, this new pattern continued [52]

Prohibition ended in 1933 with the ratification of the 21st Amendment to the United States Constitution, which expressly repealed the 18th Amendment.[53] Section 2 of the 21st

Amendment provides that "[t]he transportation or importation into any State, Territory, or possession of the United States for delivery or use therein of intoxicating liquors, in violation of the laws thereof, is hereby prohibited."[54] This provision effectively returned control of alcohol regulation to the individual states.[55]

The states, in turn, began their own process of regulating the consumption of alcohol by minors. Following the repeal of Prohibition, nearly ever state adopted an MDA of 21.[56] New York was the lone exception, with an MDA of 18.[57] In the 1970s, states began to reduce their MDAs (as well as their ages of majority) below 21.[58] A number of factors may have contributed to this change. To begin, in 1971, the passage of the 26th Amendment to the United States Constitution reduced the voting age from 21 to 18.[59] "As a result, the benchmark for achieving adulthood, as measured by participation in public life, was eighteen years old."[60] Eighteen also represented the minimum age for draft eligibility.[61] Thus, MDAs of 21 created the oft-noted irony that 18-year-old men could be conscripted into the armed forces, sent to battle, and killed, but could not drink alcohol.[62] A final factor may also have come into play: "In the late 1960's and early 1970's, American attitudes toward adolescence became less paternalistic and moved toward increased autonomy."[63] In all, during the early 1970s, 29 states reduced their MDAs, mostly from 21 to 18.[64]

During the early 1980s, in response to drunk driving statistics, the Reagan administration created the Presidential Commission on Drunk Driving.[65] The Commission ultimately recommended that the administration promote the adoption of a national MDA of 21.[66] The administration ultimately agreed.[67] This decision – which contravened the Reagan

administration's traditional deference to states' rights – was influenced in no small measure by an intense lobbying campaign conducted by Mothers Against Drunk Driving ("MADD"):

> MADD, led by founder Candy Lightner, lobbied intensely for federal drunk driving legislation. Its approach was to emphasize the deaths of innocent young people at the hands of drunk drivers. Even staunch states' rights proponents found it difficult to say no to this approach. MADD received further support from Congress members from "blood border" states--states that bordered other states with less restrictive drinking ages. Due to the drinking age differences, people traveled across state lines to drink, which led to an increase in alcohol related accidents when drivers were returning to their home state. One such state was New Jersey. It was caught between the more restrictive Pennsylvania and the less restrictive New York.[68]

In the end, MADD and other proponents of federal MDA legislation acquired the Reagan administration's support for the National Minimum Drinking Age Act of 1984 ("NMDAA").[69] The NMDAA was passed as part of the Surface Transportation Assistance Act, because its enforcement mechanism became the withholding of federal highway funds for a state's non-compliance.[70] In particular, the statute phrases this "incentive" to adopt an MDA of 21 as follows:

> The Secretary shall withhold 10 per centum of the amount required to be apportioned to any State . . . on the first day of each fiscal year after the second fiscal year beginning after September 30, 1985, in which the purchase or public possession in such State of any alcoholic beverage by a person who is less than

twenty-one years of age is lawful.[71]

Unable to tolerate the consequence of losing 10 percent of federal highway funding, all 50 states ultimately passed laws adopting MDAs of 21.[72]

Shortly after the passage of the NMDAA, South Dakota filed suit seeking a declaration that the statute was unconstitutional. In the landmark decision of *South Dakota v. Dole*, the United States Supreme Court upheld the NMDAA, reasoning as follows:

> Here Congress has offered relatively mild encouragement to the States to enact higher minimum drinking ages than they would otherwise choose. But the enactment of such laws remains the prerogative of the States not merely in theory but in fact. Even if Congress might lack the power to impose a national minimum drinking age directly, we conclude that encouragement to state action found in § 158 is a valid use of the spending power.[73]

This decision marked the end of a "widely unsuccessful" litigation campaign against the NMDAA.[74] The NMDAA has remained the law in America for more than two (2) decades now. With its adoption, the United States entered an unprecedented and lengthy era of stability in the area of MDA law. And although some commentators maintain that "the debate has resurfaced," the MDA in all American states remains 21.[75]

3. <u>How United States MDALs Compare to Others Around the World</u>

Instinctively, 21 seems to be a high number for an MDA. In fact, 21 is the highest MDA in the world – no country imposes a higher MDA under any circumstances.[76] Of course, some countries have no MDA at all.[77] As to the purchase of beer, the vast majority of countries – 64.3% for "on- premise" purchases, and 58.0% for "off-premise" purchases – impose an MDA of 17 or 18 years.[78] Some countries – 13.0% for "on-premise" purchases, and 11.6% for "off-premise" purchases – impose a lower MDA of 15 or 16 years.[79]

The United States, however, falls into the smallest category of all: countries with an MDA of 19 or older. In particular, only 7.8% of countries impose an MDA of 19 or older for "on-premise" purchases, and 8.9% of countries impose an MDA of 19 or older for "off-premise" purchases.[80] The following countries fall into this category: "Canada (19), Nicaragua (19), Republic of Korea (19), Iceland (20), Sweden (20 for strong beer off-premise, 18 otherwise), Japan (20), Indonesia (21), the Federated States of Micronesia (21), Palau (21) and the United States (21)."[81]

4. The MDAL Choice in the New Regulatory Framework

This author would recommend that a country adopting a new regulatory framework enact an MDA of 21 as its centerpiece. Of course, this recommendation could not be made lightly. As touched upon in the preceding sections, various factors – scientific, cultural, and philosophical – should no doubt be taken into account.[82] A country's MDA arguably sets the metaphorical "tone" for the rest of its regulatory framework. And, an MDA has implications which literally impact the other elements of a regulatory policy, including bases of civil and criminal liability related to alcohol sale and consumption. As such, an MDA is the linchpin of any regulatory framework, and should be carefully considered.

Furthermore, an MDA of 21 has well-known limitations. In all likelihood, other indicia of adulthood in our hypothetical country – such as the right to vote – will have arrived well before the age of 21, as they do in the United States.[83] Even more controversially, the MDA may be incongruent with certain civic responsibilities, such as the duty to participate in a military draft.[84] And as a matter of fact, selecting an MDA of 21 would place our hypothetical country in the minority camp among the world's countries.[85] These are no minor impediments.

Nonetheless, this author would recommend an MDA of 21 for one simple reason: again, it saves lives. For all its unsightly twists, the American MDA experience teaches us a great deal to this end. The broad results of the increased MDA in terms of the preservation of life have been, in large measure, analyzed, counted, and positive:

> Research continued to be conducted after implementation of the NMDA, and these studies confirmed the earlier findings. A comprehensive evaluation of the evidence base requested by Congress and reported in 1987 by the General Accounting Office (GAO) raised the profile of the evidence and dispelled any lingering doubts about the effectiveness of raising the drinking age. The GAO's thorough, 111-page review concluded that "the evidence is persuasive" that raising the MLDA has significant effects on alcohol-related crashes among eighteen-to twenty-year-olds, and that the observed effects were consistent across studies in different states and with different designs and methods.[86]

Some studies indicate drastic reductions in alcohol-related fatalities: "[T]he percentage of teenage drivers killed in traffic crashes with a blood alcohol content (BAC) above the legal limit (0.08) has dropped from 56 percent in 1982 to 23 percent in 2005," according to estimates by the National Highway and Transportation Safety Authority.[87] And the NHTSA has estimated that the MDA of 21 saves approximately 1,000 lives each year.[88]

Statistical quibbling is no doubt possible. But the MDA of 21 has saved at least some lives which would have otherwise been lost. Accordingly, this author, admittedly as a value judgment, would elevate the preservation of life above all of the other policy considerations discussed herein. An MDA of 21 would best support this policy goal.[89] For that reason, this author would recommend the adoption of an MDA of 21.

B. "Dram Shop" Liability

Dram shop liability statutes raise interesting legal and philosophical questions. For some, logic defies imposing liability upon the distributor of a product for damages directly

caused by the consumer of that product. The intervening act of drinking the alcohol breaks the metaphorical "chain" of responsibility. For others, providing the alcohol begins the process ultimately causing the injury, and in any event, the goal of compensating innocent victims is preeminent. Fortunately, this is an area in which the "mean between extremes" can be reached, at least in large part, by statute.

1. A Brief History of Dram Shop Liability in America

Absent statutory authority, common law courts were rarely imposed liability upon alcohol vendors.[90] "The underlying theory was that the consumption of alcohol, rather than the actual furnishing of it, was the proximate cause of the injury."[91] In less articulate, but equally meaningful terms, courts commonly held that it was not a tort "to sell liquor to 'a strong and able-bodied man.'"[92]

In the mid-19th century, state legislatures began passing dram shop statutes.[93] These statutes provided limited forms of dram shop liability, often creating "causes of action for spouses and children injured in person, property, or means of support."[94] Importantly, the emergence of these statutes also coincided with the rise of the temperance movement.[95]

Following the repeal of Prohibition in 1933, state legislature, in turn, began to repeal dram shop acts and return to the common law rule.[96] Much like the MDA, as shocking drunk driving statistics began to mount in the 1980s, so did interest in resurrecting some form of dram shop liability.[97] At the same time, the tort reform movement prompted some state legislatures to limit – and even cap damages for – dram shop liability.[98] Nonetheless, the era had definitely returned. Some states still refuse to impose any form of dram shop liability, but these states are

the minority.[99]

2. A Comparative Analysis of Dram Shop Liability Statutes

Because of the intersection between modern dram shop liability and the tort reform movement, a few broad principles concerning American dram shop liability may be observed:

> First, a dramshop may be liable for selling or otherwise furnishing alcohol to either a visibly intoxicated patron or a person who is not of legal drinking age. Second, the primary goal of dramshop liability is to compensate innocent third parties for injuries they suffer at the hands of intoxicated tortfeasors. Thus, in the absence of special circumstances, a dramshop's customers may not recover for injuries caused by their own intoxication. Finally, and in keeping with the general trend of apportioning financial responsibility among multiple tortfeasors whenever applicable, a dramshop will not be solely liable for the plaintiff's injuries, but will instead pay a sum of damages based on its share of comparative responsibility.[100]

Dram shop statutes may also be classified "according to their permissive or prohibitive orientation," with the former classification broadly permitting causes of action against alcohol vendors, and the latter classification prohibiting or restricting such causes of action.[101]

The distinction between "permissive" and "prohibitive" statues is particularly obvious, and helpful. South Dakota is a prime example of a state with a "prohibitive" law. South Dakota's statutes plainly preclude dram shop and social host liability, pronouncing that "the consumption of alcoholic beverages, rather than the serving of alcoholic beverages, is the proximate cause of any injury inflicted upon another by an intoxicated person."[102] By contrast,

the Illinois dram shop statute provides that

> [e]very person who is injured within this State, in person or property, by any intoxicated person has a right of action in his or her own name, severally or jointly, against any person, licensed under the laws of this State or of any other state to sell alcoholic liquor, who, by selling or giving alcoholic liquor, within or without the territorial limits of this State, causes the intoxication of such person.[103]

No express additional conditions are placed upon the sale of the alcohol to maintain a cause of action in Illinois.[104] This type of statute approaches a form of "strict liability" against dram shops.[105]

Furthermore, while there is arguably "general agreement as to the broad contours of American dramshop liability," dram shop statutes contain "unique quirks" and "oddities."[106] These variations include "requirements that suits be based on claims of drunk driving, heightened burdens of proof, and even making the plaintiff's ability to sue dependent upon the dram shop's first having been criminally convicted of the illegal sale."[107] Nevertheless, commentators have identified four (4) forms of sales which may give rise to dram shop liability: (1) all illegal sales; (2) sales to intoxicated persons; (3) sales to minors, and; (4) various other unlawful sales, such as sales to known alcoholics or "incompetents."[108] In addition, states take different approaches regarding whether the following types of plaintiffs may be barred from recovering: (1) intoxicated plaintiffs; (2) the families of intoxicated plaintiffs, and; (3) "coadventurers" of intoxicated plaintiffs.[109] Finally, states are divided on the issues of apportionment of liability, contribution, and damage caps.[110]

3. The Recommended Dram Shop Liability Framework

This author would recommend the adoption of a "permissive" dram shop liability statute. Undoubtedly, the historical reasoning for non-liability – that "[v]oluntary consumption of alcohol, rather than the mere furnishing of alcohol, is the proximate cause of any subsequent injury as a matter of law" – is persuasive.[111] However, the policy goal of compensating injured victims is perfectly reasonable.[112] And legally, imposing liability upon dram shop vendors "for foreseeable harm caused by their negligence" is rooted in well-settled tort law.[113] The remaining question, then, becomes the most effective form of dram shop statute.

In this author's view, abstract requirements for stating a cause of action are simply not justified in most circumstances. While some limitations are arguable, "it is important to remember that it is the victim who must absorb the cost of these limitations."[114] For instance, "sold and served" requirements – which basically exempt convenience stores and other vendors who do not sell alcohol for on-premises consumption – eviscerate licensing requirements for dram shop liability.[115] "Sold and served" requirements also potentially allow vendors (such as convenience store clerks) to escape liability for injuries caused by intoxicated or underage customers, despite knowing that the sale may otherwise create exposure for their businesses.[116]

As to the types of sales which may give rise to dram shop liability, a statute combining two (2) commonly accepted categories would be most appropriate: sales to intoxicated persons and to minors. The statute should require proof that the dram shop had actual or constructive knowledge of the offending condition, i.e. that the vendor "knew or should have known" that the purchaser was intoxicated or underage. For instance, Iowa's dram shop statute requires proof that the vendor "knew or should have known the person was intoxicated, or ... sold to and served

the person to a point where the licensee or permittee knew or should have known the person would become intoxicated."[117] This moderate approach tempers the "strict liability" approach advocated in some states.[118] At the same time, it simplifies the categories of illegal sales, excludes anomalies, and avoids the challenges of determining whether a sale was otherwise "illegal."[119]

Furthermore, this author would recommend adopting a dram shop statute which precluded recovery for intoxicated plaintiffs, their family members, and their "coadventurers," regardless of the age of any such plaintiffs. Specifically, our hypothetical country should adopt an express prohibition extended to all three (3) of these categories of plaintiffs, similar to Georgia's dram shop statute: "Nothing contained in this Code section shall authorize the consumer of any alcoholic beverage to recover from the provider of such alcoholic beverage for injuries or damages suffered by the consumer."[120] Intoxicated persons – unlike their innocent victims – have assumed the risks associated with becoming intoxicated.[121] An intoxicated person's family members would derive a right to recover from the intoxicated person's assumption of such risks – a legal right, therefore, would result from an arguable wrong.[122] And "coadventurers" assume the risks of associating with or encouraging intoxicated persons.[123]

Finally, our hypothetical country should adopt a statute which allows both apportionment of liability through joint and several liability, and contribution among dram shops and intoxicated tortfeasors. North Carolina's governing statute is prototypical: "The liability of the negligent driver or owner of the vehicle that caused the injury and the permittee or ABC board which sold or furnished the alcoholic beverage shall be joint and several, with right of contribution but not indemnification."[124] This approach embraces both the theoretical notion of shared

responsibility, and the practical reality that dram shops will be more capable of paying judgments than intoxicated defendants.[125]

With this type of moderate, simplified, and permissive statute in place, our hypothetical country will likely reap the bulk of the rewards, and avoid the bulk of the inequities, created by dram shop statutes.

C. Criminal Liability

The final aspect of alcohol regulation discussed in this essay is both critical and especially complex: DUI laws. No discussion of DUI laws should begin, however, without considering the tremendous human costs addressed by them. DUI laws should seek to prevent, deter, and punish alcohol-related traffic injuries. And that issue remains overwhelmingly serious. Data compiled by the NHTSA for the year 2010 in the United States alone illustrates the point. In 2010, 10,228 people were killed in "drunk-driving" crashes – crashes in which a driver had a blood alcohol concentration ("BAC") of 0.08% or more.[126]

That number represents 31% of all traffic fatalities in the United States that year.[127] "An average of one alcohol-impaired-driving fatality occurred every 51 minutes in 2010."[128] And while the number of traffic fatalities in 2010 decreased by 4.9% from the previous year, it is beyond dispute that the human costs of drunk driving remain unacceptably high.[129]

DUI laws should endeavor to curb the loss of life caused by drunk-driving above all else. With that goal in mind, a few of the most critical aspects of effective DUI laws should be considered.

1. Simplicity and Consistency

Laws deter crimes by causing fear in potential offenders: "[D]eterrence presumably stems

from the perceived threat or fear of the inherent elements of punishment itself, not through some indirect process."[130] Clearly, the deterrent effect of a law suffers if potential offenders do not understand it. And many would argue that average people do not adequately understand DUI laws. In fact, some researchers have estimated that "only 27% of driving-age people know their state's BAC limit."[131] Drivers are often not alone. Judges, prosecutors, and law enforcement officials often struggle with complexities and inconsistencies in their state laws as well.[132] As such, unnecessary complications are not just frustrating; they reduce the efficacy of DUI laws. Simplicity and understandability should be the primary goals of our hypothetical country's DUI laws.

For similar reasons, consistency is important. The following passage summarizes the problem as manifested in our country:

> Currently in the United States, no two states possess the same sentencing provision for the crime of vehicular homicide while under the influence of alcohol. Recent case law shows states are lacking uniformity in their sentencing measures for drunk drivers. This lack of uniformity in facing a national problem leads to variation in the types of convictions and punishments that drunk drivers face.[133]

State legislation punishing drunk drivers for causing fatal crashes can be roughly divided into three (3) distinctive, and sometimes conflicting categories: (1) "easy states," like Delaware, which impose maximum prison sentences of five (5) years; (2) "harsh states," like Rhode Island, which have statutes specifically geared toward punishing DUI-induced homicides, and which impose more severe incarceration penalties, and; (3) "states lacking a clear message," which have

no specific statutes addressing DUI-induced homicides, and which may take differing approaches to charging and sentencing drunk drivers that cause fatalities.[134]

To reconcile these differences, some commentators have suggested uniform sentencing guidelines for drunk drivers who have committed vehicular homicide.[135] Such legislation could arguably be enforced in the same way as the National Minimum Drinking Age Act: by conditioning the receipt of federal highway funds upon adoption of the uniform legislation.[136] To the extent that governmental subdivisions may exist within our hypothetical country, uniform legislation which addresses DUI-related offenses as specifically as possible should be adopted.

To that end, the National Committee on Uniform Traffic Laws and Ordinances has developed the "2007 DUI Model Law."[137] The Model Law is basically a compilation of various common elements of DUI laws, synthesized into a single, comprehensive statute. The Model law includes "provisions relating to repeat and high blood alcohol concentration (BAC) offenders and use of ignition interlocks."[138] Moreover, the Model Law contains provisions related to chemical testing, "zero tolerance" for drivers under the age of 21, and an "open container" provision.[139] Accordingly, the Model Law would be a terrific starting (and perhaps ending) point in enacting a DUI regulatory scheme.

2. <u>The Issue of Legal BAC Limits</u>

Perhaps the most basic question in DUI law is: How drunk is legally drunk? State legislatures have answered that question by enacting and enforcing "per se drunk driving statutes." These statutes "make driving at a given BAC a crime in itself, thus requiring no proof that an individual was actually impaired while driving."[140] In other words, American states (like most countries around the world), set a certain level of BAC as the threshold for criminalizing

the operation of a motor vehicle. Call it what you may: “imparied,” “drunk,” or “over the limit.” By any name, the legal BAC limit is the measurable point at which you are, in the eyes of the law, “too drunk to drive.”

Unsurprisingly, BAC was not a component of most early DUI laws:

> The earliest drunk driving statutes included no legal limit on BAC, only a prohibition on driving while impaired. As our understanding of alcohol's interaction with blood and the body developed, states began to incorporate the BAC into statutes. Indiana was the first to do so in 1939. This first wave of legislation did not create per se statutes, but rather allowed for the use of BAC as evidence of intoxication; subsequent laws created a presumption of intoxication at a given BAC.[141]

By 1966, however, per se laws were being adopted in the United States.[142] Although the legal BAC limit was often much higher than it is today – in some cases 0.15% – the limit set the legal ceiling.[143] State adoption of 0.08% as the legal BAC limit – again, like the MDA of 21 – ultimately became a condition for receipt of federal highway funding.[144] And as of 2004, the strategy was again effective; all American states had adopted 0.08% as the legal BAC limit.[145]

The journey to reduce the legal BAC limit in the United States was a difficult one. Proponents of a legal BAC limit of 0.10% or higher went to great lengths to discredit studies showing the potential benefits of the reduction.[146] Other commentators have suggested even more interesting sticking points with the legal BAC limit of 0.08%: “Per se statutes may have many positive effects, but in light of the scientific evidence indicating that women are generally more impaired than men at the same BAC, they also create the potential for discrimination against men.”[147] Nonetheless, the legal BAC limit of 0.08% is significantly higher (meaning more forgiving) than the legal BAC limit in most other countries:

According to the International Center for Alcohol Policies, only 15 other countries

> (including Canada and New Zealand) have the same threshold as the United States. Most European nations carry a standard of .05 or lower and a few countries, such as the Czech Republic, have zero tolerance policies.[148]

Viewed in that light, the American BAC restriction does not seem so, well, restrictive.

Moreover, research strongly suggests that lower legal BAC levels correlate with lower incidences of alcohol-related traffic fatalities. Indeed, studies have shown that "reducing blood alcohol limits from 0.10% to 0.08% in the United States led to a 6% decrease in the proportion of drivers in fatal crashes with blood alcohol levels at 0.10% or higher and a 5% greater decrease in the proportion of fatal crashes that were alcohol related at 0.10% or higher."[149] Similarly, "[a] time series study of traffic deaths in the United States between 1980 and 1997 indicated about a 14% lower rate of alcohol-related motor vehicle mortality and a 13% lower rate of motorcycle mortality when laws specifying a legal BAC of 0.08% were in effect."[150] Results in other countries were similar:

> In Sweden, which changed its BAC threshold from .05 to .02 in 1990, the results have been dramatic. According to the World Health Organization and European Commission, of road fatalities in Sweden, roughly 16% were alcohol related. In the U.S., 31.7% of traffic fatalities were alcohol related in 2007. Other countries around the world have continued to modify their standards for "drink-driving." In Switzerland, where the limit was reduced from .08 to .05 in 2005, drunk driving deaths instantly declined. France saw similar results when it lowered its limit to .05 in 1995. Changes appear to be on the horizon in other countries as well. For example, in the past few years Denmark has discussed reducing the BAC threshold to .02.[151]

In light of this research, our hypothetical country should adopt a legal BAC limit of 0.08% or lower. Furthermore, the "zero tolerance" policy for drivers under age 21, as reflected in the Model Law, should also be adopted: "Notwithstanding any other provision of law, it is

unlawful for a person under the age of 21 years who has a blood alcohol concentration of 0.02 or more, as measured by a preliminary alcohol test or a test authorized by section 103, to drive a vehicle."[152] In this crucial area – and given the potential life-saving implications of lower legal BAC limits – it is best to err on the side of caution.

3. Strengthening BAC Test Refusal Penalties

Obtaining evidence of a driver's BAC is of paramount importance. Indeed, a BAC test result "is one of the most valuable and persuasive pieces of evidence in an OUI case and is directly linked to the deterrence function of implied consent laws. BAC evidence may exonerate an individual who is wrongfully charged and may help to convict an individual who is impaired."[153] The problem is that, all too often, intoxicated drivers refuse to submit to BAC chemical testing. In those circumstances, not only is a crucial piece of evidence in a DUI prosecution often lost forever, but the deterrent effect of DUI laws is adversely impacted.[154] Moreover, "[m]issing BAC data is also a concern in terms of accurately determining the extent of impaired driving crashes."[155]

Notably, BAC test refusals are relatively common. Data collected by the NHTSA indicates alarming refusal rates on a broad scale:

> Data was received from 37 States, the District of Columbia, and Puerto Rico, and reflects arrests from 2005. State refusal rates varied from 2.4 percent in Delaware to 81 percent in New Hampshire. The average refusal rate was 22.4 percent, and the median refusal rate was 17.4 percent. The weighted mean of the refusal rates based on State populations in 2005 was 20.9 percent.[156]

To compound the problem, different American states have enacted sometimes wildly different

penalty provisions for BAC test refusal.[157]

To adequately address the problems generated by BAC test refusal, our hypothetical country should take a number of steps. First, BAC test refusal should be criminalized and stringently punished. Some research indicates an inverse correlation between the harshness of penalties for refusing to take BAC tests, and the rate at which drivers refuse:

> For example, in Minnesota, where the penalties for test refusal can include up to 90 days in jail (and up to one year in jail for repeat offenders), the rate is 14%. In Illinois, the prescribed penalty is a 6-month license suspension but offenders may receive a restricted license immediately; the test refusal rate is 38%.[158]

The Model Law specifically provides that refusal to submit to a BAC test is a criminal offense, and provides for moderate periods of incarceration, in addition to the administrative penalties of loss of license and monetary fines.[159] Although the extent of these penalties may be debatable, all should be available as sanctions for a first offense of criminal refusal.

Moreover, our hypothetical country should also enact other, more logistical measures to address the problem of criminal refusal. For instance, the DUI statute should specifically provide that evidence of a defendant's refusal to submit to BAC testing is admissible in the defendant's criminal trial. Pennsylvania's statute could serve as a template:

> In any summary proceeding or criminal proceeding in which the defendant is charged with a violation of section 3802 or any other violation of this title arising out of the same action, the fact that the defendant refused to submit to chemical testing as required by subsection (a) may be introduced in evidence along with other testimony concerning the circumstances of the refusal. No presumptions shall arise from this evidence but it may be considered along with other factors

concerning the charge.[160]

Moreover, upon a driver's refusal to submit to a BAC test, officers should be allowed to seek warrants to obtain blood samples.[161] This remedy should be used in conjunction with sanctions for criminal refusal.[162] These steps would likely limit instances of criminal refusal, and thus, help to curb one of the most challenging problems associated with DUI laws.

IV. Conclusion

There are many recipes to make the same good cocktail, and many more variations on each recipe. But the basics should rarely change. The same goes for an effective regulatory framework for alcohol policy. Admittedly, an extra twist of this and shot of that might make it just right. But someone probably tried a few other variations of the fundamental ingredients, and found out the hard way that it just did not taste good. We should take lesson.

Endnotes

1. David M. Crane, *Foreword*, 62 SYRACUSE L. REV. 167, 167 (2012) (citing Earl Warren, *The Law and the Future*, in THE PUBLIC PAPERS OF CHIEF JUSTICE EARL WARREN 221, 229 (Henry M. Christman ed., 1959)).
2. WORLD HEALTH ORGANIZATION, GLOBAL STATUS REPORT: ALCOHOL POLICY 1 (2004) [hereinafter GLOBAL STATUS REPORT].
3. Kim Bloomfield *et al.*, *International Comparisons of Alcohol Consumption*, 27 J. OF NAT'L HEALTH INST. ON ALCOHOL ABUSE AND ALCOHOLISM 95, 96 (2003).
4. *Id.*
5. *Id.*
6. *Id.*
7. *Id.*
8. *Id.*
9. CENTER FOR DISEASE CONTROL AND PREVENTION, SUMMARY HEALTH STATISTICS FOR U.S. ADULTS: NATIONAL HEALTH INTERVIEW SURVEY, 2010, VITAL AND HEALTH STATISTICS 10, Series 10, No. 252 (2012).
10. *Id.*
11. Bloomfield *et al.*, *supra* note 3, at 104.
12. *Id.*
13. *Id.*
14. World Health Organization, *Country Profiles by WHO Region, United States*, http://www.who.int/substance_abuse/publications/global_alcohol_report/profiles/usa.pdf (last visited Dec. 9, 2012).
15. World Health Organization, *Country Profiles by WHO Region, Canada*, http://www.who.int/substance_abuse/publications/global_alcohol_report/profiles/can.pdf (last visited Dec. 9, 2012).
16. World Health Organization, *Country Profiles by WHO Region, Russian Federation*, http://www.who.int/substance_abuse/publications/global_alcohol_report/profiles/rus.pdf (last visited Dec. 9, 2012).
17. World Health Organization, *Country Profiles by WHO Region, Germany*, http://www.who.int/substance_abuse/publications/global_alcohol_report/profiles/deu.pdf (last visited Dec. 9, 2012).
18. World Health Organization, *Country Profiles by WHO Region, France*, http://www.who.int/substance_abuse/publications/global_alcohol_report/profiles/fra.pdf (last visited Dec. 9, 2012).
19. World Health Organization, *Country Profiles by WHO Region, Norway*, http://www.who.int/substance_abuse/publications/global_alcohol_report/profiles/nor.pdf (last visited Dec. 9, 2012).
20. This is not to say that moderate alcohol consumption cannot have positive health implications. Persuasive research indicates that "[h]ealth benefits from moderate drinking, including a reduced risk of heart disease and heart attack, reduced risk of stroke, lowered risk of gallstones, and possibly reduced risk of diabetes have been documented by recent research." Mary Pat Treuthart, *Lowering the Bar: Rethinking Underage Drinking*, 9 N.Y.U. J. LEGIS. & PUB. POL'Y 303, 358-59 (2006).
21. DONNA E. SHALALA, SPECIAL REPORT TO THE U.S. CONGRESS ON ALCOHOL AND HEALTH, 7-12, 240-44 (2000).
22. Jared Wachtler, *Are New York's Social Host Liability Laws Too Strict, Too Lenient, or Just Right?*, 27 TOURO L. REV. 309 (2011) (citing Melonie Heron et al., Nat'l Ctr. for Health Statistics, Deaths: Final Data for 2006 11 (2009)).
23. WHO Library Cataloguing-in-Publication Data, *World Health Organization, Global Strategy to Reduce the Harmful Use of Alcohol*, p. 3 (2010) [hereinafter *Global Strategy*].
24. *Id.*
25. *Id.*
26. Wachtler, *supra* note 22, at 309 (citing NAT'L HIGHWAY TRAFFIC SAFETY ADMIN., 2007 TRAFFIC SAFETY ANNUAL ASSESSMENT: ALCOHOL-IMPAIRED DRIVING FATALITIES 2 (2008)).
27. GLOBAL STATUS REPORT, *supra* note 2, at 1.
28. *Global Strategy*, *supra* note 23, at pp. 13-19.
29. Judith G. McMullen, *Underage Drinking: Does Current Policy Make Sense?*, 10 LEWIS & CLARK L. REV. 333, 361 (2006).
30. Mary Pat Treuthart, *Lowering the Bar: Rethinking Underage Drinking*, 9 N.Y.U. J. LEGIS. & PUB. POL'Y 303, 306 (2006).

31. Michael Philip Rosenthal, *The Minimum Drinking Age for Young People: An Observation*, 92 DICK. L. REV. 649, 652 (1988) (citing Mosher, *The History of Youthful Drinking Laws: Implications for Current Policy*, in H. WECHSLER, MINIMUM DRINKING AGE LAWS, ch. 2 (1980)).
32. *Id.*
33. McMullen, *supra* note 29, at 335.
34. *Id.*
35. GLOBAL STATUS REPORT, *supra* note 2, at 29-30.
36. *Id.* at 30.
37. *Id.*
38. Rosenthal, *supra* note 31, at 658.
39. Samuel Randall, *Loco Parents: A Case for the Overhaul of Social-Host Liability in Florida*, 62 U. MIAMI L. REV. 939, 944 (2008).
40. Robert Kaestner & Benjamin Yarnoff, *Long-Term Effects of Minimum Legal Drinking Age Laws on Adult Alcohol Use and Driving Fatalities*, 54 J.L. & ECON. 365, 365 (2011).
41. GLOBAL STATUS REPORT, *supra* note 2, at 31.
42. *Id.*
43. Rosenthal, *supra* note 31, at 652.
44. *Id.*
45. *See id.*
46. *Id.*
47. McMullen, *supra* note 29, at 336-37 (citing THOMAS R. PEGRAM, BATTLING DEMON RUM: THE STRUGGLE FOR A DRY AMERICA, 1800-1933 7-10 (1998).
48. *Id.*
49. *Id.*
50. U.S. CONST. AMEND. XVIII.
51. *Id.*
52. McMullen, *supra* note 29, at 337 (internal citations and quotations omitted).
53. U.S. CONST. AMEND. XXI.
54. *Id.*
55. Treuthart, *supra* note 30, at 307-08.
56. Rosenthal, *supra* note 31, at 652.
57. *Id.*
58. *Id.* at 652-53.
59. U.S. CONST. AMEND. XXVI.
60. Treuthart, *supra* note 30, at 308.
61. *See* 10 U.S.C. § 505, formerly 50 U.S.C. § 453 ("[N]o person under eighteen years of age may be originally enlisted without the written consent of his parent or guardian . . . .").
62. Rosenthal, *supra* note 31, at 653.
63. *Id.*
64. *Id.*
65. Christopher Calvert Johnson, *The Minimum Age to Possess Alcohol in South Carolina: Are State Statutes Prohibiting Individuals Eighteen to Twenty Years Old from Possessing Alcohol Unconstitutional?*, 4 CHARLESTON L. REV. 813, 815 (2010).
66. *Id.*
67. *See id.*
68. *See id.* at 815-16.
69. *Id.* (citing 23 U.S.C. § 158.
70. *Id.*
71. 23 U.S.C. § 158 (a)(1).
72. Johnson, *supra* note 65, at 817.
73. *S. Dakota v. Dole*, 483 U.S. 203, 211-12 (1987). The MDAL provides an excellent example. Ohio's legislature made clear that, "[i]f the United States congress repeals the mandate established by the Surface Transportation Assistance Act of 1982" relating to a national uniform drinking age of twenty-one or if a court of competent

jurisdiction declares the mandate to be unconstitutional or otherwise invalid, the minimum drinking age for beer will be reduced to 19, while the minimum drinking age for intoxicating liquor will remain 21. Ohio Rev. Code Ann. § 4301.691.
74. Treuthart, *supra* note 30, at 312.
75. McMullen, *supra* note 29, at 337.
76. Treuthart, *supra* note 30, at 364.
77. *Id.*
78. GLOBAL STATUS REPORT, *supra* note 2, at 31.
79. *Id.*
80. *Id.*
81. *Id.* at 32.
82. Some commentators have suggested specific factors to be considered in this determination, including "ages of initiation," statistical analyses, health implications, the level of compliance with existing laws, and comparisons to the laws of other countries. Treuthart, *supra* note 30, at 347-355. No doubt, these (and others) are all valid points of emphasis. At some point, however, decisions between conflicting policy implications must be made.
83. *See* Treuthart, *supra* note 30, at 308.
84. Rosenthal, *supra* note 31, at 653.
85. Treuthart, *supra* note 30, at 364.
86. Michelle M. Mello & Kathryn Zeiler, *Empirical Health Law Scholarship: The State of the Field*, 96 GEO. L.J. 649, 673-74 (2008).
87. Alexis M. Farris, *Lol? Texting While Driving Is No Laughing Matter: Proposing A Coordinated Response to Curb This Dangerous Activity*, 36 WASH. U. J.L. & POL'Y 233, 259 n.104 (2011).
88. Kathyrn Stewart, *Overview and Summary, in* TRANSPORTATION RESEARCH CIRCULAR E-C123, TRAFFIC SAFETY AND ALCOHOL REGULATION: A SYMPOSIUM 6 (Nov. 2007).
89. As discussed above, other research indicates a correlation between some of the negative effects of alcohol consumption and MDALs:

> Only two studies examine longer term effects. Cook and Moore (2001) examine the association between whether a person's state of residence at age 14 has an MLDA of 18 (versus higher) and alcohol consumption at approximately age 24 (sample ages were 17-31). They find that the drinking environment at age 14 is significantly associated with binge drinking at later ages; a legal drinking age of 18 is associated with a 7 percent greater probability of binge drinking at least four times in the last month at later ages. The other study is by Norberg, Beirut, and Grucza (2009), who examine whether living in a state with an MLDA of less than 21 (versus 21) is associated with alcohol use disorders for persons ages 21-53. They report that an MLDA of less than 21 is associated with a 32 percent increase in the prevalence of alcohol use disorders.

Kaestner & Yarnoff, supra note 40, at 366. Findings such as these – which relate not just to mortality rates, but also to what may be termed the "quality of life" implications of alcohol consumption – would lend further support to this author's value judgment.
90. Richard Smith, *A Comparative Analysis of Dramshop Liability and A Proposal for Uniform Legislation*, 25 J. CORP. L. 553, 555 (2000).
91. Nina J. Emerson and Sarah B. Stroebel, *Another Look at Dram Shop Liability*, 73-AUG WIS. LAW. 14, 16 (2000).
92. Julia A. Harden, *Dramshop Liability: Should the Intoxicated Person Recover for His Own Injuries?*, 48 OHIO ST. L.J. 227, 228 (1987) (quoting Cruse v. Aden, 127 Ill. 231, 234, 20 N.E. 73, 74 (1889)).
93. Smith, *supra* note 90, at 555.
94. *Id.* at 555-56.
95. *Id.*
96. *Id.* (citing Daniel E. Johnson, *Drunken Driving--The Civil Responsibility of the Purveyor of Intoxicating Liquor*, 37 IND. L.J. 317, 321 (1961-62)).
97. *Id.*
98. *Id.* at 557.

99. *Id.*
100. Smith, *supra* note 90, at 557.
101. Daphne D. Sipes, *The Emergence of Civil Liability for Dispensing Alcohol: A Comparative Study*, 8 REV. LITIG. 1, 5 (1988).
102. S.D. Codified Laws § 35-11-1.
103. IL ST CH 235 § 5/6-21.
104. *See id.*
105. Smith, *supra* note 90, at 557.
106. *Id.* at 574.
107. *Id.*
108. *See id.* at 558-62.
109. *See id.* at 563-66.
110. *See id.* at 567-73.
111. Sipes, *supra* note 101, at 3.
112. Emerson and Stroebel, *supra* note 91, at 16.
113. *Id.*
114. Emerson and Stroebel, *supra* note 91, at 67.
115. Bradley M. Strouse, *Inconsistent Legislation, Interpretation, and Application: Iowa's Dramshop Act and Its Failed Purposes*, 56 DRAKE L. REV. 1117, 1138 (2008).
116. *Id.* at 1138-39. Other requirements create similar anomalies. In Missouri, for instance, vendors may not be held liable for injuries caused by intoxicated *adults*. Emerson and Stroebel, *supra* note 91, at 16. Louisiana's dram shop statute contains similar limitations. *See* La. R.S. 9:2800.1. For obvious reasons, these provisions create a substantial risk of under-compensation for innocent victims who happen to be injured by intoxicated adults.
117. Iowa Code Ann. § 123.92(1)(a).
118. Smith, *supra* note 90, at 575.
119. *Id.*
120. Ga. Code Ann. § 51-1-40 (b).
121. Smith, *supra* note 90, at 564. This author would not support limiting the category of intoxicated plaintiffs to "adult" persons over the age of 18. Although arguable, the balance of logic and equity do not seem to support allowing minors to recover for injuries caused by their own voluntary intoxication simply because they are minors. *Contra id.* at 576. The protective blanket of "cognitive limitation" for minors mentioned herein and elsewhere must, in this author's opinion, have limits.
122. *Id.* at 565.
123. *Id.* at 566.
124. N.C. Gen. Stat. Ann. § 18B-124.
125. *See* Smith, *supra* note 90, at 567.
126. NATIONAL HIGHWAY TRAFFIC SAFETY ADMINISTRATION, TRAFFIC SAFETY FACTS 2010: ALCOHOL IMPAIRED DRIVING 1 (Apr. 2012). Sixty-five percent (65%) of those individuals were the intoxicated drivers themselves. *Id.*
127. *Id.*
128. *Id.*
129. *Id.*
130. Kirk R. Williams & Richard Hawkins, *Perceptual Research on General Deterrence: A Critical Review*, 20 LAW & SOC'Y REV. 545, 547 (1986).
131. JAMES H. HEDLUND & ANNE T. MCCARTT, DRUNK DRIVING: SEEKING ADDITIONAL SOLUTIONS 53 (2002).
132. *Id.*
133. Amanda Staples, *Another Small Step in America's Battle Against Drunk Driving: How the Spending Clause Can Provide More Uniform Sentences for Drunk-Driving Fatalities*, 46 NEW ENG. L. REV. 353, 365 (2012).
134. *Id.*
135. *Id.* at 376.
136. *Id.*
137. NATIONAL COMMITTEE ON UNIFORM TRAFFIC LAWS AND ORDINANCES, 2007 DUI MODEL LAW, available at http://www.ncutlo.org/2007dui.htm.
138. *Id.*

139. *Id.*
140. Andrew Gore, *Know Your Limit: How Legislatures Have Gone Overboard with Per Se Drunk Driving Laws and How Men Pay the Price*, 16 WM. & MARY J. WOMEN & L. 423, 424 (2010).
141. *Id.* at 427.
142. *Id.* at 428.
143. *Id.*
144. *Id.*
145. *Id.*
146. *Id.*
147. *Id.* at 425.
148. Andrew Clark, *Drunk Driving: Is the Blood Alcohol Limit Too Liberal?*, Time (Oct. 16, 2010), available at http://www.time.com/time/nation/article/0,8599,2025301,00.html.
149. Joel W. Grube, *Alcohol Regulation and Traffic Safety: An Overview, in* TRANSPORTATION RESEARCH CIRCULAR E-C123, TRAFFIC SAFETY AND ALCOHOL REGULATION: A SYMPOSIUM 19 (Nov. 2007).
150. *Id.*
151. Andrew Clark, *Drunk Driving: Is the Blood Alcohol Limit Too Liberal?*, Time (Oct. 16, 2010), available at http://www.time.com/time/nation/article/0,8599,2025301,00.html.
152. NATIONAL COMMITTEE ON UNIFORM TRAFFIC LAWS AND ORDINANCES, supra note 137.
153. Tina Wescott Cafaro, *Fixing the Fatal Flaws in Oui Implied Consent Laws*, 34 J. LEGIS. 99, 101 (2008).
154. *Id.* at 99.
155. NATIONAL HIGHWAY TRAFFIC SAFETY ADMINISTRATION, REFUSAL OF INTOXICATION TESTING: A REPORT TO CONGRESS 19 (2008).
156. *Id.* at 5.
157. Cafaro, *supra* note 153, at 101.
158. HEDLUND & MCCARTT, *supra* note 131, at 53.
159. NATIONAL COMMITTEE ON UNIFORM TRAFFIC LAWS AND ORDINANCES, supra note 137.
160. 75 Pa. Cons. Stat. Ann. § 1547(e).
161. NATIONAL HIGHWAY TRAFFIC SAFETY ADMINISTRATION, supra note 155.
162. *Id.*