



## Crime causes the wealth gap

**To the Editor:** I would like to counter some of the assumptions in Chris Kenyon's article in the July *SAMJ*.<sup>1</sup> Discovering a relationship does not imply causality. The fact that income inequality is linked with crime does not necessarily mean that the wealth gap causes crime. A more reasonable assumption, to my mind, is that it is crime that causes the wealth gap. Crime is an activity of economic sabotage that causes the more wealthy members of society to disinvest from the economy owing to fear of theft and lost worker productivity (from murder and violence), and fears for their own persons and property (with money therefore being put into security and security firms instead of being invested in economically productive activities such as factories). Crime has the effect of reducing investment in property, people and goods – since what is the use of investing money if your property will be vandalised, your workers murdered or hospitalised, and your goods stolen? It can therefore be argued that crime is not the *result* but the *cause* of income inequality, effectively separating the rich from the poor and preventing wealth from percolating through society via economic activity. If there were no crime, the income gap would not exist as the restraints on the economy that crime induces would no longer exist, leading to far greater economic growth and far more jobs available with better pay. This logical conclusion implies that it is useless to attempt to reduce crime by poverty alleviation; rather, crime must be effectively combated before an economic environment conducive to poverty alleviation can be brought about.

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1. Chris Kenyon. What do the xenophobic attacks reveal about the health of South African society? *S Afr Med J* 2008; 98(7): 531-532.

**Chris Kenyon replies:** There is a simple empirical test of Tomek Piorkowski's thesis that crime causes income inequality via decreased economic activity. If this were so, there should be strong correlations between, firstly, high violent-crime levels and low economic activity, and, secondly, between low economic activity and high income inequality. I can find no evidence for the second relationship and only weak evidence for the first. A metanalysis of 34 studies found a weak relationship between poverty and violent crime but a strong relationship between income inequality and violence.<sup>1</sup> In addition, the direction of causation was from poverty to crime (opposite to Dr Piorkowski's proposal). Furthermore, it has subsequently been demonstrated that much of the relationship between poverty and violence was itself likely to be due to undercontrolling for income inequality.<sup>2</sup> Income inequality, on the other hand, is so tightly linked to levels of violent crime that it explains a tenfold difference in homicide rates related to

inequality.<sup>2</sup> It is remarkable how some of the richest countries in the world, such as the USA, have very high violent crime rates while some of the poorest, such as Cuba, have very low rates.<sup>3</sup> Other rich countries such as Japan have extremely low homicide rates. The striking correlation in all these examples is how accurately the countries' GINI coefficients (level of inequality) predict the levels of violent crime. High income inequality countries (South Africa, USA) have high violent crime levels, and low income inequality countries (Japan, Cuba) have low crime levels. Longitudinal data from a study of 39 countries demonstrate that the relationship between inequality and homicide is very close, and that the direction of causality is again from inequality to homicide.<sup>4</sup>

South African Community Service doctors earn around R20 000 a month, which puts them (and hence most doctors) in the top 5% of earners in a country which is one of the most unequal in the world. There is compelling evidence that income inequality has a severe effect not only on violent crime but also on a broad range of diseases.<sup>2</sup> If it is a doctor's duty to promote the health of the population, then it necessarily follows that we should campaign for more egalitarian social policies and therefore to earn relatively less than we currently do. It is my belief that this conclusion, though perfectly logical, is so unpalatable to our luxurious lifestyles that we would rather suspend our logic than our payments on our BMWs.

1. Hsieh CC, Pugh MD. Poverty, income inequality, and violent crime: A meta-analysis of recent aggregate data studies. *Criminal Justice Review* 1993; 18: 182-202.
2. Wilkinson R. *The Impact of Inequality*. New York: The New Press, 2005.
3. Watkins K. *Human Development Report*. 2007/2008. New York: Palgrave Macmillan, 2007.
4. Fajnzylber P, Lederman D, Loayza N. Inequality and violent crime. *J Law Econom* 2002; 45(1): 1-40.

## Time for adolescent medicine units in South Africa?

**To the Editor:** Stephan and Van der Merwe's call for adolescent medicine units<sup>1</sup> is timely. They highlight the special needs of adolescents, and the folly of using 13 years as an upper age limit for children to be managed by paediatric services, especially for those with long-term health conditions ('chronic illness'). In South Africa, the number of adolescents with long-term health conditions is rising as a result of much improved medical and surgical care for children with conditions such as congenital heart disease; additionally, the advent of antiretroviral therapy for children with perinatally acquired HIV infection is producing a new population of such adolescents.<sup>2</sup>

The authors suggest that paediatricians are best suited to continue clinical care through the transition process to adult-orientated care. We suggest that, while paediatricians in South Africa may be *better* suited in this area than most of their physician colleagues, a partnership is needed across



the disciplines of paediatrics, medicine, surgery and mental health to bring about a successful interdisciplinary service. Furthermore, there is much that paediatricians, physicians and surgeons need to learn in order to promote optimal transition care. Pseudo-parental infantilising and poor understanding of the needs of adolescents with longer-term health conditions are recognised faults of well-meaning child health practitioners.

In the 1990s, a survey of staff at Red Cross War Memorial Children's Hospital (RCH) and Groote Schuur Hospital (GSH) in Cape Town showed that, in general, paediatricians felt inclined to take on the care of adolescents, while physicians preferred to take over care of the more mature (A Westwood and L Henley, unpublished data). Specialised surgeons (such as neurosurgeons) found it relatively easy to span the transition to adult-orientated care for the few adolescents in their services, largely because the same staff served the child and adult services. At the time of the survey, formal transition services existed for adolescents with diabetes mellitus and cystic fibrosis.<sup>3</sup> The survey found that significant numbers of teenagers received care at RCH, varying from yearly follow-up of young people who had survived cancer, through intensive management of those who had had renal transplants, to end-of-life care for young adults with genetic muscular disorders.

From the survey, a policy on the care of adolescents with long-term health conditions was developed at RCH to 'regularise' the continuing attendance at the hospital of children over the age of 13 years. The policy also encouraged transition plans in all services. The establishment of an inpatient adolescent ward at GSH was mooted, was supported by most people surveyed and, within a few years, had become part of the GSH strategic planning process.

Plans for a 15 - 18-bed adolescent inpatient unit (which is due to open in 2009) include:

- appointment of a specialist with a special interest in adolescent health to oversee the ward (in this case, a paediatrician)
- promotion of shared care between paediatricians and physicians for adolescents with long-term health conditions
- access for most adolescents with an acute non-psychiatric disorder who require specialised care
- nurses with skills in adolescent care
- admission rights for paediatricians, physicians and surgeons from RCH and GSH
- support from mental health professionals such as social workers
- an associated outpatient service
- space for schooling
- space for relaxation.

It will be important to audit and evaluate this pioneer project to further develop the service and to provide a blueprint for

similar units in other hospitals (not only public ones) in South Africa. The authors undertake to do this.

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1. Stephan C, Van der Merwe P-L. Treating adolescents in South Africa: time for adolescent medicine units? *S Afr Med J* 2008; 98: 184-187.
2. Examining the past, seeing the future. *Mail & Guardian* 2006; 28 July - 3 August: 36-37.
3. Westwood ATR, Henley LD, Willcox P. The transition from paediatric to adult care for persons with cystic fibrosis: patient and parent perspectives. *J Paediatr Child Health* 1999; 35: 442-445.

## **Medical responsibility at inquests**

**To the Editor:** One of the duties of a forensic pathologist is to give expert testimony during an inquest or trial regarding the cause of death and/or the mechanism of death. At an inquest, nobody is on trial; its purpose is to elucidate to the inquest magistrate who the deceased is; where, when, why and how the death occurred; and whether or not someone may be held responsible by virtue of an act of commission or omission.

When patient management is the issue at stake, doctor(s), nurse(s) and even the hospital involved often have excellent legal representation. The Medical Protection Society (MPS) legal team consists of well-prepared, experienced lawyers. They have access to medical records and specialists in different fields of medicine who are paid well to give expert testimony and assist the MPS in defending their clients.

In contrast, the inquest prosecutor is often inexperienced, has poor insight into the important medical issues involved, and is unprepared.

Since the inquest is not a trial but an 'inquiry', the inquest magistrate must hear testimony from all sides and is only then able to give an objective ruling. The court case *Castell v. de Greef* set a precedent by which the code of conduct of a doctor is evaluated - '... the conduct of a doctor in both medical diagnosis and treatment should be tested against the standard of the reasonable doctor faced with the same problem'.<sup>1</sup>

A forensic pathologist performing an autopsy, where the possibility of negligence on the part of a health care worker(s)