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This is the second issue this year, with a number of papers from the region. A paper from Egypt assesses the effect of activity therapy on the activity of daily living (ADL) among schizophrenic patients in conjunction with antipsychotic medication. The authors stressed that schizophrenia is a major psychiatric disorder marked by profound withdrawal from interpersonal relationship, cognitive, perceptual disturbances and social and occupational impairment.

The study was carried out on 50 patients. The findings of the study indicate that majority of the patients (80%) were dependent or partial independent in performance of the ADL while after implementation, independent and partial dependent represented 78% and 22% respectively. The authors concluded that activities of daily living in patients with schizophrenia improved after implementation of activities therapy in conjunction with antipsychotic drugs. This conclusion leads to accept the hypothesis of the study that Activity therapy along with antipsychotic drugs that improve the activity of daily living among schizophrenic patients.

A second paper explored the relationship between epilepsy and anti-epileptic drug (AED) and sexual, reproductive and psychological functions of epileptic women. The study included 60 women with partial seizures of temporal lobe origin (TLE) and 20 control age-matched women.

Epileptic women were overweight to obese; 23 were infertile and 47 women had irregular menstrual cycle. Epileptic women had significantly higher serum testosterone and SHBG with significantly lower serum E2 compared to control women. The authors concluded that Epilepsy has deleterious effects on psychological, sexual and reproductive functions in women and such effect was magnified with AED and with lesions on right side and showed close relationship to disturbed sex hormones levels.

A case series from India looked at unconsummated marriages and its etiological factors:

The authors stressed that this is a common medical and social problem in andrology clinics in conservative communities. However, its etiological factors remain unclear. Erectile dysfunction, vaginismus, premature ejaculation and desire disorders are factors inherent in addition to psychogenic, organic and social factors represent etiological factors. The authors discussed the problems and resistance during therapy and its implications.

A paper from Iran looked at the Scientistic attitude and the perceptions of a group of young Iranian women on social justice and ways of resolving cultural conflicts. From a constructivist point of view, helping with the reconstruction of attitudes can empower youth to deal with the many challenges of adult life. Chief among such challenges are the resolution of inter-generational conflicts regarding socio-cultural and economic issues, and the achievement of a sense of social justice in these regards. Given the characteristics of the contemporary Iranian culture and society, the young women are at the forefront of any existing or emerging conflict and as a result, deserve primary attention. If the perceptions of a group of young Iranian women on issues related to social justice, and ways of resolving socio-cultural conflicts can be correlated with the extent of their attitudes being scientistic (i.e. similar to that of a scientist), then it would be the educators who are taken to the task of helping with the reconstruction of the youth’s attitudes and hence, empowering them to meet the challenge.
Scientific attitude and the perceptions of a group of young Iranian women on social justice and ways of resolving cultural conflicts

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Abstract

From a constructivist point of view, helping with the reconstruction of attitudes can empower youth to deal with the many challenges of adult life. Chief among such challenges are the resolution of inter-generational conflicts regarding socio-cultural and economic issues, and the achievement of a sense of social justice in these regards. In post-revolutionary Iran, the youth pose a major challenge to the educators, as they do to the ruling elite, since they constitute a major portion of the society and any inter-generational conflict could lead to alienation and confrontation. Hence, to assess the conflict as perceived by the youth, and ways of resolving it within a framework of social justice could be considered as a first step towards resolution of the conflict and prevention of any possible confrontation. It is expected that having a scientific attitude could help the youth in dealing with such issues. Given the characteristics of the contemporary Iranian culture and society, the young women are at the forefront of any existing or emerging conflict and as a result, deserve primary attention. If the perceptions of a group of young Iranian women on issues related to social justice, and ways of resolving socio-cultural conflicts can be correlated with the extent of their attitudes being scientific (i.e. similar to that of a scientist), then it would be the educators who are taken to the task of helping with the reconstruction of the youth’s attitudes and hence, empowering them to meet the challenge.

Keywords: Iranian women, social justice, cultural conflicts, scientific attitude

Introduction

Within the constructivist framework, the concept of learning is refer to constructing/reconstructing meaning, attitudes, like peace, this issue of construction is among other things, play a primary and important role. It is the multi-dimensional nature of both learning and attitudes that binds them together, although doing anything is affected by the doer’s learned cognitive, affective, and behavioral predispositions, i.e. attitudes. Learning is multidimensional because it involves reconstruction of not only the cognitive structures, but their accompanying affective and behavioral structures as well. Learning is total and tantamount to change (improvement), if all three dimensions are attended to. To separate these, or not attend to them equally, would be of a crippling effect, one that creates imbalance and disequilibrium. The tendency to reach cognitive equilibrium through adaptation is the very cornerstone of Piagetian constructivism. Similarly, in social constructivism of Vygotsky, the dialectics between the individual and the society works the same way. Thus, it can be said that humans have the tendency to seek equilibrium in all dimensions and areas of their existence since disequilibrium is as ever-present as the said tendency itself! In other words, the existence of conflict or imbalance is as inherent in humans’ lives as is their tendency towards justice and equality. However, in addition to these natural tendencies, the way that humans deal with conflicts and seek justice depends on their learned predispositions as well. Learning anything is based more on attitudes towards the subject of learning than the related aptitudes, and in being so, the most and foremost thing to learn/relearn is a constructive attitude towards the subject. One such attitude can be
assumed to be that held by scientists; others can have something similar to this attitude which has been called the scientific attitude (Hameedy, 2005; 2006). Scientific attitude can be helped to be developed by students if the educational approach is a constructivist one (Hameedy, 2007), because in such approaches learning is considered researching, and research is obviously what scientists do the most. Having such an attitude would affect not only the construction of concepts such as social justice and cultural conflict, but the development of values and actions related to these concepts as well.

Social justice, defined as a construct, is embedded in the general concept of justice which has traditionally been defined from two perspectives (Oreyzi, 2004): the Aristotelian perspective that emphasizes proportionality and the Platonic perspective that stresses egalitarianism. On the other hand, social justice, as Oreyzi & Golparvar (2005) points out, can be considered alongside other domains of justice like economic, legal, political, cultural, and personal justice. However, doing so ignores the fact that the first four areas of justice just mentioned are only meaningful within a social setting. Hence, we can talk of the social and individual justices as the two sides of the justice coin which are inseparable. Nevertheless, the social side of the coin of justice, according to Weatherford (1992), has itself two dimensions of distributive and procedural justice; the first refers to the actual distribution of resources among different groups, while the second refers to the processes by which decisions on how to distribute the resources are made. Such a view of social justice is indicative of both its political and economic dimensions and as such refers to the logical distribution of socio-political rights and freedoms as well. The absence of social justice, or even the perception thereof, would be problematic as it could have negative consequences, such as decrease in social participation, to say the least. However, the criteria by which the existence of social justice is measured or perceived, seems to be the determining factor. It has been said that social justice is absent, or perceived to be so, when there is unequal or disproportional distribution of rights and resources, or just when a groups’ basic needs are not met (Oreyzi & Golparvar, 2005). One such need is being included in the social fabric. From a social constructivist perspective, Benhabib (2002) views social justice as all cultural groups being included into an ever expanding dialogue with the greater society. Not being included in such a dialogue, or the absence of social justice, could lead to cultural conflicts. Cultural conflicts are not only born out of social injustice, but they could erode any existing social justice as well.

Cultural conflicts, rooted in group differences. These conflicts are like other issues in have two sides like, content and relational; but in addition to that, they also manifest “a clash of cultural values” (Williams, 1994, p. 3) and that is what makes them potent and difficult to resolve. However, to resolve cultural conflicts, the first and foremost thing to do is to acknowledge the cultural dimension of the conflict and try to understand the other group’s perspective on the matter by looking at it through their eyes and values (Ibid.). Although speaking of cultural conflicts may remind us of mostly the conflicts between different ethnic groups, the term culture in itself implies ‘group’. As such, in speaking of cultural conflicts we are actually referring to any group conflict stemming from their different values, if not from their mutual misunderstandings! Intergenerational conflicts are also cultural conflicts, as they stem from different values that different generations hold. Groups of country dwellers moving to cities bring with themselves their culture which may, at least in part, clash with that of the city dwellers and hence, bring about a conflict. The same can happen between certain families and the greater society, especially in societies with a dominant “official” culture where the subgroup of families has to conform to the dominant culture while in public. This could be said as being true in today’s Iranian society.

The post-revolutionary Iran (fearon/), is a tapestry of many ethnic groups, and is a culturally rich and diverse society with a particular concern about both issues of social justice and cultural conflicts. With the establishment of the Islamic republic in 1979, it was not just the political system that changed, as the very culture of the country was, to the extent that was possible in the short run, transformed. Further planning for the long term transformation of the general culture to that of an Islamic society has also been on the agenda of the ruling class. Also on this agenda has been the attainment of social justice. It has been said (Taghvaei & Ghanbari, 2006) that ‘in Islam, the pursuit of social justice is tantamount to securing different material and spiritual dimensions of people’s needs on their paths towards the highest ideals’ (p.101); thus an Islamic government has the duty of providing for such needs among all its citizens, especially the deprived masses (Ibid.). On the other hand, in an Islamic approach to social justice (No-roozee, 2009), justice has been defined as ‘everything being in its appropriate place, with appropriateness being determined by the very nature and meaning of things’ (p.16). However, according to the World Bank (2003, in Sharifzaadegaan, 2007) despite the improvements in areas of health, education, and reduction of poverty from 40% before the revolution, to 20% in 2003, unemployment seems to continue to fuel poverty, as 40% of the poorest Iranians are unemployed too. The most recent reports (World Bank, 2008) show that the employment ratio has increased from 46% in 1990 to an estimated 48% in 2007 among the 15+ year-olds, while the same ratio among the 15-24 year-olds has increased only from 33% to 35% in the same period. The prevalence of under nourishment is reported to have been 5.0% in 2007. Literacy rates have improved: for females ages 15-24 from 81% in 1990 to 96% in 2007, and for the same category males and period, from 92% to 97%. Proportion of seats held by women in national House of Representatives has increased from 2% to 4% in that period. Share of women employed in the
non-agricultural sector though is estimated to have been the same 13.5% in 2000 as that of 1995. What seems to have improved significantly is the ratio of female to male enrolment in elementary, secondary, and higher education. In 2007, for every 100 males there were 115 females enrolled in Iranian universities, 102 in the secondary schools, and 129 in elementary schools. According to this World Bank report, despite these improvements, the Iranian government continues to confront major challenges. To reduce poverty, it should target the poor more accurately with existing programs. These programs benefit only half of the poor in Iran, about 4.5 million people, or 1.5 million households, as they are not specifically targeted to the poor. Subsidizing things like bread, medicine, energy, and even credit are mostly untargeted as far as the poor is concerned, and favour the rich, as, for example, the richest decile of households benefits 12 times more from gasoline subsidies than the poorest decile. Such disparities could bring about socio-cultural conflicts.

In post-revolutionary Iran, cultural conflicts have not diminished, as some claim, on the contrary, in some ways they have become more pronounced. It can be said that the revolution itself came about, partly, by cultural conflict, as it has been rooted in the confrontation between the home grown and imported cultures. The rampant westernization during the Shah’s reign provoked many violent reactions from the more traditional corners of the country lead by the clerics. The conflict between the domestic and imported cultures, however, did not just start at the time of the last Shah, as it can be traced back to two earlier dynasties. It was the Iran-Ottoman war in late 16th century that first exposed Iranians to western war technology (Serree, 1987) and later on, other encounters opened the door to the importation of other material goods and even socio-cultural institutions from Europe (Haazeree, 1993). It can be said that even that war had its roots in a more basic cultural conflict between Sunni and Shiite sects of Islam, another manifestation of the conflict between tradition and innovation or domestic and imported. Thus any cultural conflict that may exist in today’s Iran stems from either this historical root on the one hand, or from the multi-ethnic nature of the population, on the other. Contemporary Iranian society consists of many ethnic groups some of whom are minority Sunnis as well. Yet, it is the conflict between the old and the new that figures more prominently, manifesting itself now in the forms of country-urban and inter-generational conflicts. The Chairman of the Social Committee in the Iranian Parliament (Bahaami Assadabadi, 2007) considers the cultural conflict experienced by country folk migrating to big cities like Tehran as the main cause of high divorce rate among them. Just as Ebraheemee (2009), considers cultural conflict as the major problem of the Iranian youth, as they struggle to construct their identity by juggling the Iranian, Islamic, and western aspects of their personalities. An official closely tied to the Expediency Council (Saalehee Ameeri, 2008) points to the cultural identity crisis and inter-generational conflict among the youth as a threat to national cohesion. Despite the recognition of the problem not all appropriate questions are posed and as a result, not much reliable research is done in these areas. Questions like whether young Iranian women perceive the concepts of social justice and cultural conflicts scientifically and pursue them in a similar fashion?

A perusal of the Iranian literature on social justice and cultural conflict would be in itself indicative of the spread and strength of attitudes not only towards these social issues, but towards social sciences and scientific solutions to social problems as well. Most of the accessible writings are opinion pieces or at best theoretical in nature and haphazard literature reviews in form. The fact that many are not accessible, as the access to them is denied, is again indicative of prevailing attitudes. The few seemingly empirical studies are mostly descriptive in nature as they examine the relationship between two constructs such as social justice and social welfare (Moemenee, 2004); perspectives on social justice and attitudes towards private schools (Golparvar & Oreyzi, 2004), or attitude towards social justice and criteria for choosing fields of study (Marasaeel & Oreyzi, 2004). On the other hand, Kaazemeepoor (2003), is a national survey indicating that 51% of Iranians consider social justice as being equal distribution of resources, while 28% think that social justice would be maintained if the distribution of resources were competence based; the remaining 21% of the population believes that the distribution should be based on people’s needs. As for the scientific attitudes among Iranians, especially the university community, studies show that their learned predispositions are not that similar to those of scientists. In a comparison of the scientific attitudes of first- and fourth-year students at an all-girl university (Hameedy, 2006) revealed similarly low attitudes among the two groups indicating the ineffectiveness of the current curriculum in promoting such attitudes. Hameedy, Naaheedpoor, Najaflooeoe, & Yaadgaaree (2007) pursued the manifestations of such attitudes among the graduate students, and especially in their theses, failed to demonstrate signs of strong scientific attitudes in these university products. Based on these findings, and the aforementioned theoretical and practical frameworks, it would be both rational and highly probable that a group of young Iranian women willing to participate in a survey would exhibit a rather weak scientific attitude in their perceptions of social justice, cultural conflicts, and ways of dealing with them.

**Methods**

Two groups of participants were separately gathered in regular classrooms and then informed of a survey being conducted on Iranian youth in which they were invited to participate if interested. Prior to data collection, participants drew their identity number from a stack of cards at random and were asked to put it on their response sheets. The data
Participants were two groups of 23-30 year old female first year graduate students, one attending a semi-public and the other a private university. Both groups, each consisting of 14 students, were familiar with research and measurement. Their selection was solely based on their gender, academic level, and accessibility.

The instruments used in this survey are two questionnaires: an opinion questionnaire and an attitude scale. The opinion questionnaire consists of two parts each containing open-answer questions. Part one simply asks how the respondents define the terms social justice and cultural conflict, and in which areas and to what extent, these phenomenon can be witnessed in Iran. In part two, both concepts are defined and then the participants are asked to indicate the extent to which Iranian women are enjoying social justice as compared to men, in areas such as economic, political, occupational, educational, and legal arenas. Furthermore, they are asked to indicate the extent to which they are experiencing conflicts between themselves and their families, themselves and the society in general, and between their family and the society in general. Finally, they are asked to indicate the way they do or think they should deal with the existing conflicts if any.

The attitude scale, on the other hand, is a set of 63 items in three subsets containing affective, behavioral, and cognitive predispositions towards life in general and student life in particular. Each item is accompanied by a four-point scale (1-4) by which the respondents are to indicate the extent, intensity, and frequency of their responses. Thus, unlike the questionnaire that yields verbal data, the attitude scale produces numerical data which are assumed to be at the interval level ranging from 63 to 262 with scores over 189 indicating an attitude approaching scientistic attitude. This instrument is the shortened version of another with the reliability of 0.86 (Hameedy, 2006).

**Results**

Data were analyzed by simply ranking members of each group according to their attitude scores and then recording a summary of their responses to the justice and conflict questions in different columns of two 14 x 4 matrices. This way, it was possible to further summarize the responses of the two groups to each of the justice and conflict questions, and also detect any co-variation between the verbal responses and the attitude scores. These scores range from 159 to 197 in the semi-private school group and from 146 to 194 in the private university group. The mean of the first set is calculated to be 171 while the other is 164, although the number of respondents approaching the criterion score is more in the second group. In both groups only one respondent scored above the threshold of 189. Dividing the attitude scores into three intervals of low, medium, and high, we can see any relationship between attitude scores and the verbal data on ways to resolve cultural conflicts.

The verbal data on the respondents’ perception of social justice and the extent to which it has been attained in Iran, in general, indicates that most respondents (+80%) equate social justice with equality in rights and opportunities. The remaining respondents refer to appropriate or proportional distribution of resources based on needs or efforts. The data on the second part of the question shows that the respondents mostly perceive an absence of social justice in their country, regardless of the area (except for education), from economics and law to politics and employment. Only two respondents estimated it to be very little. As for the extent and areas of inequality between women and men, all but three respondents agree that women have as much access to education as men; the three point out that even in education it is men (father, husband, or brother) who determine if a woman can go to school or not! Inequality, according to the respondents, is in all areas such as law and employment, because, as one respondent puts it, the men are governing the land. Another respondent points out that the men and women are mostly equal and the areas of inequality between them are sanctioned by Islam and as such are as just as equality! Those who had defined social justice as appropriate or proportional distribution of rights and opportunities seem to have abandoned their definition when it came to women against men. Such exceptions were not present in the data on cultural conflict.

The verbal data on the definition of cultural conflict, the extent of its prevalence in Iran, the extent and areas in which they/their family might have experienced such conflicts, and ways they have or could use in resolving such conflicts, seem to indicate that although a high number of the respondents (almost half!) define conflict equivalent to having differences, there are those who define it as confrontation and clash of values. The areas of such confrontations are said to be mostly between the government sanctioned culture and the popular culture as represented in women's dressing. These can be regarded as the same as those who speak of the “authentic” (meaning perhaps original) culture confronting the petty-cultures (not meaning the ethnic groups perhaps) or “Iranian” vs. western culture. It could be said that the official culture is national, Iranian, and Islamic in nature and claimed to be authentic by its proponents as well. The other area of confrontation and conflict, according to the data, is between the culture of the youth and that of their parents’ generation in values and beliefs and especially in ways that women should dress. Two respondents also mentioned the area of male-female relations, while another one spoke of the area of social liberties as a bone of contention vis-à-vis the national culture and the older generation. Most respondents have estimated the said conflicts as being very
widespread and strong, except for one who does not think that the extent of “that which is refused by the dominant culture” is that “eye catching”. One other respondent mentions the existence of ethnic, linguistic, and religious “differences” (variations) in Iran, not strongly expressed because of the dominance of “the sense of being Iranian”. However, the question coming to the reader’s mind could be whether all these estimates come from what the respondents have personally experienced.

The responses on the existence, extent, and areas of conflict experienced by the respondent between self and the family (especially parents), self and the community, and the family and the community in general, are indicative of mostly no conflict between the young women and their families, except for a few who have indicated to be at odds with them in areas of personal freedoms, pre-marital relations, and general values. As for any possible conflict between the respondents and the community in general, the situation is reversed as only a few have said that they have none. For those who have conflict with the community, it is mostly in the area of values associated with women’s dress codes and other social behaviors that are characterized as being male-determined, anti-woman, and socially unjust. One woman has indicated that the main reason for her cultural conflict with the community is that she considers the latter as being too superstitious, while another respondent sees the community’s tendency to justify everything through religion as the source of conflict! On the other hand, the minority sub-group who has indicated not having any, or very little, conflict with the community in general, are those who mention their religious beliefs and values being those of the community. As for the third locus of conflict, between the family and the community, over half of the respondents indicate the existence of such conflicts in all aspects of the culture: beliefs, values, and behaviors and especially those related to the official religion and the dressing issue! Given all the participants’ perception of conflicts existing between them and the community, the final question regarding ways of dealing with these conflicts becomes ever more interesting.

The most frequent way of dealing with the aforementioned conflicts suggested by the respondents is dialogue/counseling and education, but submission and pretense are frequent as well, and more so than increasing religiosity and spirituality, on the one hand, and escape on the other. Reducing westernization, increasing self-reliance, and simply ignoring the conflict were the other suggestions. Comparing the suggestions given by the three groups with attitude scores of low, medium, and high, reveals that most of the respondents in the high score category have suggested the dialogue and education approach, while the majority of the low-score category have made other suggestions including submission, increasing religiosity and spirituality, and decreasing westernization. The middle category, although mentioning dialogue and education at times, also spoke of pretense, escape, and self-reliance as ways of dealing with their experienced cultural conflicts. Perhaps the more interesting observation is the fact that the high score sub-group reported as having more conflicts than the lower score sub-group; the respondent with the lowest score (146) in scientistic attitude has reported as having no conflict with parents and the community, while the respondent with the highest score (194) indicates that she has “much” conflict, “in many areas”, and with both.

Conclusions
Constructing peace, both within and without, at the personal and social levels, like the construction of anything else, requires a constructive attitude, which is a matter of construction in and of itself. Much of our constructions or learning are planned, be it at the personal or the social level, but a great deal of them are brought about haphazardly and experientially. Constructive attitudes, like those assumed to be held by scientists, and those that are assumed to be held by others and yet are similar to the ones held by scientists, i.e. scientistic attitudes, are among constructions that are not socially planned for. Some of the most important concepts, like justice and conflict resolution, as precursors to peace, are also among the oversighted constructions. Constructivist systems of education, not only focus on such constructions and plan for them, but do so in a multidimensional approach aiming at the development of not only the cognitive dimension of the learners/constructors, but their affective and behavioral dimensions as well, while realizing that all these would not be possible unless the development of the physical dimension is simultaneously attended to. Any educational system not doing so would leave the door open to imbalanced development and retarded potentialities. Just as any social system not adequately planning for social justice and for the resolution of group conflicts would impede its own development and the actualization of its own potentials.

The post-revolutionary Iran, despite all planning, efforts, and achievements, is still lagging in educational achievement, social justice, and cultural harmony it has hoped for. One area in which the Islamic Republic has seemingly performed well and has managed to reverse the gender inequality is education, and especially higher education wherein women have outnumbered men in recent years. Yet the quality of this education is in question, as is the role of the government in the reversal. If the development of scientistic attitude is taken as an index of this quality, studies have shown that the quality is rather low, something that the present study has also reconfirmed. Although the present study has focused on the relationship between scientistic attitude of young Iranian women and ways they suggest for resolving cultural conflicts, the collected data give clues as to the quality of educational experience they have been going through, in
addition to the more straightforward findings on weak scientific attitude and the dependence of the suggested approaches to cultural conflicts on the relative strength of this kind of attitude. The quality of the respondents’ writings, the scope and depth of their answers, and the absence of specificity in the more constructive approaches they have suggested are all additional signs of weak scientific attitude and low quality education. These findings are as real and alarming as those regarding social justice and cultural conflicts. It should be alarming for both the educators and the policy makers when a group of young and university educated women unanimously complain about the absence of social justice in all domains of their lives, or when the overwhelming majority of them perceive themselves as being treated like second grade citizens. These perceptions further fuel the perceived cultural conflicts between them and their family on one side and the community on the other, which would be a recipe for despair and lower productivity if not social unrest and upheaval. One way to muffle this alarm would be to critically review the conducted study and question the validity of its findings. It is true that looking at the study retrospectively, it has suffered from certain methodological shortcomings, especially if viewed from a positivist point of view, as it has no representational sampling, no rigorous measuring, and no statistical analyzing. Well, it was not conducted within that framework, yet attempts at improving the data collection methods and instruments in order to get more valid data through in-depth interviews, or anonymous and open correspondence with the participants, were not heeded.

References
Abstract

Objectives: To explore the relationship between epilepsy and anti-epileptic drug (AED) and sexual, reproductive and psychological functions of epileptic women.

Patients & Methods: The study included 60 women with partial seizures of temporal lobe origin (TLE) and 20 control age-matched women. All women underwent full history taking and sexual interest and function during the preceding week, measured using the Arizona Sexual Experience Scale (ASEX) questionnaire and were evaluated in terms of possible presence of depression using the Beck Depression Inventory (BDI). Fasting, morning blood samples were obtained for estimation of hormonal profile including serum total testosterone, estradiol (E2), sex hormone-binding globulin (SHBG), luteinizing hormone (LH) and follicle stimulating hormone (FSH).

Results: Epileptic women were overweight to obese; 23 were infertile and 47 women had irregular menstrual cycle. Epileptic women had significantly higher serum testosterone and SHBG with significantly lower serum E2 compared to control women. Twenty-three women had right TLE and 16 patients had stopped AED at least 3 months before testing. Mean ASEX score in epileptics was significantly higher compared to controls with significantly higher mean ASEX score in epileptics who had right TLE compared to those who had left TLE and in those on AED compared to those who stopped treatment. Mean BDI score in epileptics was significantly higher compared to controls with significantly higher mean BDI score in epileptics who had right TLE compared to those who had left TLE, but patients maintained on AED showed non-significantly higher BDI score compared to those who stopped AED. There was a positive significant correlation between presence of TLE and high ASEX scores, BDI scores, serum testosterone and serum SHBG, but showed a negative significant correlation with serum E2. Regression analysis showed low serum E2 and presence of epilepsy as the significant predictors for high ASEX score which was the most significant predictor for high BDI score.

Conclusion: Epilepsy has deleterious effects on psychological, sexual and reproductive functions in women and such effect was magnified with AED and with lesions on the right side and showed a close relationship to disturbed sex hormone levels.

Key words: Females, Epilepsy, Antiepileptic drugs, Depression, Sexual and Reproductive functions
Introduction
The brain regulates sexual behavior by neural and neuroendocrine mechanisms. The temporolimbic system, in particular, has been implicated in both of these mechanisms. Bilateral damage to the system, especially the amygdala, can result clinically, as well as in animal models, in behavioral changes that feature hypersexuality (Kluver-Bucy syndrome) (1). Temporo-limbic epilepsy can result in altered, especially diminished, sexuality in both animals and humans. There are reports, moreover, to suggest that hyposexuality may be more prominent with right than with left temporolimbic foci (2, 3).

The effects of reproductive hormones on neuronal excitability and seizure-induced damage are complex to contradictory and depend on different mechanisms. Clinical and experimental evidence supports the role of sex and influence of sex hormones on seizures and epilepsy as well as alterations of the endocrine system and levels of sex hormones by epileptiform activity and conversely, seizures are sensitive to changes in sex hormone levels, which in turn may affect the seizure-induced neuronal damage (4, 5, 6).

The brain controls reproductive endocrine secretion primarily through the hypothalamic regulation of pituitary secretion. Regions of the hypothalamus that are involved in the regulation, production, and secretion of gonadotropin-releasing hormone (GnRH) receive extensive direct connections from the cerebral hemispheres, especially from temporolimbic structures, and most notably the amygdala. Depending on the brain region disrupted by the epileptic discharge, the hypothalamus may be stimulated or inhibited. Release of excitatory and inhibitory neurochemicals during and after seizures may also influence hypothalamic and pituitary hormone release. The location of the ictal or interictal discharge also influences the specific type of input to the hypothalamus. The laterality of limbic epileptiform discharges differentially alter hypothalamic hormone release (7, 8).

Epilepsy has wide-ranging physiologic consequences that arise from seizures and from the use of antiepileptic drugs (AED). Women with epilepsy face a lot of challenges, including reproductive health disturbances. They also have lower birthrates and a greater risk for syndromes associated with infertility, such as hypothalamic pituitary axis disruption, polycystic ovary-like syndrome (PCOS) and anovulatory cycles (9, 10). The current prospective study aimed to explore the relationship between epilepsy and anti-epileptic treatment and sexual, reproductive and psychological functions of women with epilepsy.

Patients and Methods
The current prospective study was conducted at Neurology and Gynecology Departments, Benha University Hospital in conjunction with Psychiatry Department, Faculty of Medicine, Mansoura University; from August 2011 till January 2013. After obtaining fully informed written consent, all women with partial seizures of temporal lobe origin (TLE) who attended the Neurology clinic were enrolled in the study.

Inclusion criteria included at least monthly complex partial seizures and EEG documented unilateral temporal lobe interictal epileptiform discharges. EEG documentation was obtained in the preceding 3 months in all cases. All women must not have had a clinical seizure during the day before or during testing. The study also included 20 control age-matched women who had negative histories for neurological and reproductive disorders, normal neurological and gynecological examinations, and normal EEGs. Women on hormonal therapy for any indication, major tranquilizers, or antidepressants during three months prior to testing were not included in the study. All women were tested during the early to mid-follicular phase (Days 3-7) of the menstrual cycle.

All women underwent full history taking, including age, time lapse since diagnosis of TLE and anti-epileptic drug therapy. Constitutional data were also collected. Reproductive function was assessed by characterization of menstrual cycle intervals and menses, as well as documentation of hirsutism and galactorrhea. Obstetric history included the number of previous pregnancies, number of living offspring and the current fertility status.

Sexual interest and function during the preceding week were measured using the Arizona Sexual Experience Scale (ASEX) questionnaire which is a standardized validated, reliable five-item rating scale that quantifies sexual drive, arousal, vaginal lubrication, ability to reach orgasm, and satisfaction from orgasm. Each question is scored out of 6. A total score between 5 and 30 is determined and higher scores reflect greater sexual dysfunction. Scores that exceeded the control mean plus two standard deviation value were used to categorize sexual dysfunction (11).

All patients and controls were evaluated in terms of possible presence of depression using the Beck Depression Inventory (BDI) consisting of 21 items; each is awarded with a score ranging from 0 to 3. A raw score for each item was given and a total BDI score was calculated by adding the raw scores which may be in range of 0-63: 1-10 indicated that these ups and downs are considered normal; 11-16 indicated mild mood disturbance, 17-20 indicated borderline clinical depression; 21-30 indicated moderate depression; 31-40 indicated severe depression and >40 indicated extreme depression. For statistical purposes, BDI ≥ 17 was considered as the cutoff point for differentiation between women who had depression from normal women or those who had mild mood disturbance (12).

Fasting morning blood samples were obtained for estimation of hormonal profile including serum total testosterone, estradiol, sex hormone-binding globulin (SHBG), leutinizing hormone (LH) and follicle stimulating hormone (FSH).
**Statistical analysis**

Obtained data were presented as mean±SD, ranges, numbers and ratios. Results were analyzed using Wilcoxon; ranked test for unrelated data (Z-test) and Chi-square test (X² test). Possible relationships were investigated using Pearson linear regression. Studies were evaluated as predictors for high ASEX and BDI using Regression analysis (Stepwise Method). Statistical analysis was conducted using the SPSS (Version 15, 2006) for Windows statistical package. P value <0.05 was considered statistically significant.

**Results**

The study included 60 epileptic women with a mean age of 27.6±2.9; range: 23-35 years. All women were overweight to obese with mean body mass index of 34.2±2.6; range: 30.5-39.5 kg/m². Twenty-three women were infertile; 17 were primary infertile and 6 had secondary infertility. Forty-three women had irregular menstrual cycle; 13 had metrorrhagia, 11 had amenorrhea, 6 had scanty menstrual cycle, 8 had menorrhagia and 5 had polymenorrhea, while 17 women had normal regular menses (Table 1).

Epileptic women were found to be more androgenic than control women as manifested by significantly (p<0.05) higher serum testosterone and SHBG with significantly (p<0.05) lower serum E2 in epileptic women compared to control women. However, serum LH and FSH were non-significantly (p>0.05) lower in epileptics compared to control women, (Table 2 - next page).

Mean duration of disease was 7.8±2.7; range: 3-13 years with the majority of patients in the range of 6-10 years duration of disease. Mean number of seizures per month was 4.9±1.9; range: 1-8 fits/month with the majority of patients having number of fits in the range of 4-6 fits/month. Twenty-three patients (38.3%) had right TLE, while 37 patients (61.7%) had left TLE. Sixteen patients had stopped AED at least 3 months before testing because of medication intolerance or lack of efficacy, while the remaining 44 patients were maintained on anti-epileptic therapy; 12 received carbamazepine, 7 received phenytoin, 6 received valproate, 9 gabapentin, 10 polytherapy, (Table 3).

Mean ASEX of control women was 13±2.5; range: 9-19, so the cutoff point equals ≥18. The frequency of patients who had ASEX score ≥18 was significantly higher (X²=13.218, p<0.01) compared to such frequency among control women. Moreover, the frequency of patients who had ASEX score ≥18 was significantly higher (X²=9.339, p<0.01) in patients who had right TLE compared to those who had left TLE and in those maintained on AED (X²=7.245, p<0.05) compared to those who stopped AED, (Figure 1). Consequently, mean ASEX score in epileptics was significantly (p<0.05) higher compared to mean score of controls, with significantly (p<0.05) higher mean ASEX score in epileptics who had right TLE compared to those who had left TLE and in those on AED compared to those who stopped treatment, (Table 4, Figure 2).

As regards BDI, all controls showed a collective score <17 and were considered to have normal to mild mood disturbance. On the other hand, 39 epileptic women (65%) had BDI score of ≥17 and were considered as depressed to a varying extent, while 21 epileptic women (35%) were in range of normal to mild mood disturbance. Interestingly, all epileptic women with right TLE and 16 of those with left TLE who had a score of ≥17 were considered as depressed to a varying extent, while 21 women with left TLE were in the range of normal to mild mood disturbance. Moreover, AED also induced bad mood, 28 women maintained on AED had BDI score of ≥17. Consequently, mean BDI score in epileptics was significantly (p<0.05) higher compared to controls, with a significantly (p<0.05) higher mean BDI score in epileptics who had right TLE compared to controls.
Table 2: Hormonal profile of studied population

<table>
<thead>
<tr>
<th></th>
<th>Control (n=20)</th>
<th>Epileptics (n=60)</th>
</tr>
</thead>
<tbody>
<tr>
<td>LH</td>
<td>14.92±3.1 (8.5-19.2)</td>
<td>14.2±2.4 (10.3-18.2)</td>
</tr>
<tr>
<td>FSH</td>
<td>6.12±1.07 (3.9-7.2)</td>
<td>5.8±1.22 (3.9-8)</td>
</tr>
<tr>
<td>Testosterone</td>
<td>2.17±0.64 (1.05-3.16)</td>
<td>2.61±0.48 (1.45-3.41)*</td>
</tr>
<tr>
<td>SHBG</td>
<td>30.8±5.8 (13.5-39.5)</td>
<td>38.6±11.1 (19.5-61.9)*</td>
</tr>
<tr>
<td>E2</td>
<td>35.6±5.7 (28-43)</td>
<td>21.7±5.4 (10-28)*</td>
</tr>
</tbody>
</table>

Data are presented as mean±SD; ranges are in parenthesis; LH: luteinizing hormone; FSH: follicle stimulating hormone; SHBG: sex hormone binding globulin; E2: estradiol

Table 3: Epilepsy data

<table>
<thead>
<tr>
<th>Data</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duration of disease (years)</td>
<td></td>
</tr>
<tr>
<td>Strata</td>
<td></td>
</tr>
<tr>
<td>3-5</td>
<td>13 (21.7%)</td>
</tr>
<tr>
<td>&gt;5-10</td>
<td>35 (58.3%)</td>
</tr>
<tr>
<td>&gt;10</td>
<td>12 (20%)</td>
</tr>
<tr>
<td>Total</td>
<td>7.8±2.7 (3-13)</td>
</tr>
<tr>
<td>Frequency of seizure/month</td>
<td></td>
</tr>
<tr>
<td>Strata</td>
<td></td>
</tr>
<tr>
<td>&lt;3</td>
<td>16 (26.7%)</td>
</tr>
<tr>
<td>&gt;3-6</td>
<td>31 (51.7%)</td>
</tr>
<tr>
<td>&gt;6</td>
<td>13 (21.7%)</td>
</tr>
<tr>
<td>Total</td>
<td>4.9±1.9 (1-8)</td>
</tr>
<tr>
<td>Lateralization</td>
<td></td>
</tr>
<tr>
<td>Right</td>
<td>23 (38.3%)</td>
</tr>
<tr>
<td>Left</td>
<td>37 (61.7%)</td>
</tr>
<tr>
<td>AED data</td>
<td></td>
</tr>
<tr>
<td>No treatment</td>
<td>16 (26.7%)</td>
</tr>
<tr>
<td>Polytherapy</td>
<td>10 (16.6%)</td>
</tr>
<tr>
<td>Carbamazepine</td>
<td>12 (20%)</td>
</tr>
<tr>
<td>Phenytoin</td>
<td>7 (11.7%)</td>
</tr>
<tr>
<td>Valproate</td>
<td>6 (10%)</td>
</tr>
<tr>
<td>Gabapentin</td>
<td>9 (15%)</td>
</tr>
</tbody>
</table>

Data are presented as mean±SD & numbers; ranges & percentages are in parenthesis; AED: antiepileptic drugs

Fig. (1): Distribution of control and epileptic women according to functional ASEX cutoff point

<18
≥18
Data are presented as mean±SD & numbers; ranges & percentages are in parenthesis; TLE: Temporal lobe epilepsy; AED: Antiepileptic drugs; ASEX: Arizona Sexual Experience Scale; BDI: Beck Depression Inventory; *: significantly higher compared to control women; †: significantly higher compared to patients who had left TLE; ‡: significantly higher compared to patients on AED

Table 4: Sexual and Mood functioning evaluation data

<table>
<thead>
<tr>
<th></th>
<th>ASEX score</th>
<th></th>
<th>BDI</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Functional cutoff point</td>
<td>Total score</td>
<td>Functional cutoff point</td>
<td>Total score</td>
</tr>
<tr>
<td></td>
<td>&lt;18</td>
<td>≥18</td>
<td></td>
<td>≤17</td>
</tr>
<tr>
<td>Controls (n=20)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laterality</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Left TLE (n=37)</td>
<td>22 (59.5%)</td>
<td>15 (40.5%)</td>
<td>16.6±3.3 (12-23)</td>
<td>21 (100%)</td>
</tr>
<tr>
<td>Right TLE (n=23)</td>
<td>7 (30.4%)</td>
<td>16+ (69.6%)</td>
<td>19.2±3.8+ (12-25)</td>
<td>0 (100%)</td>
</tr>
<tr>
<td>On AED (n=44)</td>
<td>19 (43.2%)</td>
<td>25 (56.8%)</td>
<td>18.1±3.4 (12-25)</td>
<td>16 (36.4%)</td>
</tr>
<tr>
<td>Treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stopped AED (n=16)</td>
<td>11 (68.7%)</td>
<td>5+ (31.3%)</td>
<td>15.6±3.9+ (12-23)</td>
<td>5 (31.3%)</td>
</tr>
<tr>
<td>Total (n=60)</td>
<td>29 (48.3%)</td>
<td>31* (51.7%)</td>
<td>17.6±3.7* (12-25)</td>
<td>21 (35%)</td>
</tr>
</tbody>
</table>

Fig. (2): Mean (±SD) ASEX score determined in controls and studied patient categorized according to laterality and maintenance on treatment
those who had left TLE. However, patients maintained on AED showed a non-significantly (p>0.05) higher BDI score compared to those who stopped AED, (Table 4, Figure 3).

There was a positive significant correlation between presence of TLE and high ASEX scores identifying sexual dysfunction (r=0.456, p<0.001), bad mood manifested as high BDI scores (r=0.569, p<0.001) and masculine-hormonal behavior manifested by high serum testosterone (r=0.351, p=0.001), high serum SHBG (r=0.321, p=0.004) and low serum E2 (r=-0.741, p<0.001) which showed a negative significant correlation with presence of TLE.

Using regression analysis for identifying predictors for bad sexual function, manifested as high ASEX score, showed low serum E2 as the significant predictor in 4 models, presence of epilepsy in three models, disturbed hypothalamic function manifested as high serum LH in two models and obesity manifested as high BMI in one model (Table 5). For identification of predictors for bad mood, manifested by high BDI score, regression analysis showed that bad sexual function manifested as high ASEX score was the most significant predictor in five models, followed by
low serum E2 in four models, presence of epilepsy in three models, high serum SHBG in two models and high serum testosterone in one model, (Table 6).

**Discussion**

The relationship between neurological and/or psychological disorders, hormonal milieu and female sexual and reproductive functions is still a matter of concern and multiple debates. The current study included 60 women with TLE, 23 women who were infertile and 43 women who had irregular menstrual cycle. These data indicated disturbed ovarian function manifested as irregular menstrual cycle with concomitant infertility. In support of this assumption serum E2 was significantly lower with significantly higher serum testosterone and SHBG in epileptic women compared to controls. Thus, epileptic women were mostly deviated to hyperandrogenemic state; a picture simulating that of polycystic ovary syndrome (PCOS). Concomitantly, epileptic women were found to be more obese than controls, a finding supporting the picture of PCOS.

These findings supported that reported that reduced fertility and disturbance in various aspects of sexual function are common in women with epilepsy who may additionally develop menstrual disturbances, weight gain, hyperandrogenism, ovulatory failure, and PCOS. Verrotti et al. (14) documented that women with epilepsy have a higher incidence of reproductive endocrine disorders than the general female population and these alterations include PCOS, hyperandrogenemia, infertility, hypothalamic amenorrhea and hyperprolactinemia. Also, Noe & Pack (15) reported that women with epilepsy have higher than expected rates of menstrual disorders and infertility and Bhat et al. (16) found that women with epilepsy could have increased infertility by a percentage of 26.8%. Vlasov et al. (17) reported that among epileptic women, menstrual dysfunction was found in 47.7% distributed as follows: oligomenorrhea in 68.3%, amenorrhea in 9.5% and dysfunctional metrorrhagia in 22.2%.

Such a relationship between epilepsy and reproductive dysfunction could be attributed to the direct influence of focal epileptic discharges from the temporal lobe on the function of the hypothalamic-pituitary axis, thus altering the release of sex steroid hormones (18, 19).

Epileptic women showed significantly higher ASEX and BDI scores indicating sexual dysfunction in association with bad mood compared to control women. Moreover, there was a positive significant correlation between the presence of epilepsy and higher ASEX and BDI scores. The relationship between the triad of epilepsy, disturbed mood and sexual dysfunction could be attributed to the epilepsy-induced changes of the hormonal milieu towards hyperandrogenemia. In support of this, regression analysis defined low serum E2 and presence of epilepsy as significant predictors for high ASEX scores and as a feedback effect, the sexual dysfunction itself was found to be the most frequent significant predictor for bad mood manifested as high BDI scores. In line with such relations, Zelená et al. (20) found Beck Depression Inventories score was significantly correlated with Female Sexual Function Index.

The reported relationship could be attributed to the finding that sex hormones, which are known to contribute to remodeling of the hippocampus, play a pivotal role in

**Table 6: Regression analysis for prediction of bad mood manifested as high BDI score**

<table>
<thead>
<tr>
<th>Model 1</th>
<th>β</th>
<th>t</th>
<th>p</th>
<th>Model 2</th>
<th>β</th>
<th>t</th>
<th>p</th>
<th>Model 3</th>
<th>β</th>
<th>t</th>
<th>p</th>
<th>Model 4</th>
<th>β</th>
<th>t</th>
<th>p</th>
<th>Model 5</th>
<th>β</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serum testosterone</td>
<td>0.349</td>
<td>3.867</td>
<td>&lt;0.001</td>
<td>Serum SHBG</td>
<td>0.315</td>
<td>3.262</td>
<td>=0.002</td>
<td>Presence of epilepsy</td>
<td>0.203</td>
<td>2.563</td>
<td>=0.012</td>
<td>Serum E2</td>
<td>0.188</td>
<td>2.270</td>
<td>=0.026</td>
<td>High ASEX score</td>
<td>0.170</td>
<td>2.064</td>
<td>=0.043</td>
</tr>
<tr>
<td>Serum SHBG</td>
<td>0.351</td>
<td>3.659</td>
<td>&lt;0.001</td>
<td>Presence of epilepsy</td>
<td>0.354</td>
<td>3.853</td>
<td>&lt;0.001</td>
<td>Serum E2</td>
<td>0.199</td>
<td>2.369</td>
<td>=0.020</td>
<td>High ASEX score</td>
<td>0.168</td>
<td>2.124</td>
<td>=0.037</td>
<td>Serum E2</td>
<td>0.356</td>
<td>3.596</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Presence of epilepsy</td>
<td>0.221</td>
<td>2.462</td>
<td>=0.016</td>
<td>Serum E2</td>
<td>0.356</td>
<td>3.815</td>
<td>&lt;0.001</td>
<td>High ASEX score</td>
<td>0.359</td>
<td>4.446</td>
<td>&lt;0.001</td>
<td>Serum E2</td>
<td>0.432</td>
<td>6.836</td>
<td>&lt;0.001</td>
<td>High ASEX score</td>
<td>0.612</td>
<td>8.236</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

SHBG: sex hormone binding globulin; E2: estradiol; ASEX: Arizona Sexual Experience Scale; β: Standardized coefficient
both epilepsy and depression and in women, the role of sex hormone levels may be more important because of their physiological cyclic fluctuations and estrogens, more than other ovarian hormones, show an effect similar to antidepressant drugs by stimulating hippocampal synaptogenesis, thus exerting a protective role against seizures as well (21).

Interestingly, there was significantly higher frequency of sexual dysfunction in women who had right TLE compared to those who had left TLE and in those maintained on AED compared to those who were not on ADE. These findings indicated an impact of localization of epileptic focus on the sexual function, but define a more deleterious effect of AED more than epilepsy itself. In line with these data, Herzog et al. (22), documented that epilepsy-induced sexual and reproductive dysregulation may relate to the laterality and focality of the epilepsy and some hormonal changes may develop in close temporal relation to the occurrence of epileptiform discharges and the significance of these reproductive endocrine disorders is that they may contribute not only to sexual dysfunction and infertility but may also have an adverse impact on seizure control. Murialdo et al. (22), (2009) found patients with more severe disease showed more relevant changes in their sex hormone profile and impaired progesterone levels during the luteal phase. Pack (23) reported that women with epilepsy have a higher than expected prevalence of sexual and reproductive dysfunction, the epilepsy syndrome and localization influence the presentation of these dysfunctions and specific AED influence the presentation of reproductive dysfunction.

The deleterious effects of AED could be attributed to their modulatory effect on hormone release from the hypothalamic-pituitary-gonadal axis and this may alter the metabolism of sex hormones and their binding proteins. Hepatic enzyme-inducing AED, such as carbamazepine and phenytoin, may be most clearly linked to altered metabolism of sex steroid hormones, but valproic acid, an enzyme inhibitor, has also been associated with a frequent occurrence of PCOS and hyperandrogenism in women with epilepsy (14). Moreover, Noe & Pack (15) found that antiepileptic drugs also can adversely affect reproductive health. Herzog et al. (24) suggested that epilepsy, AED levels, ovulatory status, and hormone levels and ratios may all influence premenstrual dysphoric disorder (PMDD) in women with epilepsy. PMDD severity scores may be greater in people with right-sided than in those with left-sided epilepsy, and in people with temporal than in those with nontemporal epileptic foci and mood score may vary with particular antiepileptic drugs, favoring carbamazepine and lamotrigine over levetiracetam.

The obtained data and review of literature allowed concluding that epilepsy has deleterious effects on psychological, sexual and reproductive functions in women and such effect was magnified with AED and with lesions on the right side and showed a close relationship to disturbed sex hormone levels. Judgment use of AED and keeping an eye on hormonal balance in women with epilepsy is mandatory.

References
Unconsummated marriage and its Etiological factors: A Case series

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Abstract

Unconsummated marriage is a common medical and social problem in andrology clinics in conservative communities. However, its etiological factors remain unclear. Erectile dysfunction, vaginismus, premature ejaculation and desire disorders are factors, inherent in addition, to psychogenic, organic and social factors which represent etiological factors. This case series aimed to define the probable etiology of unconsummated marriage. With similar clinic picture, six couples were involved in this study, three males and three females, aged 17 - 36 years. Duration of marriage was 6 days to one and half years; arranged marriages used matched horoscopes. ICD-10 diagnosis- adjustment disorder -depressed type, intentional self harm, Dysthymia and Anxious Avoidant Personality Disorder; Specific Phobia with Anankastic traits and Bipolar Affective Disorder. Substance abuse among males. In women ignorance and lack of knowledge about anatomy and physiology of sex and misconceptions had contributed to the problem. The problems and resistance during therapy and its implications are discussed.

Key words: Unconsummated marriages; erectile dysfunction; vaginismus; premature ejaculation

Introduction

Unconsummated marriage is a common medical and social problem facing medical practitioners in conservative communities. It accounts for up to 17% of visits to sexual health clinics (1).

Normal erectile function requires the involvement and coordination of multiple regulatory systems and is thus subject to the influence of psychological, hormonal, neurological, vascular and cavernosal factors. An alteration in any of these factors may be sufficient to cause erectile dysfunction (ED). In the literature, performance anxiety is considered the major etiological factor of unconsummated marriage that is discussed among other types of psychogenic ED (2-3). Other psychogenic and/or organic factors may contribute to such a dysfunction. Furthermore, social and cultural constraints exert extra pressure on the couple. This is particularly evident in conservative societies where there is lack of sex education, sexual prohibition and misconception about genitalia along with unrealistic expectations (4-7). Vaginismus has been reported as a leading cause for unconsummated marriage (8).

Addar (2004) studied a sample of 36 couples seen at King Khaled University Hospital, Riyadh, Saudi Arabia during a5-year period, with inability to consummate their marital relationship. The results revealed that vaginismus was the primary cause in 63.9% of the cases, erectile dysfunction in 11.2%, severe premature ejaculation in 8.3%, low male sexual desire in 2.7%, and low female sexual desire in 13.9%. A significant correlation was found between the age of the females and low sexual desire and a significant correlation between consanguinity and low sexual desire in the males (9).
Mirzaie & Saremi (2002) reported a case where a couple had undergone treatment due to 14 years history of UCM and wanting a child. During marriage and UCM follow up the wife had undertaken multiple surgeries for cervical dilatation, myomectomy, electrocautery and a course of psychotherapy. According to their pleas to have a child, 10 times IUI had been performed, all of which were unsuccessful. Approximately, after psychiatric assessment, couples were treated by sex therapy methods and then individual psychotherapy was performed for the wife to reduce anxiety. After 5 months, pregnancy occurred via normal intercourse, which resulted in a term delivery (10).

Still, little is known about the causes of unconsummated marriage in our context. The present case series aimed to define the probable etiologic and contributing factors of unconsummated marriages.

Materials and Methods

Patient population

The study was comprised of six patients attending the Department of Psychiatry, Kasturba Medical College Hospital Manipal, India. All patients have been evaluated through history taking and physical examination. Of the six, three were males and three females who sought consultation. Their ages ranged from 17 - 36 years.

The history taking included detailed medical examinations (drugs, drug abuse, surgical history, progression through puberty and developmental milestones). The sexual history included a review of the person’s educational, familial and religious background. Moreover, gender identity, sexual orientation and sexual behaviour (e.g. desires, fantasies, current and previous interpersonal sexual activity, same sex relations, rejection experience, sexual abuse and body image) were carefully explored. All patients underwent complete physical examination that focused on external genitalia and secondary sexual characteristics.

After this initial evaluation, the nature of the problem and different management options were discussed with the patient or the couple. When simple education failed to resolve the problem, the patient was invited to continue with the subsequent tests.

Case 1

Mr. G, a 36 years old married for the last one and half years came along with his wife to the Dept of Psychiatry with a history of some sexual problems. Though he had done his Diploma in Engineering, he was involved in the cashew nut business. He hailed from a rural Hindu and extended family and was the eldest and only son among three siblings.

He married a 25 year old B.Com graduate. It was an arranged and a non-consanguineous marriage and involved taking some dowry from the girl’s party.

A detailed evaluation revealed that Mr.G suffered from symptoms suggestive of a Dysthymic Disorder since the last 1 year which was related to his sexual problems. He also fulfilled an Axis II diagnosis of Anxious Avoidant Personality Disorder. Evaluations revealed that he had severe anxiety and fears during his early childhood. Fears related to darkness, authority figures, large bodies of water which had led to avoidance behavior which persists even till this date. He had no history of hypertension, diabetes mellitus. One month back he had herpes zoster. He also reported a family history of his mother suffering from symptoms suggestive of Generalized Anxiety Disorder, who is currently 62 years old and is on irregular treatment.

Mr. G was engaged three months prior to his marriage. He was calling her regularly and used to visit her occasionally. However, at the time of the engagement he observed that she appeared very dark in complexion and short and stout too and was a bit reluctant to go about the engagement. However, relatives pressured him and he did not think about it much. However, after marriage his repeated attempts to have sexual intercourse with his wife failed. He reported that on the first night and subsequently too, he had an adequate erection but started feeling repulsed at the sight of his wife. He goes to the extent of kissing and fondling her but could not progress further as he reported that he gets repeated images of her physique and cannot proceed with the act. A diagnosis of Sexual Aversion Disorder was entertained.

Detailed examination revealed no erectile dysfunction as he had adequate erection with masturabation. There was no history suggestive of performance anxiety or spontaneous anxiety symptoms. No premarital or extramarital relations were reported.

Several sessions with the couple both independent, as well conjoint, helped Mr.G to accept his wife as she was and looked at the plus points in her character and after 10 sessions, the marriage was consummated.

Case 2

Mrs. S a 27 year old post graduate M.A. in English literature and B.Ed lecturer in a local Government junior college and her spouse a Medical Officer in a PHC in a neighboring talaq came with the history of fear of penetrative sexual intercourse. The patient reported that she developed the fear around 17 years of age when one of her friends told her that the first intercourse would be painful with bleeding. She also stressed on ‘pure love’ and emotional relationship with her spouse without sex and was said to have viewed a movie with this theme where the hero and heroine are emotionally bonded without physical contact. She denied any obsessive, blasphemous sexual or other obsessions or compulsions. The spouse reported that she is stubborn and has fear of contamination and washes her hands repeatedly but it always had been manageable. She has also been sensitive by nature and had some Anankastic traits. There was no history of childhood abuse or fear of males.
She is the eldest of 2 siblings, has a 23-years old brother who has done his MBA and is working in Mumbai. She initially worked in the excise department as a First Division clerk for 2 years and got the current job as a lecturer 1 year back and is quite satisfied with it.

Married for the last 5 months, it was an arranged marriage with her consent. Spouse is 39 years (12 years elder to her) and working as a medical practitioner in a Primary Health Centre and he stays about 50 kilometers away and due to his duty schedule visits her on weekends and the patient has been staying with her parents. Both parents have been very strict and orthodox and the patient reported that discussing marriage or sex has been a taboo in their house. So she grew up with many misconceptions and always felt that sex was ‘dirty’, and thought of ‘pure love devoid of the sexual act’. She however denied any fears related to conception or childbirth or going through the process of labor.

A diagnosis of specific phobia (of penetrative sexual intercourse) was entertained and also Anankastic traits vs Obsessive Compulsive Personality Disorder and the patient was put on Fludac 20 mg 1-0-1 & Lonazep 0.25 0-0-1 with which she reported slight improvement in the sense her sexual desire improved after 6 weeks.

The patient, her parents and spouse were seen in independent sessions. From sessions with her, it was evident that she had severe fears related to the act and a lot of misconceptions about the sexual act and avoided it despite reassurance from the therapist. She, according to the spouse was interested and cooperated in the foreplay but closed her thighs when he approached and the spouse too was hesitant to proceed further. Before coming for psychological help, the spouse tried to stimulate her by showing her blue films. In therapy, finger technique was suggested but patient refused to cooperate though repeatedly promised to comply. She was also educated to dispel the misconceptions. It was also observed that her parents were also indirectly contributing to the problem. Her husband used to visit her at her parents’ place on weekends and they were very anxious about the matter and repeatedly enquiring whether they succeeded that night and also asked the patient to conceive at the earliest. All this again complicated the matter. Later the couple reported for the last time when he said he was transferred to the same place as his wife lived and wanted to set up an independent house where he felt that privacy would resolve their problems.

**Case 3**

Mr. N a 27 year old male educated up to S.S.L.C. from a rural background and agriculturist, eldest of three siblings, was married to a 23 year old woman 5 months back. It was an arranged and a non-consanguineous marriage. There was no dowry issues or horoscopes tallied in arranging this match. Mr. N was admitted with an index episode of Intentional Self Harm (ISH) and evaluations suggested a diagnosis of Adjustment Disorder-Brief Depressive Disorder with ISH. There was no substance use in Mr. N. He did not consummate his marriage as he reported that he was having a relationship with a widow with a child for the last 7 years and refused to stay with his wife and used to occasionally physically abuse her. When his family members learnt about his illicit relationship with the widow and insisted on breaking it, he attempted to end his life by ingestion of organophosperous. The patient refused to comply with the family members’ requests and pleas to leave the widow and he was not willing for any psychological intervention.

**Case 4**

Ms. J a 17 years old girl educated up to PUC from an extended family, and urban background was married six days back to her 35 year old maternal uncle. She was the middle child of three siblings. The marriage was arranged against her wishes. No dowry or horoscopes were involved. Ms. J reported that she wanted to study further and was against marrying at an early age. In subsequent sessions she also reported that her uncle was twice her age, not good looking and worked in the military and was away from home most of the time. She also reported that her husband had substance use. She was admitted with a diagnosis of Adjustment Disorder- Depressed with ISH with pesticides of moderate intent and lethality. In further sessions she reported that she intended to fulfill her ambition to study further to become a doctor and refused to make any changes in her decision to compromise and consummate the marriage.

**Case 5**

A 25 year old woman from an upper middle class background who had completed her Engineering course and was working as a software engineer in a local company was married to a 30 years old also an engineer in Mumbai 6 months back and she returned to her parental household within no time and reported not being able to adjust to her spouse. Despite parents insistence she did not elaborate exactly what was the problem. She sat at home idle after her return as she had resigned her job when her marriage was fixed. She appeared sad and disinterested and resented when there were suggestions from her parents and relatives to go back to her husband. There were neither any calls from her spouse nor did she ever try contacting him. At this juncture, she was brought for consultation to the counselor. In the first, two-three interviews she reported that she was not accustomed to the city life and also said she could not adjust to her husband’s temperament but failed to elaborate any further. However, in subsequent sessions when there developed sufficient rapport she reported that her spouse forced her into oral sex, which she felt repulsive about, hence withdrew from him, and returned to her parental household. Here the husband had no normal or genital sex with her. She also reported that she felt scared and ‘dirty’ about it, and it seemed that her knowledge about sexual intercourse was not satisfactory and had many
Case 6
A 32 year old Engineer working in a steel plant suffering from B.A.D (Bipolar Affective Disorder) had several episodes of both phases and hospitalizations and had been non-compliant on medication on and off. He stayed with his old parents. He had several premarital relationships. On the insistence of the parents, he was married to a 27 year old graduate average in looks about 6 months back. The spouse came to know about his earlier sexual adventures, refused to consummate the marriage though she continued to live with him the next 6 months, and came for the sessions regularly. She refused to change her decision and come to a compromise. She also was treated for a depressive episode during this time. Though she never mentioned divorce during sessions, she left him subsequently to live with her parents.

The facts conform to the phenomenon defined as unconsummated marriage in literature in all the cases reported in this report (7,9). Unconsummated marriage is a threatening problem in oriental society with an incidence of 4-17% among patients attending andrology clinics (1, 11). Causes of unconsummated marriage vary widely in the literature. Classically, performance anxiety is considered the major etiological factor (1).

This report demonstrated the various etiological factors of unconsummated marriage. Although performance anxiety is the main contributor, a number of patients complained of unconsummated marriage owing to other sexual problems, such as premature ejaculation, low sexual desire or even vaginismus, in addition to other psychogenic and non-organic factors.

Other cognitive and developmental psychogenic factors were also identified in a previous and the current report, particularly, inadequate sexual information (14). The occurrence of a sexual problem can cause a secondary problem, or a problem in the sexual partner. Sometimes a sexual problem can cause the emergence of a relationship problem, or a relationship issue can give rise to a serious sexual problem(15).

On the other hand, the transition between a relationship issue and a
sexual problem may not be apparent. The couple may deny the primary issue and force the secondary problem in excess for a solution. The determination of the primary cause and the couple’s approach to treatment are essential for the prognosis (8,15).

Major psychiatric disorders, namely depression, obsessive compulsive disorder and personality disorders, were identified in our patients. Most of the reported studies did not reveal psychiatric pathology as an etiology for unconsummated marriage.

Resistance to treatment means not reaching the correct diagnosis and not getting the desired response to the right treatment. Here, the concept of resistance is considered as not having the motivation to continue treatment or to solve the problem, either internally or externally.

Apart from the clinical complaints presented in UM cases, there may be underlying complex emotional problems. Care must be taken with couples with limited treatment attempts in spite of long lasting problems on the subject of clinical resistances. Whatever the treatment method, history must be taken from both the sexual partners, a distinctive diagnosis of the sexual problem must be made by the multidisciplinary team, and the primary sexual issue must be correctly identified. In this context, the initial evaluation of unconsummated marriage may consist of a detailed medical, sexual and psychosocial history, a focused physical examination and diagnostic testing. The socio-cultural and psychodynamic factors pertaining to the failure to consummate the marriage should be investigated in detail and addressed. Since inadequate knowledge about sexual relationship and dependency to paternal family are of the most important and frequent reasons of this disorder, it seems sexual relation education in educational and health centers in our country is necessary. In conclusion, identification of the etiological factors of unconsummated marriage may be essential for the proper management to achieve a successful outcome. In addition to providing explicit sex education and behavioral counseling, physicians often find prescription medications useful.

References
Senior Libyan doctors and power: use and abuse

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Abstract

Professional morals, values and behaviours are fundamental to all medical practice; yet hitherto linger as one of the trickiest themes to amalgamate explicitly into a syllabus.

Medical ethics and professionalism is about practicing medicine the right way. Duties should always be exercised purely in a humane manner. Doctors must always strive to maintain the utmost set of proficient conduct, and should not be swayed by any means; neither motives nor profits. In fact, too many ethical challenges are encountered by physicians in every day practice.

Medicine has lately transformed and developed into de-professionalised (in other words has been amateurish) profession with steady changes in the manners of physicians; as a result of socio-economic issues escorting to mounting commercialization and immoral fiscal incentives translating it into a purely business matter.

This paper aims to appraise some ethical dilemmas that arise in the medical practices by some seniors in power positions and charges.

Key words: Libya, professional morals, Hippocratic oath, monopoly

Introduction

Medical practice is a challenging and a rewarding profession. There are a wide group of Libyan medical professionals and seniors who are in charge by using their supremacy and abusing hospital facilities as their own properties and who lock it up in a cabinet without any consideration to colleagues, who are at the same level, and have the right to use, apply and utilise it. This will unfortunately stop colleagues from progressing, learning, and thus killing the decent competition. I will give a few examples which I will illustrate as a case scenario, some from my own experience which I personally witnessed, and some others I have heard.

Case scenario in point, when the ultrasound system begun in Libya dating back to the early 80s, there was only one doctor, who was qualified in the previous regime, connections and recommendations used the machine as if it were his own property and locked it in and no one could ever dream of using it at all. The same story goes on; when the Gastroscopy equipment was initially introduced and began in Libya and now the tale (saga) continues with Laser device (appliances) in the Dermatology department (the lucrative profession for many professionals nowadays).

Additionally; in the previous few years with the existence and the entry of different pharmaceutical companies promoting their medical products, they acted by sending out their representatives ‘Medical Representation’ to the governmental hospitals and some busy private clinics, only to those who are holding positions and are sitting in power, so that they may ensure that their medical products are used and prescribed by those influential doctors, as their position will allow them using it to instruct others, and thus the customer (patients)
are utilising such medical product brand names even if at higher and unaffordable prices as targeted physicians will make efforts to persuade them to do so by many different means.

Thus such influential physicians are rewarded by such pharmaceutical companies, by having them sent out to conferences abroad, and shower them with gifts. In short, the same faces, the same people who make use effectively and take the whole advantages singly. What is really astonishing is that the same people who were supporting the previous regime and now are yet still in their positions and are even more empowered sadly. There is no data confirming that as there are not any statistics in the literature in the first place. Also searching the internet did not yield any data about Libya in that theme.

Another case scenario; a personal colleague’s experiences which I witnessed in one of the hospitals I worked in, dated back three years ago, as a director was put in charge by influential people in the previous regime. He issued a warning letter in front of his office on the notice board, whereby any Med Rep won’t have the right to bypass him and see colleagues until has been seen by himself firstly and thus anything as a reward will only be granted to him alone. Not only that, I personally heard from a Med Rep describing that doctor as selfish and arrogant, as some of the pharmaceutical representatives sometimes have the budget for 2-3 doctors to attend a conference abroad and requested him to select according to his liking and preferences another two doctors with him to attend as an offer, and he just refused without a valid explanation, and never responded, which reflects abuse of his position for his only sake and favour, as he wanted to be the only one who would go, and represent others who never gave him that right, nor nominated him in the first place, which would reflect bad, selfish arrogant behaviours.

If we take the prospect from the western countries angle, there is a lot of debate on the relationship of the medical professionals and drug companies. There is however a code of conduct which is followed precisely to regulate the interaction with the medical professionals, and thus equity and fairness is ensured (Kwon, 2012).

From what I highlighted above with such attitudes, it envisages that many doctors do not practice in an ethical way, which could harm patients due to lack of values and principles. Imagine a doctor who is in charge of one piece of equipment and locking it up, and when he/ she is not around, the service cannot be used and thus patients keep coming and going until that doctor shows up in the workplace without consideration at all to the wasted time of the patients. Also such doctors will subsequently stop the progress of other colleagues which reflectively will harm the patient due to lack of experience, proper training, and thus the same cycle keeps going on. This all can be called ‘MONOPOLIZATION’.

Monopolization can be defined as; ‘a situation in which a single company or group owns all or nearly all of the market for a given type of product or service’. It is the exclusive possession or control of the supply or trade in a commodity or service. Moreover monopolization is characterized by an absence of competition, which often results in high prices and inferior products. This definitions applies when an authority supplies that and purchases it with their own money. So how about when a single person who is practicing in a governmental property and holds monopoly power and performs all that on purpose for his own benefits and advantages, to deprive and divest others from that unique opportunity to learn, update and apply knowledge. Monopoly is the extreme case in capitalism. Most believe that, with few exceptions, the system just does not work when there is only one provider, and in our case one user who gave himself/ herself the right to exercise that with the help of a person in power, to use this good or a service for their own greediness and covetousness. And the fact with such a thing, there is no incentive to improve it to meet the demands of consumers. Such a conduct would not create an innovation or competition to improve the service whatsoever. Thus the outcome of monopoly is high prices, and the utilities will be offered at non affordable prices to the public and the one will use it that has the ability to pay or has no real need to. This would make the public believe that doctor who practiced it solo knew it the best.

In Libya it works that the sole user of a good or service by one person solo and not allowing others to use it without a legal right. All of which is due to lack of morals and discipline, where taking properties as if it is your own. Locking it in a cabinet and keeping it with you and many stories are just like that, as it is a normal practice in Libya - controlling people and dominating power.

The issue of government monopoly system in the health care system in Libya is a big issue to debate and should be taken forward seriously, so no one should dare to misuse or control.

Analysis of the Problem
Moral considerations play a major role in our daily life practices. Special attention on such morals may be needed in the implementation of workplace health promotion progress. All such illegal competitiveness should be addressed and tackled properly. But that argument fails to hold up as many are still in higher positions and the corruption keep going on, and no one dares to care or raise up the issue and contest. This could be attributed partly to the misguided and misused legislation and transparency.

Alarms about immoral, unethical or illegitimate conduct on the part of a physician member should go through a complaints filed form to the medical council who should be authorised to
take action and to take it further. This system is totally lacking in Libya and may be it should be included in the new Libya health system reform.

There should be a ‘Code of Ethics’ which can articulate and promote a body of ethical principles to guide doctors’ conduct in their relationships with patients, colleagues and society. Sustaining ethical relationships with industry such as the pharmaceutical industry, medical equipment and other health care product suppliers, and facilities is paramount. This is dated back to history of the Hippocratic Oath.

Ethical questions may not always have ‘one-size-fits-all’ answers. On the other hand, embedding ethical values and principles in every aspect of daily life as well as the medical practices to ensure optimal health care is of vital importance and must be achieved, no matter what. Reviewing the legal and the organisational regulations, developing health care related guidelines, as well as an adequate supply of service to all for ethical competences are among the most critical steps to improve the current situation.

We are in deep need to tackle and fight the violation of ethical principles in clinical practice. A close appeal to virtue ethics could help address the current problem or issues in professionalism in clinical practice is a prerequisite. Avoid temptations to discuss moral distress as a mere hidden curriculum problem. Furthermore, we need to teach medical students the importance of medical ethics and professionalism and incorporate it in the medical curricula, in order to build up proficient manners and conduct among medical scholars and residents.

We also should aim to reduce the disparity between doctors in clinical practice, because such attitudes of colleagues who are in charge would only reflect extreme selfishness and greediness, which will create extreme disliking and hatred among colleagues. Provision of ethically and clinically sound patient care, addresses the message, and improves performance. Practice of medical virtue is a must and should be monitored to emphasise the following guidelines and regulations.

Contemporary medical ethics is far from the traditional concept which emphasises so much the personality or the character of a doctor. Currently, medical ethics should be considered as professional ethics which regulates the acts and medical practices of doctors in their daily practices.

The solution to such failure needs a proper system in place, judging every one for whatever he/ she has done and giving him/ her the credit to use it solely, so no such thing could happen again in the future.

Discussion and Conclusion
Professional morals, values and behaviours are the foundation to all medical practice (O’Sullivan H, et al, 2012). Medicine is not simply about distinguishing those arrogant selfish practitioners’ who only want to make profit no matter what choices they make (Bernat, 2012). Medicine is about having bona fide and real doctors who should act in a decent competent ways with their white coats, and should strive to maintain a paramount set of qualified approaches (Judicial Council, 1957). Usually Libyan doctors tend to be reactive instead of proactive to critiques, thus innovation would be hard to accomplish. We need to evolve the medical practice in Libya in order to improve the health system.

Huge ethical challenges are encountered by physicians in every day practice (Kwon, 2012). Ethics is a distinctive material specifically because of its widespread acquaintance in all aspects of our life, and therefore any teaching has to start from the concept of ethical understanding to guarantee intellectual respectability. Physicians always face ethical dilemmas when dealing with their patients. They should adopt and conduct moral rules and develop attitudes within the frame of ethical concept, and aims to implement it in their normal practice, in order to improve and understand its application.

There are huge misconceptions, and misapplication of this big shell game, where all these power-hungry people think they can convince their colleagues and the public that health care is all about them and they are the centre of it only without any consideration to others and their rights as well. Thus shifting roles around them and deciding who plays it more. But I say that you cannot talk about health care system nor reform without any degree or sense of sincerity, transparency or credibility until you talk about those major issues we are facing in real life.

There should be no monopoly in medicine, as a spoonful monopoly in medicine makes it go down and never innovate nor bring it up to date. Professional monopolists should be banned and should be judged with the existence of a law in place to implement it with legislation to avoid such attitudes.

We need to say no to a monopoly in medicine and the health care system. Medical ethics should be considered as professional ethics to regulate the acts and the medical practices of any physician in their daily clinical practice. It needs a sole integrity and professional standard. The core of medical professionalism is inserting devotion and commitment to the wellbeing of patients above physicians’ private or proprietary benefits. A proper well-constructed Anti-monopolization legislation as well as regulations is needed, to protect such self interested marketing from being dominated by a single entity of such cruel selfish behaviours. This would emphasis and call for the existence of a concrete, clear, ethical and well-formed discipline to be followed and implemented.

In closing, Doctors should owe the patient their complete loyalty and resources of science. They should help when needed. A doctor should behave to colleagues as he/ she
would behave to them. A medical doctor should not lure patients from his colleagues. Doctors should follow the declaration of Geneva agreed by the world medical association in 1948. It is a revision of the Hippocratic oath. It stated that doctors should practice their profession concisely and with dignity bearing in mind the sole consideration to their patients and their confessions, and should not refer their patients for some costly treatment, investigation and take charges for that; this is unethical (Judicial Council, 1957). Also marketing for some pharmaceutical companies and receiving gifts and food for that manner is unethical and unacceptable. This means influencing prescribing practice for some companies’ products.

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