Temporal lobe epilepsy in the priestly source of the Pentateuch

To the Editor: Starting with the work of German scholars in the 19th century[1] consensus has developed based on linguistic, stylistic, textual and other grounds that the Pentateuch was written by at least five authors, traditionally denoted J, E, P, D and R.[2] Almost all of the best-known stories and finest prose narratives from Genesis, Exodus and Numbers are in the J (the 'Yahwist') or E (the 'Elohist') texts, mostly J. In contrast P, the Priestly source, contains some narrative material but mainly consists of the lengthy tracts and codes in Exodus, Leviticus and Numbers on sacrifice, worship, duties and responsibilities of priests, and personal conduct and behaviour. D is the Deuteronomist, and R the Redactor or editor. Recent work has found similarities in style and content between the material from P and the biblical Book of Ezekiel,[2] although P is thought to have been written earlier than Ezekiel. I have noted previously that the Book of Ezekiel[3] is written in a style often found in the writings of individuals with the interictal temporal lobe epilepsy (TLE) syndrome.[4] Here I note that the P text, especially when it can be read separated out from the other texts,[2] also has many characteristics consistent with having been written by someone with TLE.

In 1975 Waxman and Geschwind[4] noted a constellation of signs and symptoms in some patients with TLE, viz. hyperreligiosity, hypergraphia, and altered sexual behaviour during interictal periods. Other signs of this 'Geschwind syndrome' can include aggression and pedantic speech.[5] Many patients with TLE do not demonstrate this flagrant 'temporal lobe personality'; however, when present it is quite characteristic, especially the sign of hypergraphia.

As can easily be discerned from the text,[2] P writes in a pendantic and aggressive style, e.g. (Leviticus 26: 27-29) 'And if, through this, you will not listen to me, . . . you will eat your sons' flesh, and your daughters' flesh you will eat.' While clearly pious and devout, P also shows extreme religiosity, concern with the process and mechanistic workings of a given religion or religions, e.g. lengthy sections in minute and exacting detail on the very dimensions of construction blueprints, priestly garments and sacrifice (Exodus chapters 26 - 30, Leviticus chapter 7) — not seen in the remarkable stories of J and E. The P text is more than twice as long as the J, E, D or R texts and demonstrates a redundant style typically seen in TLE.[4] P is a dogged regulator of sexual behaviour, with repeated proscriptions (e.g. Leviticus chapters 18 - 20). No evidence is present in the text that the author of the P text suffered form seizures; however, P offers no personal information, unlike in Ezekiel where some is found.

While the authors of both the P text and the Book of Ezekiel[3] demonstrate most of the key features of the interictal TLE personality, the lens of TLE is useful in comparing their texts, showing differences in style, consistent with current thinking[2] that they were written by different authors. Thus, P is also then the oldest known case of TLE.

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1. Wellhausen J. *Prolegomena zur Geschichte Israels*. Berlin: Druck und Verlag von G Reimer, 1883.
2. Friedman RE. *The Bible with Sources Revealed*. San Francisco: Harper, 2003.
3. Altschuler EL. Did Ezekiel have temporal lobe epilepsy? *Arch Gen Psychiatry* 1877; **59:** 561-562.
4. Waxman SG, Geschwind N. The interictal behavior syndrome of temporal lobe epilepsy. *Arch Gen Psychiatry* 1975; **32:** 1580-1586.
5. Fedio P. Behavioural characteristics of patients with temporal lobe epilepsy. *Psychiatr Clin North Am* 1986; **9:** 267-281.

Unfair treatment

To the Editor: It is sad to realise how medical doctors are treated considering how much they put into their professional careers. One can say 'life is unfair' or 'medical doctors don't care' or 'we don't know how to handle these matters', etc. This is very interesting and I personally don't think we deserve this.

Think of how one comes to be a qualified doctor. One has to maintain an excellent academic standard in high school, especially in maths, science and English. One has to have leadership qualities, vision, and be determined overall. To be selected to enter medical school you need to be the' cream of the country'.

Fine, here you are at medical school. From your first year until your final year you have sleepless nights, day in and day out. Too much information bombards you. From 8 a.m. till 4 p.m. it is lectures throughout. Towards your final year, you start spending time in hospitals, have intakes, and are humiliated by consultants and professors for knowing too little. This requires extra time to study to make up. From 6 p.m. till 11 p.m. you either go to a library or you study in your room, so you end up studying big time. Sleep during these years is really terrible. Often one has nightmares of failing tests or exams, of being humiliated by consultants and professors and of things one sees in the hospital or dissecting halls.

One thinks of other students at university. Those law, human resource management, social science and commerce students have a great time! They don't have to struggle that much to get into university — just a matric exemption and that's it. They attend two or three lectures a day lasting 2 - 3 hours. In the residences they are the ones who make a noise, and play loud music with their neighbours. They bring girl- and boyfriends to their rooms, talk until late, and disturb their neighbours, including the medical students. After 3 or 4 years they are out of university and they start working.

The same law, human resource management, social science and commerce students who give us a hard time at university are the people who will make decisions about our lives. They determine where we will work (such as in rural areas where there is no water, electricity and few other resources). They also determine how much we will earn every month, and set up rules for medical people (e.g. crazy work hours in the public hospitals). Big question: Do we really deserve to be treated like this?

I personally have a feeling that doctors and other health professionals have little say in their professional careers. We are the 'cream of the country' and we deserve better treatment than this. Maybe human resource management, law, commerce and social sciences should be part of our curriculum. In this way we will become 'Jacks of all trades' and can probably make a difference. But again this would be terrible, if one thinks of the additional work one would have to cover.

This letter is to support the protest march by doctors that took place earlier this year.

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Errata

We regret that there were two errors on the title page of the article by Connolly *et al.* entitled 'Epidemiology of HIV in South Africa — results of a national, community-based study' (p. 776 of the September 2004 *SAMJ*). Dr Olive Shisana's name was mis-spelt, and she should have been listed as second author and not third author.

In the scientific letter entitled 'Unnoticed decline in the number of unnatural deaths in South Africa' by Sulaiman Bah (June 2004 *SAMJ*), it was stated in the last sentence of the left-hand column on p. 442 that the turning point in unnatural deaths occurred in 1996 for males and 1997 for females. That part of the sentence should have read: '. . . the turning point is estimated to have occurred in 1997 for both males and females'. The author sincerely regrets the error.

There were a few errors and omissions in Table VIII of the Guideline for the Management of Chronic Obstructive Pulmonary Disease: 2004 Revision (p. 575 of the July 2004 *SAMJ*, part 2). The corrected table is printed below for you to cut out and stick over the incorrect version in your copy of the guideline.

Table VIII. Classification of bronchitis — diagnostic criteria, risk factors, usual pathogens and recommended treatment

Diagnosis	Criteria/risk factors	Usual pathogens	Recommended treatment*
1. Acute bronchitis	• Acute • No underlying lung disease	• Viruses	• Symptomatic • No antibiotic
2. Simple chronic bronchitis	• Symptoms define chronic bronchitis • Recent increase in sputum volume and purulence • $FEV_1 \geq 60\%$ predicted	• *H. influenzae* • *M. catarrhalis* • *S. pneumoniae* • Beta-lactam resistance possible	• High dose aminopenicillin *or* • Amoxycillin-clavulanic acid *or* • Macrolide/azalide/ketolide
3. Complicated chronic bronchitis	• COPD with $FEV_1 < 60\%$ • Advanced age • ≥ 4 exacerbations/year • Recent increase in sputum volume and purulence • Significant morbidity (ill)	• Same organisms as in 2, but beta-lactam resistance more common • Sputum Gram stain and culture advised	• Amoxycillin-clavulanic acid *or* • Second or third generation cephalosporin *or* • New generation fluoroquinolone
4. Complicated chronic bronchitis with chronic bronchial sepsis	• As above with purulent sputum for long periods in year • ± X-ray evidence of structural lung disease	• Same as 3, but also • Enterobacteriaciae • *Pseudomonas aeruginosa* • Sputum Gram stain and culture advised	• Ciprofloxacin *or* • Other quinolone • Alternative based on result of sputum culture

*Selection of antibiotic is influenced by knowledge of antibiotic resistance patterns in different areas of the country.
This table was adapted with permission from Grossman RF. Acute exacerbations of chronic bronchitis. *Hosp Pract* 1997; **32:** 85-94 (McGraw-Hill Companies) and from Grossman RF. The value of antibiotics and the outcomes of antibiotic therapy in exacerbations of COPD. *Chest* 1998; **113:** 249S-255S.