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ARTICLE

Uncertain Cures: The Medical Marketplace in Pahlavi Iran

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Abstract

Historians of Pahlavi Iran have demonstrated that physicians, pharmacists, dentists, and nurses were encouraged by early nation-builders to civilize patients and shepherd the masses into modernity. Medicine, however, was not only a top-down affair. Medical professionals maintained a dialogue with their patients, cognizant of the cultural mores of local communities and the threat of medical malpractice lawsuits. In fact, medicine, far from a universal science, was highly localized, inflected by traditional curatives (like herbs and spices), shortages of medical equipment and drugs, and local policing to safeguard patient rights. Through social history, scholars may examine the dialectic between patient and provider, which proved fundamental to the practice of modern medicine in Pahlavi Iran.

Keywords: Iran; medicine; Pahlavi monarchy

In 1928, the parents of a ten-year-old girl in Khuzestan, the southwest province of Iran, turned to their local pharmacist, Mohammad Alikhān, to cure their daughter's illness. The pharmacist offered the child four capsules and instructed her to take two per day at thirty-minute intervals. The girl's illness, however, worsened. Desperate, her parents rushed her to the local Indian pharmacist. The Indian pharmacist, who ultimately cured the child of her ailment, reported the Persian pharmacist's shoddy work. With little knowledge of chemistry, the authorities appealed to the expertise of a Russian physician for an examination of the Iranian pharmacist's equipment. The Russian physician, serving as a medical intermediary for the police, found that the capsules prescribed to the child were supposed to contain a dosage of 18 mg of a medical substance; instead, they contained 50 mg.[1] The Persian pharmacist's measuring equipment was faulty: he had been guessing the weight. In response to the investigation and the complaint lodged by the parents, the local police shut down the pharmacy.[2]

This case caused some controversy at Khuzestan's central pharmacy. What right did the local police have to shut down the facility? One representative of the central pharmacy of Khuzestan, ʻAbd al-Majid, wrote a letter to the parliament in Tehran. There were laws, he

[1] Indian and Russian practitioners served as intermediaries for the state, advising them on how best to handle the issue through the province's central pharmacy. Emergent literature on medical intermediaries, particularly their relationship with patients, shows great promise as a means to "capture the practice and implementation of public health policy on the ground." Johnson and Khalid, *Public Health*, 3. See also Boyle, "Saints and Doctors"; and Baron, *Orphan Scandal.*

[2] Ministry of the Interior, May 26, 1928, Iranian Library of Congress, 02/07797/00004-5; ʻAbd al-Majid, Letter from Khuzestan's Central Pharmacy, June 14, 1928, Iranian Library of Congress, 02/07797/00010.

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insisted, that existed to deal with cases such as this one. The central pharmacy, in conjunction with the state, should have investigated the matter with professionals well-versed in medical equipment and medicines. Apparently, before the establishment of a 1960 law I describe later, a procedure had developed with the provincial central pharmacy to evaluate prescribed medication and establish the possible liability of a provider.

As a result of the hasty police who shut down the pharmacy, the reputation of the pharmacist was ruined. This was, after all, the first time in the seven years of operation that such an incident had taken place with a patient at the pharmacy; why was it the fault of the pharmacist and not the individual using the medical equipment? The "rights" of the pharmacist had been "violated," and the author of the letter insisted that the parliament must intervene to hold a proper investigation, and not allow the local police, who were unqualified to assess the matter, to serve as judge and jury in the case.[3]

Interestingly, the pharmacist did not necessarily contend that the Indian and Russian providers were incorrect in their assessments. He emphasized that the pharmacist's reputation should have been taken into consideration, and that the case should be evaluated by native, local practitioners. The central pharmacy, affiliated with the state, had the expertise and authority to contribute to this matter, argued ʻAbd al-Majid.

The case illustrates two themes: first, an Iranian family residing in a peripheral province had the capacity to evaluate the care they received and seek out alternative care, in this case a foreign practitioner trained in Western medicine; in other cases, patients recruited practitioners trained in traditional Iranian medicine for their perspective. Patients and their families shaped the practice of medicine in Iran (and, indeed, globally, as European empires spread Western medicine through various means). The second theme illustrated by this case is the muddled nature of malpractice procedures, which the parliament would clarify in the 1960s. In the decades to come, procedures would offer patients concrete recourse if they received poor medical care, and aggrieved families and patients could air their concerns with medical boards and prosecutors.

In 1928, when Mohammad Alikhān was prosecuted for poor patient care, the state had invested very little in funding public health. In fact, between 1928 and 1938, "only 2.3 percent of the total budget was devoted to public health, rising from 1 percent in 1928," due to the Pahlavi monarchy's investment in the military.[4] In these early years, few had the ability to engage with Western medicine; if a provider made an error, patients likely struggled to find recourse or even a different practitioner trained in Western medicine to properly evaluate the care they received.

The archives offer valuable documentation about the local procedures of medical boards and their cooperation with local prosecutors. These documents are sometimes brief (a summary of findings written by a medical board) and sometimes lengthy (investigations that include transcripts of interviews by investigators). This article also uses medical research specifically written by Western-trained medical practitioners of the Pahlavi period, focused on traditional curatives, including herbs and spices. These sources offer a glimpse into the practitioner-patient relationship, as the practitioners who wrote these texts describe the interests and concerns of their patients. This combination of archival records, published medical research, and newspaper articles contribute to a larger story about patient agency and the dynamics of modern medicine.

Historians of the Pahlavi period to date have not paid close attention to the patient-provider dialogue, instead emphasizing the patient-provider hierarchy.[5] A robust historical

[3] ʻAbd al-Majid, Letter from Khuzestan's Central Pharmacy, June 14, 1928, Iranian Library of Congress, 02/07797/00010.

[4] Good, *Heart of What's the Matter*, 54.

[5] This is curious, since historians of nineteenth-century Iran, like Willem Floor, have offered abundant evidence of this give-and-take between patients and practitioners; Floor, *Public Health*. This might be part of a general trend among scholars of Pahlavi Iran to overemphasize the hegemonic influence of the Pahlavi state; Schayegh, "'Seeing Like a State,'" 38.

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literature, influenced by Michel Foucault, has explored the consequences of Western medicine in the Middle East.[6] Similar to histories of medicine in Latin America, scholars have emphasized "public health," with its political and institutional legacies, and the "sociocultural history of disease and healing," highlighting "the complexity of both illnesses and health as concepts."[7] This article adds a different layer to studies of medicine by centering patient agency through an examination of "the unrelenting resilience of health care practitioners using very diverse medical traditions" because of pressure from their patients.[8]

There is no question that the state used medicine to insert itself into the lives of citizens, as historians like Cyrus Schayegh, Firoozeh Kashani-Sabet, and Afsaneh Najmabadi have fruitfully explored. The movement to reform and modernize Iran, which gained steam at the turn of the twentieth century, reproduced European and colonial prejudices, casting peasants as "uncivilized" defenders of superstition in public life.[9] The state considered Western-educated physicians, on the other hand, as the models and vehicles of national advancement. In this nationalist scheme, the patient represented the uncivilized subject in need of social and medical discipline by the trained and licensed Western-educated physician.

A nationalist propagandist, however, did not have to complete a medical residency in an Iranian village, where patients challenged their expertise. As Najmabadi presents in her fascinating anthropological-cum-historical study of Iran's trans community, patients strategically and successfully assert themselves in medical (and religious) spaces to advocate for their interests.[10] I add to this broader patient-centered paradigm by focusing on medical malpractice lawsuits and traditional medicine, both of which complicate the top-down vision of the patient-practitioner relationship, especially as envisioned by early nationalists. Indeed, social history may privilege the role of the patient in the history of Western medicine. Furthermore, this article encourages scholars of Iran to reflect on the development of a "medical marketplace" that reimagines doctors as the vulnerable actors, subject to the prejudices and preferences of their patients.[11]

The historiographies of Latin America and Africa, with their impressive investment in local medicines, have engaged with the "plurality of specific nontraditional medical practices," termed medical pluralism.[12] Alternative or complementary medicines were then, as they are now, "largely unregulated," causing a debate among Iranian practitioners in the Pahlavi era about their use.[13] These medicines introduced challenges: What represented a proper dosage for particular ailments? How could one evaluate malpractice when a pharmacist prescribed treatments that had not been studied for efficacy? What was the evidence that specific herbs might improve a patient's outcome? What were the chemical properties of natural curatives? These questions continue to animate those who challenge holistic medicine around the world.

Iranian physicians, trained to practice European-style medicine, often derided those who espoused more traditional forms of health-care practices, as Kashani-Sabet has illustrated.[14] Claire Wendland, who studies African midwives, writes that licensed and informal providers "level blame at one another for the dangers involved in contemporary childbirth. In doing

[6] There is an extremely robust literature on this topic in Middle Eastern history. I will limit myself here to Iranian historiography, although this by no means captures the full breadth of literature on the intersection of nationalism, modernity, and medicine. Kashani-Sabet, *Conceiving Citizens*; Schayegh, *Who Is Knowledgeable Is Strong*; Ebrahimnejad, *Medicine in Iran*; Afkhami, *Modern Contagion*.

[7] Armus and Gomez, *Gray Zones*, 5.

[8] Ibid., 6.

[9] El Shakry, *Great Social Laboratory*, 39.

[10] Najmabadi, *Professing Selves*.

[11] Boyle, "Saints and Doctors," 2.

[12] Napolitano, *Migration, Mujercitas, and Medicine Men*, 96.

[13] Mills, "Regulation in Complementary and Alternative Medicine," 158.

[14] Kashani-Sabet, *Conceiving Citizens*, 97.

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so, each group seeks to bolster its own authority." The debate does not prove the success of modern medicine in devaluing the contributions of non-Western medicine, however; quite the contrary, some medical providers, in "contests over authority and legitimation," offered (and continue to offer) patients the space to express their preferences and confer with family members about their experiences of different medical traditions.[15]

Historians have yet to illustrate the ways in which, rather than ignore patient pressure, Iranian physicians engaged in natural curatives as well as local knowledge to serve the needs of their patients. The exchange above, between an aggrieved family, a pharmacist, the police, and the central pharmacy of the province illustrates a dialogue between the state, local residents, and medical practitioners. Cyrus Schayegh astutely argues that historians of Pahlavi Iran convey "modernization as a top-down affair in which society was the object rather than a participant."[16] Even parents in an Iranian borderland could strategically engage with medical providers and cooperate in a police investigation. Rather than examine the development of modern medicine and institutions that allowed for easier access to trained professionals, this study examines the productive patient-provider dialogue, which accommodated patient concerns and built the reputation of modern medicine throughout the country.

European Medicine in Iran

Although this piece emphasizes the patient-practitioner dialogue, there is no doubt that imperial actors shaped the practice of medicine in Iran. In the nineteenth and twentieth centuries, Europeans headed various bureaucracies as well as university departments devoted to the study of medicine. In fact, "the International Sanitary Commission Meetings of Istanbul (1866) and Vienna (1874) obligated Persia to create a Board of Health in Tehran."[17] Europeans participated in guiding the Iranian state and Iranian students to establish centers of medical learning and hospitals. French physician Joseph Desire Tholozan (1820–1897) served as the first president of Majles-e Sehbeh (the Council of Health); French professor Pierre Roux (1853–1933) supervised the creation of the Pasteur Institute of Iran; and Joseph Mesnard served as the first director of the institute (in fact, the first three directors, from its founding until 1961, were French).[18] These strong institutional European influences shaped the practice of medicine and the research of curative substances in Iran.

European physicians traveled to Iran, contributed to founding institutions of medical learning, and by training local doctors disseminated knowledge about hygiene and health to the local population. The aim of European physicians, especially medical teachers like Jacob Eduard Polak (1818–1891) and Johan Louis Schlimmer (1819–1881), was to transmit knowledge and encourage local medical practitioners, from dentists to nurses, to practice in areas that needed more medical attention. Many Iranians also were sent abroad for training. Beginning in the nineteenth century, students from Dar al-Fonun were sent to study medicine in England and France; this practice continued through the twentieth century.[19]

This European training had tremendous consequences for the study and practice of medicine in Iran. Mohammad Hossein Aziz and Farzaneh Aziz argue that because of the institutional influence of Dar al-Fonun physicians were no longer beholden to the "theory of the Four Humors consisting of blood, yellow bile, phlegm, and black bile," nor did they have to resort to "bloodletting and herbal medicine" to cure ailments.[20] Nevertheless, other historians have argued that, even in these early institutions promoting modern science,

[15] Wendland, "Legitimate Care, Dangerous Care," 244.
[16] Schayegh, "'Seeing like a State,'" 37.
[17] Floor, *Public Health*, 206.
[18] Azizi and Azizi, "Government-Sponsored Iranian Medical Students," 352.
[19] Ibid., 355.
[20] Ibid., 352.

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traditional medicine continued to play a role. For instance, Mirzā Nosrat-e Tabib, a graduate of Dar al-Fonun and a professor of medicine at the institution, argued in the 1870s that there existed "historical links between modern and traditional medicine," thereby expounding a "continuity between Greek and modern medicine," as Hormuz Ebrahimnejad has explored.[21] The use of "Greek" (Yunani) medicine never disappeared, despite the arrival of European hospital directors and medical teachers.

Early in the twentieth century, Iranian physicians expressed interest in traditional medicines, in large part because of their own family heritage and interactions with local patients. As in other cultures, "health is not simply an absence of disease but, rather, the fortuitous, fleeting outcome of a struggle for balance between a permeable self and an unpredictable outside world."[22] Consuming a balance of hot and cold foods, another example of this system of health "maintenance," had historically been considered critical for an individual's internal equilibrium, signaling that "health must be managed personally on a daily basis."[23] This allows for "both proactive and reactive . . . approach[es] to the care of the body and spirit."[24] This regimen of daily care was an area of interest to physicians invested in studying native practices. Agnes Loeffler, who traveled to Iran in 1998–1999 to conduct her study of allopathy at the University of Shiraz, discovered that many Iranian physicians continued to believe that traditional medicines and ideas of health would hold up to the rigors of clinical trials.[25]

Local traditions informed the practice of medicine long after the founding of Dar al-Fonun. Even as the Pahlavi monarchy expanded the number of universities teaching Western medicine and physicians treating patients throughout the country, patients continued to seek out alternatives to Western science.[26] Herbs and spices, readily available in rural and urban bazaars, allowed Iranians in the Pahlavi period to take their health care into their own hands, as described in more detail below. On the other hand, chemical medications, which had entered the Iranian market, allowed traditional practitioners trained through apprenticeships and in bazaar settings to prescribe drugs for diseases like malaria and dysentery.[27] Iranians made demands of their practitioners, whether to improve their methods through malpractice suits or to integrate traditional therapies into treatment protocols, that pharmacists and physicians heeded.

Medical Malpractice Laws and Lawsuits

In addition to the founding of medical institutions, the Iranian parliament also passed medical malpractice laws beginning at the turn of the twentieth century to deal with dissatisfied patients and the complexity of modern litigation. By engaging these laws, patients showed their agency in the patient-practitioner relationship, which has often been characterized as hierarchical and disciplinary in nature. Although I focus on the Pahlavi period (1925–1979), medical malpractice laws in Iran did not originate with Reza Shah Pahlavi.

The framework for medical malpractice following the Constitutional Revolution of 1905 was not robust; nevertheless, the second parliament passed the first (and only) law on the "criminal liability for medical procedures" in June of 1911. Article 12 of that law states that "the issuance of a secret prescription (*noskheh ramz*) is completely forbidden and any

[21] Ebrahimnejad, *Medicine, Public Health and the Qajar State*, 123.
[22] Whitaker, "Idea of Health," 348–49.
[23] Wellman, *Feeding Iran,* 85.
[24] Whitaker, "Idea of Health," 348–49.
[25] Loeffler, *Allopathy Goes Native*, 93. Although she does not elaborate on the effect of Islamist ideology on this interest in traditional medicine, there is a clear connection between the revolution and a kind of "people's medicine" that emerged in 1980s Iranian discourse.
[26] I explore this further below, using the information provided by census records in Abrahamian, *History of Modern Iran*, 134.
[27] Good, *Heart of What's the Matter,* 41.

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medical practitioner issuing a secret prescription will be imprisoned for four months."[28] The first of its kind, this medical malpractice law likely refers to prescriptions without the dosage details of the medication provided on the script.[29] Schayegh considers this law a victory for Western-trained physicians, demonstrating the productive cooperation between modernizing agents (medical practitioners) and the state. As a result of this law, "modern-educated physicians" now had a "monopoly on state medical services," he writes. This also offered legal protection for patients who had been fooled by an imposter. Although the law's primary purpose was to limit those who could legally practice medicine, it was, ultimately, impractical. After all, "there simply were not enough modern-educated physicians in the provinces" and the parliament was forced "to permit traditional doctors to continue practicing," Schayegh continues.[30]

Nevertheless, as early as 1911, the constitutional assembly "passed a physicians' licensing law . . . requiring all physicians to be registered and new licenses to be restricted to those trained in Western-style medical schools." Similar rules applied to pharmacists beginning in 1919.[31] Still, in some areas, unlicensed practitioners continued to operate into the 1930s. Some traditional practitioners, trained through apprenticeships, passed the medical exam, thereby qualifying for licenses.[32] Although these licensed practitioners, influenced by their preparations for the exam, introduced more Western medicines, for many patients, little changed after the passage of licensing laws.[33] These Qajar era reforms did not end the debate about health care, of course; patients continued to express concerns about medical providers, and Reza Shah's parliament implemented laws that played a part in the struggle between Tehran and the nation's physicians.

The Penal Code of Iran, passed by the Iranian parliament in January of 1926, did not, however, secure patient rights by introducing an apparatus to deal with malpractice.[34] Instead, the parliament affirmed the state's control of medical practitioners, particularly the services medical practitioners could provide their patients. Because of concern about forged documents produced by medical practitioners to help Iranians escape obligatory military service, the parliament threatened offending practitioners with imprisonment and hefty fines.[35] This was a disciplinary measure to force "physicians and surgeons" to do their part as modernizing agents. Article 183 of the Penal Code also upheld state interests by threatening physicians with prosecution should they perform an abortion, unless the physician could prove that the abortion was intended to save the mother's life.[36] This law inserted the state into the patient-provider relationship, preventing the latter from offering the former a type of service.[37]

Article 220 of the Penal Code did demand that medical professionals, entrusted with confidential knowledge about the health of their patients, not reveal personal information unless required by the state.[38] Unlike previous laws, which mandated that physicians not cede to patient pressure (for either forged documents or elective procedures), this law seems to offer patients the right to confidentiality, which they had likely demanded. The

[28] Golduzian and Mo'zami, *Ta'ghib-e Keyfari va Entezāmi*, 28.
[29] The full text can be found on the Iranian Parliament's website, "Qanun-i Tebbabat."
[30] Schayegh, *Who Is Knowledgeable Is Strong*, 55–56.
[31] Good, *Heart of What's the Matter*, 34.
[32] Ibid., 56–57.
[33] Ibid., 57.
[34] These laws can be found, in Persian, on the Iranian Parliament's website, "Qanun-i Mojazat-i Umumi."
[35] Golduzian and Mo'zami, *Ta'ghib-e Keyfari va Entezāmi*, 28.
[36] Ibid., 28–29.
[37] For a more robust discussion of abortion laws, see Kashani-Sabet, *Conceiving Citizens*. It is important to note that the law did not prevent abortion. In fact, as Kashani-Sabet writes, "many medical professionals in Iran believed that 'clandestine abortions are frequent,' especially in urban areas" (196).
[38] These laws can be found, in Persian, on the Iranian Parliament's website, "Qānun-e Tarz-e Jologiri az Bimārihāy-e Āmuzeshi va Bimārihāye Vagirdar."

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monarchy here attempted to safeguard the trust between patients and their medical providers. During World War II, the Pahlavi monarchy's parliament passed several important laws regarding patient care secondary to the sexually transmitted disease crisis.[39]

But what of medical malpractice? What were the methods employed by patients and their aggrieved families during World War II? The medical landscape differed from town to town, depending on the medical culture preceding the reforms. In the 1930s, some areas saw the rise of physicians distinguishing themselves from pharmacists, offering prescriptions rather than mixing drugs themselves.[40] This differentiation of responsibilities invariably affected malpractice cases. Was the patient given a faulty prescription by the physician, or would the prescription have been effective but for an incompetent pharmacist? Indeed, medical malpractice cases revolved around these very issues as investigations exhaustively examined each link in the chain to determine the practitioner at fault.

In one such investigation, in 1944, a patient had been given the wrong medication, and investigators were tasked with discovering the responsible party. To accomplish this, the judiciary hired a doctor to evaluate the materials. After interrogating the deceased patient's son about whether or not he might have harbored ill will toward his father, the investigators turned their attention to the pharmacist and physician.[41] Someone had either prescribed the wrong medication or mislabeled a bottle. The patient's physician, eager to lay the blame at someone else's feet, told the authorities that the pharmacist had not given the patient the laxatives prescribed. The doctor working with the judiciary assessed the bottle, in the possession of the deceased patient's family, and agreed with the patient's physician. The pharmacist had "negligently and carelessly" given the patient a poison, "contrary to the duty and order" of the patient's doctor.[42]

Frustrated relatives were not the only people inviting state officials into their lives to better monitor medical practitioners. By the mid-twentieth century, not long after World War II, the absence of medical malpractice standards had created a bureaucratic crisis and local authorities complained about the failure of the central state and provincial governors to address medical providers practicing illegally. In 1950, over two decades after Dr. Alikhān was reprimanded for worsening the illness of a ten-year-old girl, the mayor of Ahwaz received public complaints that unlicensed pharmacists had not been arrested, despite the fact that their identities were known to law enforcement.[43] The mayor, frustrated that the police refused to act, took his concerns to the governor. The governor responded quickly, informing the city that the province's Ministry of Health had already given the police the right to arrest the pharmacist.[44] By mid-January, nothing had changed and the mayor's office sent another disgruntled letter to the governor.[45]

Now, more animated by the issue, the governor wrote a letter to the province's Ministry of Health, stating that some pharmacists in the city practiced "without a license" and other licensed pharmacists "hire[d] people without information or without licensure."[46] Although the Ministry of Health's response is unknown, this exchange illustrates a problem with the enforcement of licensure laws. The Ministry of Health permitted the police to address the problem but the police had not; what recourse did the mayor, governor, and Ministry of Health have? Why was there a dereliction of duty by law enforcement, particularly given the pressure from the mayor's office and the governor's office? Why did the city's chief prosecutor fail to press charges? Federal law did not yet exist to deal with these issues, leaving local law enforcement some leeway. The police had clearly made the decision to ignore state

[39] Ibid.

[40] Good, *Heart of What's the Matter,* 59.

[41] Investigative transcript, 1956, no.3, National Library and Archive of Iran (hereafter NLAI).

[42] Investigative notes, 1956, no. 5, NLAI.

[43] Letter from the City of Ahwaz to the Police, November 1950, NLAI, 293/050775/0003.

[44] Letter from the Governor of Province Six (Khuzestan), November 28, 1950, NLAI, 293/050775/0007.

[45] Letter from the Mayor's Office, January 15, 1951, NLAI, 293/050775/0009.

[46] Letter to the Ministry of Health, January 22, 1951, NLAI, 293/050775/0007.

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pressure and allow the pharmacists to continue operating. Apparently, the chief prosecutor made a similar decision, although local authorities leveled their frustration at the police rather than the prosecutor.

Why did the police ignore the mayor, the governor, and the Ministry of Health? The problem of pharmacists practicing without a license, as well as licensed pharmacists hiring unlicensed pharmacists, suggests a supply-and-demand problem in the medical landscape of the 1950s. With a high demand for, but low supply of, pharmaceuticals and pharmacists, perhaps an understanding emerged between local law enforcement and pharmacists that a shakedown would too dramatically alter access to care. This is speculation, but it is useful to consider whether the pressures of public access to medicine might influence law enforcement's application of federal laws in the days before local medical boards were mandated by Tehran.

Consider the fact that Ahwaz did not have a medical program at all until 1957, resulting in a small number of hospital beds and medical residents in the city.[47] Furthermore, in 1960, although there were 272 teaching hospital beds in Ahwaz, none were in use "because no students have reached the clinical year,"—this compared to 2,100 teaching hospital beds in Tehran.[48] Just as the Ministry of Health invested more in Ahwaz, the capital city of Khuzestan, the province itself had undergone a population explosion due to the discovery of oil in its southwest corner. In fact, the three cities with the greatest population growth due to immigration, according to the monarchy's 1956 census, were Abadan (the oil-rich city of Khuzestan, with 52 percent of the population claiming non-native status), Tehran (with 48 percent of residents stating that they had immigrated to Iran's capital), and Ahwaz (with 45 percent non-native residents).[49] In this context, it is no wonder that locals appealed to unlicensed practitioners: they would have had few options in this rapidly urbanizing environment, with only a few European-trained physicians available.

In this marketplace, the patients competed for care, and unlicensed practitioners did not have trouble finding those in need of curatives. Not only did these providers offer patients care they were familiar with, but they likely also spoke local dialects and appreciated the cultural norms of their patients when describing the medicinal properties of their drugs. This was likely an even greater comfort in a rapidly developing environment like Ahwaz, where many had recently settled, with their own traditions of health care and medicinal preferences.

In May of 1960, the parliament took a radical step toward standardizing medical malpractice laws by creating Nezam-e Pezeshki (a medical order), with the "authority for maintaining the dignity and progress of medical affairs and regulating professional relations between doctors and protecting the rights of the people."[50] In December of 1960, the Iranian Parliament passed a law that described the way in which provinces should handle malpractice suits, privileging civilian doctors to make evaluations of cases. "The medical system must have a central board of directors and in the center of each city, which has established such a board, a head for that board will be selected." This board would administer the laws locally, making recommendations to their province's Ministry of Health about what should be done about cases of malpractice.[51] Any town with more than twenty-five medical professionals and dentists was obligated to organize this Nezam to oversee the profession, with a focus on the treatment of patients in its jurisdiction.[52] The state mandated that the representatives be thirty-five years or older, with at least ten years of experience in the field, and the head of the Nezam could not serve for longer than three years, ensuring the

[47] *Conference on Teaching*, 269.
[48] Ibid., 270.
[49] Bharier, "Growth of Towns," 57.
[50] Vahman, *Majmu'eh*, 368.
[51] "Qānun Raje' be Nizam-i Pezeshki."
[52] Vahman, *Majmu'eh*, 369–70.

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participation of many members of the profession in the legal apparatus addressing medical malpractice.[53]

One case below illustrates an investigation by a local board. These investigations, which were a mechanism for physicians and dentists to police their profession, were critical in building trust between patients and practitioners. In the cases I have examined, the board's attention to detail revealed improprieties beyond the accusations leveled by a patient's family, proving their concern with maintaining the reputation of their profession. These practitioners had been selected by members of their own profession in their place of practice and appeared invested in maintaining their reputation and the reputations of their colleagues.[54]

Separately, the parliament also decreed the formation of a disciplinary council "composed of the provincial prosecutor, and at the head of the forensic medical department, five doctors and one dentist who have twenty years of experience" in their field as well as one elected member of the medical board. Following a statement of liability from the Nezam, the disciplinary council would adjudicate the case and produce a letter of recommendation to the prosecutor, who would then decide whether or not to press charges.[55] Prosecutors, therefore, interviewed patient families in the cases of patient deaths. Leaving no stone unturned, prosecutors examined family dynamics to ensure that the family member raising concerns had not themselves purposefully administered the medication incorrectly, thereby evaluating anyone who had interacted with the aggrieved patient.

The laws of the Pahlavi period, however, did not offer a standard for prosecution. Nevertheless, the parliament did establish prison time and fines associated with certain crimes. In May 1969, the parliament issued a series of laws that could be considered best practices. For instance, article 1 demanded that medical providers offer care to anyone, regardless of their nationality, race, or faith. Article 2 stated that medical providers should act in good conscience. Article 3 demanded provider discretion. Article 7 enjoined providers from causing panic in their patients. Article 8 insisted that physicians not prescribe medication that might cause addiction unless the medication proved absolutely necessary. Article 28 emphasized the necessity of national registration.[56] This did not establish the legal framework for prosecution since that responsibility lay with the municipal prosecutor; instead, these laws gave medical boards, the Nezam, and the disciplinary council a framework for selecting members and engaging with other state departments in the case of legal liabilities subsequent to poor care from a member of the profession in their jurisdiction.

By establishing a licensure and certification framework, the Pahlavi monarchy attempted to bring medical providers under state purview. These medical boards provided an added benefit to seeking care with Western-trained practitioners. If something should go wrong, there was recourse: a panel of experts who could evaluate the care the patient received. Paul Starr writes that, in the American context, these medical boards protected their colleagues, making it "almost impossible for patients" to win their cases.[57] In Iran, on the other hand, there seems to have been more accountability; the archives capture many instances of physicians who lost their cases, and newspapers describe zealous prosecutors, eager to take up cases when medical negligence appeared likely.

Medical boards, composed of a rotating group of local doctors selected by local practitioners, evaluated possible cases of malpractice and worked with the local prosecutor if a medical professional seemed liable. There was, of course, the danger of corruption, as some towns had a small number of practitioners, all of whom would have likely served on the medical

[53] Ibid.

[54] Ibid.

[55] Ibid.

[56] Ibid., 373–77.

[57] Starr, *Social Transformation*, 111.

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board at some point in their careers. Despite these challenges, patients sought out the support of authorities who could address their concerns; far from being passive subjects, patients advocated for their interests by engaging with these local medical boards.

One wonders how these patients learned about the medical boards. Were they referred by a lawyer? Did the practitioner recommend the cases be investigated to clear his name? What was the order of operations that led from a medical incident to an investigation? We do not know these details for the cases I review in this section, although I believe the archives may shed light on some of this information. Newspapers from the late 1970s suggest that the families of aggrieved patients could directly approach their local police departments or their city's prosecutor's office, who would begin the technical process of investigating the cause of death and the liability of the provider with the local medical board and coroner.[58]

Some cases gained the attention of lawyers and the court system, and some, inevitably, did not. Although we do not know why some cases were examined and others ignored, one particular case from a province in northern Iran sheds light on the local approaches adopted by patients dealing with medical malpractice. In 1966, a young boy in the city of Gorgan died under the care of a doctor. His father, Seyyed Bābā Bani Hāshem, had taken his son to Dr. Homāyun for severe diarrhea. The boy died under the doctor's care and Seyyed Bābā Bani Hāshem leveled a suit against the doctor, claiming that the vaccine administered to his son caused his death. The case was handled by one Mr. Niābati, the head of the board of physicians of Gorgan, and reviewed by a panel of doctors who agreed that the boy was fatally ill, and that the vaccine was not the cause of his death.[59] The families of patients advocated on behalf of the aggrieved, demonstrating the involvement of Iranian families not only in seeking out medical care but also in attempting to redress practitioners following a poor outcome.

The same board, investigating a different case regarding Shahr-Bānou Gholami, illustrates the limited jurisdictions of the local boards of physicians, however. A patient from Gorgan, who had been administered penicillin, had filed a lawsuit against the practice. The board had discovered that the person injecting the shot was untrained. In a letter addressed to Gorgan's Ministry of Health, the board explained that Dr. Ghofari, who lived in Shah Pasand and worked outside the board's jurisdiction, should be investigated for hiring an unlicensed person to administer a shot.[60] This case, handled as recommended by the 1960 national law, demonstrates the thorough investigative procedures of physicians, eager to reprimand incompetence to maintain the reputation of their profession, but careful to allow the appropriate regional board to address the issue. The problem local residents in Ahwaz observed, that of unlicensed pharmacists, represented the concern of the panel evaluating Shahr-Bānou Gholami's case. Despite the fact that penicillin had not necessarily caused an issue, the board recommended penalizing the practice that had hired the unlicensed nurse.

These thorough examinations do not necessarily reflect patient complaints (the patient, in this case, did not know the nurse might be unlicensed); instead, they reflect professional pressures to maintain the reputation of physicians, dentists, and nurses. Early on, the state had focused on licensure laws to give Western-trained medical practitioners a privileged status in the emergent medical marketplace of the twentieth century; medical boards continued to invest in upholding the privileged status of licensed providers, redressing those who operated outside the bounds of legality.

It was in the best interest of the medical boards, I believe, to work in conjunction with patients to create a safer and stronger network of providers.[61] Similarly, the press

[58] "Dāruye Ghabl az Aksbardāri-e Rangi-e Dokhtari ra beh Koshtan Dād," 30; "'Aleyheh Seh Pezeshk E'lām-e Jorm Shod," 22; "Tazrīgh-e Penicillin," 30.

[59] Letter from Governor's Office of the Province of Gorgan, September 1966, NLAI, 293/071511/11.

[60] Ibid.

[61] Paul Starr echoes this in his assessment of the utility of medical malpractice suits for providers themselves; *Social Transformation*, 13.

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cooperated with patients to better the field of medicine by drawing attention to the incompetence of hospitals and doctors. Journalists took up patient cases, sharing their stories with the general public; these stories were, of course, sensationalized, but also demonstrated a capacity to openly question the faith the public should place in doctors, and often demanded reforms to improve access to care. Although I will delve into these cases to a greater degree in the conclusion as evidence of another venue for patients to express their agency and make their voices heard by providers, it is of note that doctors appreciated that public opinion could be swayed to distrust their care.

In 1965, the daily newspaper, *Keyhān*, published a piece criticizing a hospital for the death of a patient who had arrived at their facility in critical condition. One of the head physicians was on a government-mandated vacation that night, and the newspaper had implied that the incident took place under his supervision. Alarmed by the effect this might have on his reputation and patient confidence, he wrote to the state, providing the dates of his vacation and insisting officials reach out to the journalist at *Keyhān* to clarify that the patient had not died under his care.[62] Popular media, in this story as well as many others, advocated for the patient, whereas the physician, eager to find favor with the public, refuted the claims made by the journalist to prove his commitment to his patients.

Journalists, the judiciary, local and national medical boards, public health experts, and patients all cooperated to uphold a higher standard of care in the health-care industry. Medical malpractice cases invited patients into the practice of medicine. In most cases the families of aggrieved patients advocated on behalf of a deceased patient, actively shaping the local medical community's engagement with particular physicians and pharmacists. Furthermore, physicians were eager to curry favor with their patients, appreciating that their personal reputations mattered in their local communities; without good standing, they would not be trusted and sought out for their services. The patient-provider dynamic therefore cannot be characterized as purely top-down, with the provider civilizing the patient. The state opened an avenue for the patient or the patient's family to address errors made by medical professionals—and medical professionals encouraged a discourse with their patients, taking an interest in non-Western forms of medicine.

Tradition

Historians often characterize herbs as traditional medicine. These were associated, by early nationalists, with the superstitious female influence. Physicians and pharmacists represented the modernizing agents who, "in cooperation with the state, sought to employ biomedical science to tackle social problems, strengthen Iran, and recast it into a united, fit, modern society."[63] This emphasis on the state's power to regulate citizens and the body benefits from the rich literature on the power states have exerted on the human body and populations, developed by scholars like Ian Hacking, Sheldon Watts, and Thomas Lemke, who have built on and complicated Michel Foucault's contributions.[64]

As the editors of *The Gray Zones of Medicine* note, however, it is inaccurate to describe Western medicine as wholly separate from other epistemologies.[65] In fact, Western authors and modernizing agents, just like Iranians, actively expressed an interest in natural curatives. Historians of nineteenth-century Iranian medicine, like Willem Floor and Hormuz Ebrahimnejad, emphasize the ways in which Iranians influenced pharmacists and doctors who attempted to address the maladies of their patients. "The new generation of [Iranian] medical students preferred to study Western medicine. Moreover, some of the European

[62] Letter to the Governor of the Province of Nur from the Physician of the Hospital of Chamestan Nur, May 30, 1965, NLAI, 293_076135_0007.

[63] Schayegh, *Who Is Knowledgeable Is Strong*, 2.

[64] Hacking, "Biopower," 279–95; Watts, *Epidemics and History*.

[65] Armus and Gomez, *Gray Zones*, 6.

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teachers did not reject Islamic-Galenic medicine blindly and totally."[66] Far from a hegemonic application of Western medicine in Iran, Floor demonstrates that, due to the demands of Iranian patients, European practitioners adjusted their medical training to better equip Iranian doctors with the skills to treat their patients.

This was not only true of nineteenth- and early-twentieth-century European physicians and researchers, however. David Hooper, the leader of Chicago's Field Museum Anthropological Expedition in the Near East in 1934, examined herbal "specimens . . . [from] the native markets of Tehran and Isfahan" and studied their functions. Erich Schmidt practicing in Ray, Iran, and Walter Kennedy at the Royal College of Medicine in Baghdad, Iraq, assisted Hooper's medical analysis of the herbs. Hooper also recruited a Jewish doctor from Isfahan, Mirzā Muhammad Alikhān, a "ninety-five-year-old" who "dictate[d] his prescriptions . . . for various ailments." Hooper demonstrated Alikhān's credentials not through his educational pedigree but his heritage: "His father, several uncles, and his grandfather were medical practitioners using the oral tradition and two large handwritten volumes of prescriptions."[67] For Hooper, medicine was not only received knowledge from institutions of higher education but also inherited knowledge transmitted from father to son. Europeans and Iranians alike stated that the demands of patients for herbal cures, which they purchased in bazaars, caused the medical community to examine these medicines. Meticulous in detail, Dr. Hooper recorded the many natural cures for ailments that ranged from constipation to rheumatism.

Many of these cures, however, were superstitions (*khorāfāti*) and highly localized. Abu Turāb Nafici, who headed Isfahan University's Institute for Research in Traditional Medicine in the 1980s, recorded notes as a young physician working in a public health clinic in Isfahan between 1941 and 1946, only a few years after Hooper's expedition. Under the title Examples of Superstitions and Medical Ideas in Iran, he writes his observations from the period, including, among other things, the belief that eye infections could be cured by extracting tears from a young Seyyed or that needle pricks cured ailments.[68] Historians writing in the West, referring to the source material recorded by Iranian physicians in the Pahlavi period, have been critical of these practices, emphasizing the most unusual and illogical traditions.

Although the tears of a young Seyyed might not have appeared compelling to a scientist, there were certain local curatives that physicians considered worthy of study. Consider, for instance, 'Abd Haghir Nāsir bin Ahmad, "nicknamed Nāsir al-Atba', the pharmacist of the whole system" due to his role in the pharmacy inspection task force and his successful book, *Jang-e al-Advieh*. He encouraged patients to seek out those knowledgeable about spices and herbs so that they did not cause themselves harm. The text, published in 1940, would be released in two more editions, one in 1944 and the next in 1952.[69]

Nevertheless, despite the draw of traditional curatives, by the 1940s, the country had been flooded with chemicals from Western companies to address dysentery, gout, inflammation, and bacterial infections.[70] These companies, however, regularly complained about late payments, or sometimes nonpayment, for the goods they had shipped.[71] Even as the Ministry of Finance attempted to stabilize prices, Iranian pharmacies struggled to stock the basics,

[66] Floor, *Public Health*, 186.

[67] Hooper, *Useful Plants*, 73.

[68] Nafisi, *Pazhuhesh,* 50–51.

[69] Najmābādi, *Fehrest-e Ketābhāye Chāpi-e Fārsi*, 283.

[70] Letter from Wallace Pharmaceutical Products Ltd. to the Foreign Transaction Department, August 21, 1944, NLAI, no. 141607; Letter from the Washington Chemical Company Ltd. to the Foreign Transaction Department, August 11, 1944, NLAI, no. 141939.

[71] Letter from T. & H. Smith, Ltd., Blandfield Chemical Works, August 24, 1944, NLAI, no. 141616; Letter from the Foreign Trade Department to T. & H. Smith Limited, December 13, 1944, NLAI, no. 141442.

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including necessities like bandages.[72] There also were problems with the supply chain during and after World War II, as drugstores complained that the medicines they requested had not been sent by the National Institute for Pharmaceuticals.[73] The state created a commission to evaluate the needs of pharmacies around the country and distribute needed chemicals, equipment, and products to the people; the problem of shortages, however, plagued Iran, despite bureaucratic attention.[74]

The regular lack of resources caused many Western-trained practitioners to encourage the use and research of traditional curatives. Although historians of Iran describe a gradual transition from traditional to modern medicine at the turn of the twentieth century, in the 1930s, Iranian physicians continued to promote systematic studies of Iranian herbs to the public.[75] By the late 1960s, as I describe below, a professor at the University of Tehran, Ali Zargari, had published a comprehensive Persian-language study of herbal curatives—evidence that, through the twentieth century, there was a need to consider complementary medicines.

In fact, through the Pahlavi period, many physicians and pharmacists, both in the West and in Iran, expressed interest in studying the herbs that generations of testing had made famous as cures. Despite the increasing accessibility and (to some extent) affordability of care following the White Revolution, traditional curatives remained popular. Contrast the medical landscape in 1961, on the eve of the White Revolution, with 1977, on the eve of the Islamic Revolution. In 1961, the University of Shiraz held a conference, "Teaching of Preventative Medicine," organized by the Central Treaty Organization (originally the Baghdad Pact, comprised of Iran, Iraq, Pakistan, Turkey, and the United Kingdom), to examine public access to health care in Turkey, Iran, and Pakistan. According to Pahlavi records cited by the volume published following the conference, by 1959, 40.64 percent of hospitals were owned and operated by the Ministry of Health. About 13 percent were privately operated and "the remainder are operated by the government or semi-governmental agencies and voluntary organizations."[76] The official number of hospital beds in the capital province, Tehran, was 8,858 for a population of 3,246,341. For Khuzestan's population of 2,111,663, there were a total of 1,814 hospital beds.[77] (In other words, Khuzestan, with 65 percent of the province of Tehran's population, could offer residents only 20 percent of Tehran's number of hospital beds.)

Between 1953 and 1977, however, the number of universities quadrupled and the number of university students increased more than tenfold.[78] At those universities, "health programs increased the number of doctors from 4,000 to 12,750; nurses from 1,969 to 1,4105; medical clinics from 700 to 2,800; and hospital beds from 24,100 to 48,000." This led to a marked improvement in the effects of "famines and childhood epidemics," thereby raising "the overall population from 18,954,706 in 1956—when the first national census was taken—to 33,491,000 in 1976."[79] There is no question that many areas observed a tremendous improvement in access; still, some of those who had access to and could afford the health-care services did not place their entire trust in Western medicines, and instead complemented Western medical care with traditional curatives.

Iranians appealed to traditional medical providers because of need *and* preference. This was a noisy marketplace, filled with professionals who communicated their expertise in ways that appealed to the local population. As Stephanie Boyle writes of Tanta, the "city . . .

[72] Letter to the Office of Drug Procurement, June 7, 1944, NLAI, no. 22774; Letter from British Unicorn Ltd. to the Prince Stabilisation Centre of the Ministry of Finance, November 13, 1944, NLAI, no. 141417, no. 141708.

[73] Letter to the Ministry of Health from the Imperial Iranian Pharmaceutical Institute, March 8, 1945, NLAI, 31655/39725/15.

[74] Letter to the Department of Health, October 23, 1942, NLAI, no. 14164.

[75] Kashani-Sabet, *Conceiving Citizens*, 100.

[76] *Conference on Teaching*, 213.

[77] Ibid., 215.

[78] Abrahamian, "Structural Causes of the Iranian Revolution," 22.

[79] Abrahamian, *History of Modern Iran*, 134.

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drew a variety of local healers, mystics and sick people"; indeed, major cities drew the sick and the providers to care for them.[80] Rather than solely imagine the city as a hierarchical space, reinforcing modernity, I also imagine patients and providers in major cities (like Tehran, Tabriz, and Ahwaz) as "challeng[ing] modernist trends" by engaging "methods [of health care] that contradicted and often contravened" state-sanctioned medical practices.[81]

For many patients, these herbs and spices with medicinal properties would have been used in conjunction with other forms of medicine. Although patients would have sought out these traditional medicines regardless of the expense or accessibility of modern cures, of note is that chemical pharmaceuticals remained inaccessible to many well into the Pahlavi period. For instance, in December of 1967, *Ettela'at* lamented that patients could not access effective medications for their ailments due to unnecessarily high standards for the purchase and circulation of drugs from the West. The parliament demanded that every drug imported to Iran have a five-year history of use to determine efficacy. Furthermore, a 1954 law fixed the prices of medication, preventing many patients from purchasing drugs that were plentiful, had a long history of use, and had decreased in price over time.[82] Therefore physicians and patients approached the options available to them, including traditional cures. There might have been some ideological prejudice against these cures in nationalist circles, but I believe that physicians were far more concerned with their patients' access to and comfort with medications to address illnesses.

In 1969, employing far less political and nationalist rhetoric than later texts on the subject, Ali Zargari, a professor at the University of Tehran, published *Herbal Medicines*, emphasizing the understudied medical uses of herbs and plants. According to Reza Owfi, Zargari's five-volume series represents "the most comprehensive investigation of the use of medicinal plants" from Iran.[83] "Due to the abundance of medicinal plants in our country, their lack of identification has led to not enough effort to use them," Zargari wrote in the opening of his detailed compendium, complete with beautiful hand-drawn images of various plants, herbs, and flowers used for ailments.[84] Ali Zargari won the Royal Prize for books in the early 1950s and, through his support of this line of inquiry, offered credibility to herbal curatives. For Zargari, this interest derived not from the historical, nationalistic, or universalizing values of herbal medicines; he wrote that the chemicals imported into the country may not have been well-prepared, and native plants could offer people immediate treatment.[85] In other words, an absence of one type of treatment necessitated some engagement with other forms of curatives, which rural Iranians had a vested interest in. Zargari set out to account for all the available options that grew naturally and were readily accessible to providers and patients.

Clerics as well as international physicians also threw their weight behind local practices and beliefs that fruits, minerals, and herbs had curative properties. As Ebrahimnejad writes, historically, the "[p]ractice of medicine by clerics was not rare in Iran."[86] Thus, it is not surprising that the clerics questioned modern medicine, given the initial rumblings about "European" science in the early Pahlavi period.[87] Although this article emphasizes the role of patients and Western-trained medical practitioners, the clergy proved influential in medical discourse, as they were in other areas of public and private life that experienced rapid modernization.[88]

[80] Boyle, "Saints and Doctors," 3.
[81] Ibid., 4.
[82] "Dārū va Moshkelāt-e Ān," 7.
[83] Owfi, *Natural Products*, 1.
[84] Zargari, *Giah-han-e Daruyee*, 1.
[85] Ibid.
[86] Ebrahimnejad, "Religion and Medicine in Qajar Iran," 409.
[87] Good, *Heart of What's the Matter,* 56–57.
[88] There is a robust corpus of literature on the topic of clergy and their role in shaping the discourse on modernity in Iran. Consider just a handful of these texts: Afary, *Sexual Politics*; Ghiabi, *Drugs Politics*; and Keddie and Richard, *Modern Iran*.

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There also was a noticeable international interest in studying Iranian beliefs about nonchemical curatives, explained by the transcultural nature of these traditional methods.[89]

For instance, the senior research officer in New Delhi's Ministry of Health and Family Planning, Hakim M. A. Razzack, and Ummil Fazal, the research officer of the Central Council for Research in Indian Medicine and Homeopathy in New Delhi, collaborated on their study of homeopathy in Iran during a visit in the spring of 1973. They studied the Yunani (Greek) system of medicine (or, as they alternatively called it, the "Traditional System") in various cities, including Shiraz, Isfahan, and Tehran.[90] In Shiraz, they asserted, "we came across a shop which was stocked with all the traditional herbs and the dealer told us that his customers were mostly from villages and about 25% were from cities."[91] The fact that most customers resided in villages does not necessarily mean that access to modern medicines corresponded with demand (i.e., that city dwellers had more access to modern medicine and therefore demanded fewer herbal curatives). We know that city dwellers also leaned on traditional curatives as their main or supplemental form of medical care. Nevertheless, it is meaningful to note that 75 percent to 25 percent does not proportionately represent the demographics of 1973 Shiraz, the capital of the province of Fars. In 1971, the census reported that 40 percent of the residents of Fars lived in cities.[92] More pertinently, if the herb dealer sold locally from a shop in Shiraz, over 90 percent of residents of Fars in *manāteq-e shahri*, or city districts, lived in the city itself rather than surrounding villages.[93]

The Indian doctors expressed delight about the continued interest in herbal medicines and insisted that practitioners trained in Western methods of medicine take herbal cures into consideration. Despite the Pahlavi monarchy's "best efforts, . . . medical aid is yet to reach all the people, especially the rural population" and, in place of modern pharmaceutical care, they argued, Iranian doctors owed their patients a serious examination of cures that were readily available to rural people.[94] Razzack and Fazal wrote that this assessment reflected the opinions of Iranian physicians and pharmacists: "almost all doctors whom we had the privilege to meet [sic] felt the necessity of immediate establishment of a pharmacy which could manufacture medicines out of Herbs."[95] In other words, the doctors suggested standardization of these services, subjecting them to licensure and thereby bringing them under the purview of the law, making them liable to malpractice, and in turn making them more legitimate players in the medical marketplace.

This integration of traditional medicine, as in places like China, would mean "improved" study of these curatives "by modern scientific methods and technologies." However, these proponents of traditional medicine also implied that non-Western "and Western medicines each had advantages as well as disadvantages in treating certain specific health problems," meaning that the two approaches could complement each other to offer patients a systematic and holistic approach to the maintenance of their health and curing of their ailments.[96]

In this way, far from dismissing "traditional systems" of medicine, Iranian practitioners assimilated local and Western forms of medicine to best respond to the needs of their patients. European practitioners, in fact, did not dismiss the contributions of traditional medicine. Instead, twentieth-century doctors and pharmacists were sensitive to the uses of herbs, and some actively engaged with herbs and spices in their practices. This was

[89] Nie defines transcultural bioethics as "rooted in particular cultural experiences" while also "transcend[ing] their limitations by following the dictates of ethical ideals and moral imperatives"; *Medical Ethics*, xvi.

[90] Razzack and Fazal, "Report," 3.

[91] Ibid., 9.

[92] Vezārat-e Kār va Omur-e Ejtema'ee, *Natāyej-e Āmārgiri-e Niru-e Ensāni*, 1.

[93] Ibid., 4.

[94] Razzack and Fazal, "Report," 13.

[95] Ibid., 17.

[96] Guo, *Ginseng and Aspirin*, 62–63.

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not an aberration or an open admission of failure by the medical establishment, but a dynamic program for integrating various systems of knowledge.

Conclusion

In the late Pahlavi period, access to medical services expanded, but many continued to feel skeptical about the care they received and the investment their physicians made in their well-being. Although this article emphasizes medical malpractice lawsuits and the use of traditional medicine during the Pahlavi period, these were far from the only ways that patients asserted themselves in modern medical spaces. As alluded to earlier, patients appealed to the press for support when they felt that they received subpar care. In fact, the press represented a venue in which the public could express their concerns and physicians could defend themselves, allowing a dialogue and possible resolutions to emerge.[97]

The reforms of insurance policies in 1966 presented new problems with access to care, failing to offset the spectacular increases in costs.[98] By the late 1970s, the press regularly reported on the problem of high doctor's fees and the absence of a national health-care system to properly address rising costs. Instead, many argued, the Ministry of Health adopted sometimes arbitrary rules that hurt patient care and did not offer coverage to all citizens, leaving many without recourse when confronted with a life-threatening event. Letters to the editor and responses by physicians filled the national newspaper and informed a debate about health-care in the months before and after the Islamic Revolution.[99]

In July of 1978, a father wrote to *Ettela'at* a detailed description of the medical care his son received. Following a serious head injury at a local park, the father, Assadollah Mir Shafi'i, rushed his fourteen-year-old to the hospital. "The first question he [the doctor] asked was if the patient had insurance, and because the answer was in the negative, he said for the stitches . . . 400 tumans must be paid [immediately]. I did not have the necessary money at that time and the doctor was unwilling to proceed without payment, and my pleas did not matter." With his son losing blood quickly, he rushed to a different hospital, which asked for 150 rials (with ten rials to the tuman, this amounted to less than 4 percent of the cost of the first doctor). Due to the delayed response time, his son suffered more long-term damage from the head trauma and blood loss. "It's unfortunate that some doctors exchange emotions and love for humanity with money and the death and life of human beings have no value to them! If my child had, in that moment, died, this doctor would not have seen himself as responsible, either from a legal perspective or in the court of public consciousness, and is the value of a human life really 400 tumans?"[100]

The story that began this article, the case of a ten-year-old girl whose parents questioned the competence of the pharmacist caring for her, is different from this one, of course. There, the parents had recourse, appealing to another pharmacist and later cooperating with the police; here, the aggrieved father struggled with the refusal of care and the subsequent absence of legal recourse. At their heart, however, they are both stories of parents advocating for their children and finding venues that will listen to them. In other words, patients and their families advocated for themselves in a variety of ways, inserting their demands into the practice of medicine and, in the late 1970s, the modifications in health insurance.

Whether the problem was poor hospital hygiene, incompetence in surgery, the arbitrary cost of doctor's visits or pharmaceuticals, the types of curatives systematically studied, or the inaccessibility of care, patients and community members made their voices heard.[101]

[97] "Risheh-hāye Su'e Tafāhom," 6.
[98] "Bāzār-e Āshofteh Dāru va Darmān," 21.
[99] For more on the topic of health care in the Islamic Republic, see Harris, *Social Revolution*.
[100] "Be Mattab-e Een Pezeshk!" 23.
[101] Stories of poor hospital hygiene were common, and not limited to aggrieved patients and their families. At times, residents of a community near a hospital wrote to newspapers to complain about the poor practices of

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Sometimes these efforts were successful, with the Ministry of Health addressing concerns by amending laws, and sometimes the patients and members of the community were unsuccessful, losing their medical malpractice cases.[102] Ultimately, however, patients shaped the practice of medicine throughout the Pahlavi period and would continue to do so after the revolution. Although Western medicine represented one of the pillars of the modern nation–state, people from humble backgrounds with no medical training expressed their needs and traditions to practitioners, journalists, and the state.

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