The Journal *of* Medicine, Law & Public Health (JMLPH)

ISSN (P): 2788-9815
ISSN (E): 2788-791X

JM
L&P
HEALTH

Vol. 5 No. 3 (2025): Jul-Sept

Submitted: 23/10/2024
Accepted: 08/03/2025
Published: 25/04/2025

A Competition Law and Medical Ethics Analysis of the Medical Discipline in Iran

Ahad Gholizadeh Manghutay
Department of Law, University of Isfahan, Iran.

Article Link:
https://www.jmlph.net/index.php/jmlph/article/view/161/version/161
DOI: 10.52609/jmlph.v5i3.161
Citation: Gholizadeh Manghutay, A. A Competition Law and Medical Ethics Analysis of the Medical Discipline in Iran. The Journal of Medicine, Law & Public Health, 5(3), 660–670. https://doi.org/10.52609/jmlph.v5i3.161
Conflict of Interest: Authors declared no Conflict of Interest.
Acknowledgement: No administrative and technical support was taken for this research.
Copyright: The Author.

Licensed under a Creative Commons Attribution 4.0 International.

E-mail: Gholizadeh@ase.ui.ac.ir

A Competition Law and Medical Ethics Analysis of the Medical Discipline in Iran

Ahad Gholizadeh Manghutay

***Abstract*— From a legal perspective, competition can be disrupted through various mechanisms including conspiracy, individual actions, interlocutory management, and corporate mergers or acquisitions. In the context of the Iranian medical guild's operations, numerous instances potentially constitute competition disruption, including price fixing, market division, supply limitations, third-party referrals, supplementary undertakings, and various individual anticompetitive actions such as compulsory sales, misleading statements, non-standard service provision, and dominant position abuse. This research identifies a significant power imbalance between medical service providers and consumers. The analysis demonstrates that coordinated activities between the medical disciplinary organisation, Ministry of Health, medical sciences universities, insurance companies, and related entities have resulted in the medical profession occupying a position of economic dominance that transcends standard regulatory frameworks. The medical guild's self-regulatory authority represents a significant deviation from standard competition principles. To address these competition issues, restructuring of regulatory oversight through dissolution of the current self-regulatory framework and realignment with standard guild disciplinary mechanisms is proposed.**

***Index Terms*— Competition Law; Conspiracy; Medical Disciplinary Organisation; Medical Ethics; Ministry of Health; Monopoly.**

I. INTRODUCTION

The 2019 incident in ChenarMahmudi village of Chaharmahal va Bakhtiari province, where more than two hundred residents, including children, contracted HIV, exemplifies the significant power imbalance between healthcare providers and patients within the Iranian healthcare system. The incident, initially attributed to a clinic's medical aide who was subsequently accused, was later characterised by the relevant ministry as resulting from "individual and tribal immorality," thereby demonstrating the institutional challenges faced by individuals when confronting established medical authorities. This case illustrates the systemic disparities between healthcare consumers and providers, particularly when the latter are supported by both ministerial authority and an influential medical disciplinary organisation [1, 2].

Recent years have witnessed multiple phenomena that warrant examination through the lens of competition law, including the substantial increase in elective caesarean procedures [3], cases of infected haemophilia patients [4], instances of patient discharge due to financial constraints, utilisation of patients as medical education subjects [5], and the marginalisation of traditional practitioners [6]. The extent to which patients can effectively assert their rights within a system where healthcare providers maintain significant institutional advantages presents a fundamental question for legal and ethical analysis.

This research represents a novel approach in analysing the Iranian medical system, as previous scholarly work has primarily focused on anticompetitive practices in the pharmaceutical industry [7], the general role of competition law in public health [8], or the foundations and challenges of competition law in the health sector [9, 10]. Unlike previous studies, this research specifically examines the medical guild's position and practices within the competition framework, with particular attention to the institutional structures that potentially enable anticompetitive behaviours.

II. COLLUSION TO DISRUPT COMPETITION

The Iranian Competition Act, as in Common Law [11], operates as a comprehensive regulatory framework that encompasses all economic sectors without differentiation between public entities, including the Ministry of Health and Medical Education; non-governmental organisations; cooperative ventures; and private institutions, such

Ahad Gholizadeh Manghutay (gholizadeh@ase.ui.ac.ir) is with the Department of Law, University of Isfahan, Iran.
DOI: 10.52609/jmlph.v5i3.161

as the medical discipline organisation (a quasi-autonomous non-governmental organisation with governmental affiliations). The legislation functions as a general competition law rather than being limited to commercial competition [12], thereby extending its jurisdiction to non-commercial economic actors within the healthcare sector [9].

Within this legal framework, collusive practices are defined as those that impede market competition through any of the seven specific violations enumerated in Article 44 of the Iranian Competition Code. While the legislation does not explicitly define "disturbance of competition," jurisprudential interpretation suggests it encompasses any unjustifiable interference with the economic activities of other entities, whether within the same professional domain or across different sectors. Activities such as artificial cost inflation and price manipulation constitute clear examples of competitive disturbances [9], as they contradict the fundamental objective of competition law: ensuring consumers (in this context, patients) receive goods and services of optimal quality at minimal cost [13].

The regulatory jurisdiction over anticompetitive practices is distributed according to the market position of the involved parties. The Competition Council maintains authority over cases involving collusion between wholesalers or between wholesalers and retailers, while the State *Ta'ziraat* (Punishment) Organisation oversees cases involving solely retailers [10]. Notably, the Competition Council may also assume jurisdiction over retailers' anticompetitive activities in exceptional circumstances. Healthcare providers, including medical practitioners, operate predominantly as retailers in direct transaction with end consumers, despite contrary perspectives. The enforcement mechanisms within competition law incorporate both civil and criminal sanctions, establishing a robust regulatory apparatus rather than a merely advisory framework [14].

III. PRICE

The coordination between market participants, whether primary or secondary economic actors, in establishing prices for goods or services, or their collaboration in determining pricing methodologies, constitutes a prohibited practice under competition law when such actions disrupt market competition [15]. This principle, recognised in multiple jurisdictions including France [16], emphasises that pricing mechanisms should fundamentally operate through market forces of supply and demand rather than through predetermined arrangements. It is noteworthy that collaborative pricing practices among healthcare practitioners extend beyond mere retail-level collusion, potentially manifesting as systematic, industry-wide coordination with significant market implications.

Within the Iranian healthcare system, the medical discipline organisation maintains authority over the determination of medical service tariffs [10]. This arrangement facilitates collective action among diverse stakeholders in the healthcare sector, including physicians, the medical discipline organisation itself, the Ministry of Health, and insurance providers. The predominantly state-owned nature of Iranian insurance companies further embeds governmental influence within this pricing structure [17]. According to the statutory framework governing the medical discipline organisation, this entity was established as a singular professional association dedicated to protecting and advancing the interests of healthcare practitioners [18]. Consequently, the organisation's authority to establish pricing structures for medical services on behalf of healthcare consumers presents a fundamental conflict of interest that lacks reasonable justification.

Empirical observation suggests systematic underservice by medical practitioners who, in coordination with regulatory bodies, classify standard medical conditions as "epidemics," thereby justifying abbreviated patient consultations averaging approximately five minutes per encounter [19]. Clinical experience indicates that effective diagnosis and treatment typically requires consultation with multiple specialists, necessitating substantially more comprehensive medical engagement than current practices provide.

IV. AMOUNT AND CONDITIONS

The analysis of market supply constraints in the Iranian healthcare sector reveals a significant dichotomy between pharmaceutical and clinical services. While the deliberate restriction of pharmaceutical products, particularly specific medications, operates primarily through black market mechanisms, there appears to be limited empirical evidence of systematic collusion to restrict the overall volume of medical services available to consumers. This distinction merits

E-mail: Gholizadeh@ase.ui.ac.ir

further investigation within the competitive framework.

Discriminatory practices in healthcare service delivery constitute a substantive impediment to market competition. The phenomenon of informal payments, colloquially termed "undertable payments" and functionally equivalent to bribery, represents a widespread mechanism for preferential treatment within clinical and hospital settings. This practice systematically undermines equitable access and introduces discriminatory outcomes among healthcare recipients. Similarly, preferential treatment based on personal relationships ("Relationship") operates as an additional mechanism of market distortion.

The consequences of financial non-compliance within the healthcare system can manifest in severe clinical repercussions. Documentation in national media reports indicates cases where patients who failed to meet financial obligations were abandoned without appropriate care. A notable case involving a paediatric patient from Khomeini Shahr reportedly resulted in the premature removal of surgical sutures as retributive action [20]. While financial indebtedness for medical services does not constitute a legal violation, the premature removal of sutures may be legally classified as wound re-infliction, potentially resulting in liability for compensatory damages under applicable regulations.

Certain discriminatory practices within the healthcare system operate under ostensibly legitimate legal or contractual frameworks, though evidence suggests these mechanisms often conflict with fundamental principles of equitable market access and fair competition.

V. REFERRAL TO THIRD PARTIES AND ADDITIONAL OBLIGATIONS

The practice of third-party referral within healthcare systems constitutes a recognised phenomenon in both Iranian regulatory frameworks and comparative Common Law jurisdictions, wherein a healthcare provider directs patients to specific affiliated practitioners through coordinated arrangements. This referral pattern manifests systematically across the Iranian healthcare sector, as evidenced by empirical observations wherein basic diagnostic procedures, such as lipid profile assessments, are rendered contingent upon physician authorisation despite lacking medical necessity for such gatekeeping [21].

The structural interconnection between primary and ancillary healthcare services facilitates coordinated referral networks that extend beyond individual practitioner relationships to incorporate institutional stakeholders, including insurance entities and regulatory authorities. This systematic referral ecosystem operates through formal administrative mechanisms, including standardised circulars and procedural directives that facilitate coordinated provider behaviours across multiple service levels.

The economic interdependence between physicians and ancillary healthcare services creates conditions wherein the financial viability of complementary practitioners becomes contingent upon referral patterns established by physicians. This relationship generates incentive structures wherein increased prescription of services and pharmaceutical products by physicians corresponds directly with increased utilisation of ancillary services, creating aligned economic interests among disparate provider categories.

Within clinical settings, service monopolisation strategies manifest through the imposition of unnecessary intermediary consultations for basic healthcare procedures, as exemplified by requirements for physician authorisation for routine procedures such as auricular hygiene maintenance. Conversely, physicians systematically direct patients toward specific ancillary service providers, including pharmaceutical dispensaries [22], while some practitioners internalise ancillary diagnostic services, such as electrocardiography, rather than referring to independent specialists [22]. This practice pattern extends to radiological diagnostics, wherein dental practitioners routinely prescribe unnecessary radiographic examinations that generate revenue while potentially imposing iatrogenic risk to patients through radiation exposure [23].

VI. DISRUPTING COMPETITION WITHOUT COLLUSION

The Iranian Competition Act establishes comprehensive regulatory parameters that recognise certain transactions, market conditions, pricing structures, and commercial behaviours as inherently disruptive to market competition, even in the absence of collusive arrangements between economic actors. This regulatory framework identifies several specific categories of unilateral conduct that constitute anticompetitive practices,

E-mail: Gholizadeh@ase.ui.ac.ir

including speculative market activities; misappropriation of undisclosed official information; improper utilisation of institutional positions; exploitation of proprietary competitive intelligence; and implementation of coercive sales practices.

The distribution of non-standard goods within markets where mandatory quality standards have been established similarly constitutes a recognised violation of competition principles. Price manipulation strategies, particularly predatory pricing mechanisms that establish market values below production costs, present significant potential for market distortion through competitor displacement. Additional prohibited practices include dissemination of false commercial statements; exploitation of dominant market positions; interference in competitor operations through infiltration of management structures, shareholder relations, or employee networks; unauthorised acquisition of proprietary information; and exertion of undue influence over competitor decision-making processes.

Within the healthcare context, several of these unilateral anticompetitive practices manifest distinctly within medical professional conduct, meriting particular regulatory scrutiny and enforcement consideration.

VII. FORCED SALE

The healthcare sector exhibits distinctive patterns of compulsory service acquisition that warrant analysis from a competition law perspective. These manifestations range from structurally embedded referral requirements to the mandated purchase of ancillary clinical services and pharmaceutical products. Empirical evidence suggests insurance coverage variables significantly influence clinical decision-making, with more comprehensive insurance plans correlating with increased diagnostic intensity and therapeutic interventions.

The implementation of the family physician program represents a significant policy intervention with notable competition implications. This systematic approach establishes mandatory financial contributions from all citizens regardless of health status or service utilisation, effectively creating a captive market. The execution of this program under the Health System Transformation Plan resulted in substantial increases in healthcare deductions from employee compensation, reportedly increasing sevenfold according to documented employment records.

Potentially harmful interventions frequently demonstrate patterns of non-discretionary provision within clinical settings. Diagnostic imaging modalities including radiography, computed tomography, magnetic resonance imaging, and laser-based interventions—all involving varying degrees of risk exposure—are reportedly prescribed beyond strict clinical necessity. In dental practice, routine radiographic examination appears systematically integrated into standard procedures without specialist oversight, despite established radiation exposure concerns [24]. Similarly, certain therapeutic interventions with significant risk profiles, such as chemotherapy, are reportedly positioned as primary treatment options despite their established position in clinical algorithms as interventions of last resort. The regulatory framework established by the integrated authority structure comprising the Ministry of Health, Medical Disciplinary Organization, and Medical Sciences Universities does not facilitate transparent data generation regarding these practices.

VIII. MISLEADING STATEMENTS AND SUPPLY OF NON-STANDARD GOODS OR SERVICES

The healthcare sector manifests significant information asymmetry that facilitates potential misrepresentation of clinical information. Empirical observations suggest diagnostic complexity frequently necessitates consultation with multiple specialists, with an estimated eight physicians typically required for comprehensive disease identification and management. This fragmentation potentially enables prolonged diagnostic processes that increase healthcare expenditure through both direct patient payments and insurance reimbursement mechanisms [25].

Healthcare institutions exhibit substantial economic dimensions that transcend traditional categorisation. The significant financial scale of hospital operations necessitated legislative adaptation through the Financial Convictions Act of 2014, which reclassified these entities under bankruptcy provisions rather than insolvency regulations due to the complexity of their asset structures. Educational concerns further compound quality issues, as medical training conducted in large-scale educational environments potentially compromises clinical competency development.

Notable examples of clinical error have been documented in high-profile cases, including reports of surgical misidentification resulting in inappropriate organ removal affecting prominent public figures.

As is common in Common Law [26], the regulatory framework establishes physician certification authority across multiple domains, including the issuance of medical leave documentation for employment and academic contexts. Misleading clinical communication may manifest through various mechanisms, including inaccurate testimonials and unrealistic prognostication. Marketing practices within healthcare networks employ sophisticated communication strategies through broadcast and print media that potentially combine factual and misrepresentative content [27, 28]. For instance, epidemiological claims regarding diabetes prevalence potentially create perpetual patient dependence due to the chronic nature of the condition.

Institutional practices regarding informed consent merit particular attention within healthcare facilities. Documentation processes frequently require comprehensive authorisation for interventions, with institutional responses to patient hesitation potentially emphasising adverse outcomes [28-30]. Research indicates extended hospitalisation correlates with decreased patient satisfaction, potentially reflecting inadequate recognition of patient autonomy within clinical settings. These practices raise significant concerns regarding equitable access to quality healthcare services and fundamental patient rights within the healthcare delivery system [31 & 32].

IX. ABUSE OF THE DOMINANT ECONOMIC POSITION

The medical sector demonstrates significant patterns of market dominance exploitation through institutional structures and operational practices. Empirical evidence suggests that the consolidated authority of medical institutions has facilitated self-regulatory mechanisms that potentially undermine standard competitive frameworks. This institutional arrangement manifested notably during public health emergencies, wherein decision-making authority remained concentrated within established medical hierarchies.

The pharmaceutical distribution ecosystem exhibits complex interconnections with broader healthcare governance structures. Self-medication practices, while representing natural adaptive behaviours among biological organisms, face systematic institutional constraints through regulatory mechanisms and information asymmetry. Concurrently, marketing communications regarding emerging medical technologies, including nanotechnological applications, potentially obscure comprehensive risk assessment in favour of demand generation [27].

Educational credential frameworks within the healthcare sector merit particular examination. The disproportionate allocation of advanced academic designations across healthcare disciplines potentially serves as a mechanism for establishing market differentiation beyond functional requirements. This phenomenon manifests particularly within pharmaceutical sciences, where doctoral credentials are conferred for competencies that empirical observation suggests could be developed through less resource-intensive educational pathways. These educational classification systems potentially function as economic positioning mechanisms rather than reflections of necessary clinical competency requirements.

Pharmaceutical manufacturing and distribution networks operate within highly concentrated market structures characterised by significant entry barriers and regulatory constraints [26, 33]. Competitive dynamics within this sector demonstrate patterns consistent with established European jurisprudence regarding monopolistic practices, as exemplified in landmark cases concerning proprietary pharmaceutical formulations [34] (for instance see the Teva Copaxone Case [35]). Recent regulatory interventions by competition authorities regarding market saturation provisions in pharmacy establishment regulations demonstrate evolving recognition of competitive distortions within pharmaceutical distribution networks [8, 36, 37].

The regulatory framework governing intellectual property within healthcare markets establishes significant potential for competitive distortion, particularly regarding pharmaceutical and biomedical engineering patents. Contrary to certain interpretations [38], the Competition Act establishes comprehensive opposition to monopolistic rights derived from intellectual property that potentially interfere with competitive market dynamics, including mechanisms involving royalty-free technology transfer that may constitute aggressive pricing strategies.

E-mail: Gholizadeh@ase.ui.ac.ir

X. SELF JUDGMENT

The medical disciplinary organisation, leveraging its dominant economic position and benefiting from legislative support provided by Parliament and the Expediency Council, has been designated as the primary authority for investigating disciplinary offenses within the medical field. This arrangement, contrary to competition law principles and common practices under Common Law systems [39], introduces a potential conflict of interest [10]. Critics argue that the organisation effectively serves both as claimant and judge in proceedings against physicians who allegedly fail to comply with its directives [18].

Although each of its primitive, revisionary, and supreme boards includes a judicial representative, this individual constitutes only one member among more than ten individuals on each board. Decisions are rendered by an absolute majority of participating board members, with meetings convened in the presence of two-thirds of the members. Therefore, decisions may be made without the involvement or agreement of the judicial member, which raises concerns about the adequacy of adjudication expertise among the board members. To enhance transparency and fairness, the inclusion of a proportionate number of patient or public representatives in these deliberations, as is customary in Common Law jurisdictions [39], is recommended.

Decisions by the judicial authority within the organisation are subject to appeal before the Administrative Court of Justice. While this offers an additional legal recourse, as noted in similar cases in Common Law [23], members of the Medical Expert Board within the Administrative Court are typically prominent representatives of the same disciplinary organisation, potentially reinforcing institutional biases.

Public grievances against medical professionals can also be addressed in the General Criminal Court. However, unlike practices in Common Law jurisdictions [39], the issuance of criminal judgments in these cases often hinges on prior convictions issued by the disciplinary organisation. The same dependency applies to civil proceedings, including damage assessments in the General Civil Court for the patient.

In this context, the Competition Council has jurisdiction to address anticompetitive practices carried out by medical organisations, including the Ministry of Health, Medical Sciences Universities, and Insurers. The Administrative Court of Justice is also empowered to address public complaints and objections against decisions made by agents and units affiliated with these organisations. However, concerns have been raised [40] that the Competition Council itself may inadvertently contribute to monopolistic practices through its elective measures, as its board members are often government-appointed [15]. This potentially limits the Council's ability to effectively challenge monopolies or anticompetitive behaviours extending to the public or governmental sectors.

The operation of emergency medical rooms often prioritises administrative tasks intended to mitigate liability over direct medical care. Practitioners, instead of focusing primarily on patient treatment, allocate significant time to completing necessary documentation to transfer responsibility to the patient or their companions. These efforts, which include ensuring patients remain in the facility until expenses are settled, reflect an inclination toward financial interests rather than patient welfare. Contrary to practices under Common Law [23], where providers ensure exoneration only after legal procedures, medical professionals in this context require patients' certificates, signatures, and fingerprints for every procedure performed to preclude any future "evidence crisis."

Additionally, the lack of clear identification for medical personnel undermines accountability. Patients and their companions are often unable to determine the identities of those administering treatment, such as those taking blood samples, providing injections, or connecting intravenous fluids. This lack of transparency and failure to properly document such interactions in the patient's clinical records creates significant obstacles for presenting claims when necessary. Consistent, accurate, and immutable documentation, comparable to the commercial ledgers required for businesses under the Commercial Code, should be implemented for patient records as is common in Common Law jurisdictions [26].

The interactions between patients and the medical guild frequently result in experiences of humiliation and ignorance of patient rights [41]. Instances observed by the author include breaches of confidentiality and lack of dignity preservation [42], such as the public display of a woman's radiology image with identity information in an emergency centre. Despite these actions, the

general function of the medical guild lacks sacredness, as others have also observed [18]. The consent obtained for medical examination and treatment grants only non-binding and revocable authorisation to perform procedures on the patient's body, consistent with practices in Common Law [26]. However, unlike both Common Law [39, 43] and European law [44], and despite some opinions [18] & [45, 46], medical staff are held liable for any harm caused to the patient unless they can conclusively demonstrate non-negligence or adherence to scientific and technical standards.

Placing the burden of proof on unconscious and vulnerable patients to establish negligence places an undue obligation on them [42, 45]. The principle of entrustment—observed for goods in cases involving transport operators—should extend to the entrustment of patient bodies to medical professionals. Furthermore, uninformed consent and acquittal documents have no legal standing, as such practices can be tantamount to deception. Prior consent, as others have noted [47], does not absolve medical professionals of liability arising from their errors, nor does it waive the patient's rights for redress.

XI. DEALING WITH COVID

The response of the Ministry of Health to the COVID-19 pandemic during 2019-2021 demonstrates significant operational inefficiencies potentially attributable to institutional market dominance and coordinated economic positioning. Initial pandemic management was characterised by delayed acknowledgment of viral transmission within national borders, followed by resistance to implementing targeted containment measures in epidemiological epicentres such as Qom. Concurrently, media representations consistently portrayed the medical establishment in favourable terms despite evident systemic challenges.

International travel protocols maintained air transportation connections with China, the identified source of viral transmission, while implementing inconsistent containment measures across different institutional contexts—legislative bodies suspended operations while educational institutions remained operational. Supply chain preparedness demonstrated significant inadequacies, with essential protective equipment and sanitisation materials experiencing distribution failures that necessitated alternative procurement channels.

The eventual implementation of comprehensive national isolation measures prompted critical reassessment of medical governance structures, with observers noting the absence of alternative institutional frameworks that might have facilitated broader analytical approaches and therapeutic interventions. The dominant institutional framework adhered strictly to World Health Organization protocols that critics characterised as overly simplistic, paternalistic, and dismissive of both public participation and traditional knowledge systems, including potentially beneficial interventions supported by scientific evidence such as garlic consumption for thrombosis prevention.

Patient management protocols maintained established institutional practices of collective rather than individualised containment, with high-density, humidity-controlled environments contributing to nosocomial transmission while simultaneously exacerbating patient conditions. The economic dimension remained significant throughout this period, with diagnostic testing services commanding substantial fees—primary testing costs equivalent to approximately three kilograms of mutton and secondary testing at approximately twice this amount. Healthcare institutions potentially derived financial benefits from systemic deficiencies, while the pandemic context potentially obscured non-COVID mortality within institutional settings.

XII. CONCLUSION

This research analysis has elucidated the fundamental causes of significant power imbalance in supplier-consumer relationships within healthcare services. The disruption of competitive market dynamics through both collaborative and individual actions by medical practitioners represents a substantial concern within the healthcare delivery system. Evidence indicates systematic collusion between the Medical Discipline Organization, Ministry of Health, Medical Sciences Universities, and insurance providers in several anticompetitive practices including: unfair tariff determination, provision of unnecessary services and goods, medicalisation of normal conditions, artificial cost generation, market competitor exclusion, supply restrictions, price fixing, and unjustified third-party referrals.

Individual practices that undermine market competition include: service undersupply, excessive pricing, mandatory complementary

product purchases, disregard for patient dignity, confidentiality breaches, misleading communications, abuse of dominant economic positioning, exploitation of client vulnerability, and delivery of substandard goods or services.

The medical establishment, comprising its ministerial bodies, disciplinary organisation, and numerous independent universities, in conjunction with insurance entities, has established a position that extends considerably beyond conventional dominant economic status. This structural arrangement facilitates extrajudicial operations, creating a system where the organisation effectively adjudicates complaints against its own members. This self-regulatory mechanism has received institutional reinforcement through legislative actions by Parliament and the Expediency Council, which have enacted the Medical Discipline Act and related regulations that effectively circumvent standard judicial oversight.

The Competition Council, as a governmental subsidiary, cannot be reasonably expected to provide effective oversight in this context. Demographic factors, including the disproportionate ratio of medical personnel to the general population and economic motivations, may contribute to this systemic imbalance.

XIII. REFERENCES

[1] Salemi V. HIV rumours trigger angry protests in southwest Iran. Aljazeera. 2019. Available from: https://www.aljazeera.com/news/2019/10/9/hiv-rumours-trigger-angry-protests-in-southwest-iran

[2] Sharififar S, Nazari S, Ahmadi Marzaleh M. Lessons Learned from the AIDS Crisis in Lordegan, Iran, 2019. Health Emerg Disaster Q. 2022;7(3):97-100. Available from: https://hdq.uswr.ac.ir/article-1-388-en.pdf

[3] Bahadori F, Hakimi S, Heydarzade M. The Trend of Caesarean Delivery in the Islamic Republic of Iran. East Mediterr Health J. 2013;19(Suppl 3):S67-S70. Available from: https://applications.emro.who.int/emhj/v19/Supp3/EMHJ_2013_19_Supp3_S67_S70.pdf?ua=1

[4] Cheraghali AM, Eshghi P, Abolghasemi H. Social Consequences of Infected Haemophilia Cases in the Islamic Republic of Iran. East Mediterr Health J. 2011;17(6):552-6. Available from: https://www.emro.who.int/emhj-volume-17/issue-6/article14.html

[5] Beigzadeh A, Yamani N, Bahaadinbeigy K, Adibi P. Challenges and Problems of Clinical Medical Education in Iran: A Systematic Review of the Literature. Stud Dev Med Educ. 2019;16(1):1-15. Available from: https://sdme.kmu.ac.ir/article_90571_9730ab1cd6d2d8481b70ed569d8ddcb8.pdf

[6] Nejadsarvaryi N, Ebrahimi A, Ebrahimi A, Hashemzade H. Medical Ethics in Plastic Surgery: A Mini Review. World J Plast Surg. 2016;5(3):207-12. Available from: https://www.sid.ir/FileServer/JE/1046920160301

[7] Khalilpour Gorgani M, Niknejad J. A Comparative Study of Anticompetitive Practices in the Pharmaceutical Industry in the Legal System of Iran, the European Union and the United States of America: Emphasis on Corona. Med Law J. 2021;15(56):993-1008. Available from: https://ijmedicallaw.ir/article-1-1314-en.html

[8] Bakhtiarvand M, Jamalinejad S. The Role of Competition Law in Improving Public Health. Med Law Q. 2017;11(42):165-90. Available from: http://ijmedicallaw.ir/article-1-773-fa.html

[9] Vakili Moghaddam MH. Foundations, Legal Challenges and Grounds for the Enforcement of Competition Law in the Field of Health and Treatment. Majlis Strategy. 2023;30(114):141-62. Available from: https://ensani.ir/file/download/article/6525232c00015-9428-114-5.pdf

[10] Moradkhani F, Kazemi D. Legislative Policies and Monopoly in Health Regulations. Mod Res Adm Law. 2023;4(13):113-41. Available from: https://www.malr.ir/article_253242_6d5a84eaeb7e85d76a7dd8ea28c9c5f3.pdf

[11] Rodger BJ, Lucey MC. Convergence and Divergence Within the EU's Supranational Competition Law Framework. In: Ong B, editor. The Regionalization of Competition Law and Policy within the ASEAN Economic Community. Cambridge:

Cambridge University Press; 2018. p. 236-71.

[12] Nasehi A, Esaei Tafreshi M, Parsapour MB, Khodadad Kashi F. Explaining Competition Rights Based on Different Perceptions of the Rule of Non-Detriment. Comp Law Res. 2016;20(4):165-86. Available from: https://clr.modares.ac.ir/article-20-7283-fa.html

[13] Sadeghi Moghadam MH, Ghaffari Farsani B. The Spirit of Competition Law (Comparative Study on the Objectives of Competition Law). Legal J Justice. 2011;75(73):113-46. Available from: https://elmnet.ir/doc/1373507-61422

[14] Jafarzadeh M, Omarvani R. License of OpenSource Software and Competition Law: Interactions and Conflicts. Legal Res Q. 2014;(68):107-40. Available from: https://lawresearchmagazine.sbu.ac.ir/article_56522.html

[15] Alaeddini AA, Shiri M. Rules of Competition Law in Iran and its Developments in Light of the General Policies of Article 44 of the Constitution. Q Judgm. 2016;87:119-48. Available from: https://www.ghazavat.org/article_162154.html?lang=en

[16] Hervey TK, McHale JV. European Union Health Law; Themes and Implications. Cambridge: Cambridge University Press; 2015.

[17] Bagheri M, Rahmani S. Monopoly and Competition in the Insurance Industry. Q J Program Budget. 2016;21(2):67-94. Available from: https://jpbud.ir/article-1-1485-en.html

[18] Sadat Akhavi SM. The Basis and Purpose of the Physician's Disciplinary Responsibility, the Demand and the Morality of Medical Law. Q J Med Law. 2015;9(32):11-52. Available from: https://www.noormags.ir/view/en/articlepage/1101394

[19] Dirkavand Moghadam A, Hashemian A, Sayeh Miri C, Soheili F. Factors Affecting the Satisfaction of Providing Health Care Using Factor Analysis. J Med Counc Organ. 2013;31(1):34-9. Available from: https://www.sid.ir/paper/41106/fa

[20] Tabnak News. What Should Be Understood from Khomeini-Shahri Child's Surgical Sutures? Tabnak News. 2015. Available from: https://www.tabnak.ir/fa/news/552507

[21] Mossadegh Rad AM, Esna Ashari P. Awareness of Physicians and Patients about Patient's Rights and its Observance in Isfahan Shahid Beheshti Hospital. Iran J Educ Med Sci. 2004;(11):45-56. Available from: https://ijme.mui.ac.ir/browse.php?a_code=A-10-1-10&slc_lang=fa&sid=1

[22] Elsan M, Driss K, Najafizadeh L. Togetherness in Franchising Contract from the Perspective of Competition Law: A Comparative Study on the Laws of Iran and the United States. Bi-Q J Encycl Econ Rights. 2016;23(10):21-38. Available from: https://lawecon.um.ac.ir/article_29339_c3815fc3b4a3a116cef6f4e4d1243ee1.pdf

[23] Giesen D. International Medical Malpractice Law; A Comparative Law Study of Civil Liability Arising from Medical Care. Dordrecht: Martinus Niijhoff Publishers; 1988.

[24] HSE. Introduction to Radiation in the Workplace. [Internet]. [cited 2025 Jan 7]. Available from: https://www.hse.gov.uk/radiation/introduction.htm#:~:text

[25] Seplaki L. Cost and Competition in American Medicine; Theory, Policy and Institutions. New York: University Press of America, Inc.; 1994.

[26] Zetler J, Bonello RP. Essentials of Law, Ethics and Professional Issues for CAM. Sydney: Elsevier Australia; 2012..

[27] Dumanloo F, Khodaparast AH, Mohammadi Z. Ethical Review of Medical Advertising with Emphasis on Nano-Therapeutic Products. Iran J Biomed Law Ethics. 2019;1(1):2-13. Available from: https://www.sid.ir/paper/269041/fa

[28] Davarzani M. Comparing Patients' Rights in Medical Research in the World. Q J Med Law. 2019;4(14):101-29. Available from: https://elmnet.ir/doc/1488745-40256

[29] Asteraki P, Mahmoudi GA, Anbari K, Hosseini N. Evaluation of Observance of Patient's Rights Charter from the Perspective of Hospitalized Patients. Q J

Lorestan Univ Med Sci. 2015;17(5):5-14. Available from: https://yafte.lums.ac.ir/article-1-1841-fa.pdf
[30] Kazemnejad SM, Hesamzadeh A. Studying the Level of Observance of Patient Rights Charter by Physicians and Nurses from the Viewpoint of Their Colleagues. J Mazandaran Univ Med Sci. 2012;22(97):216-23. Available from: https://jmums.mazums.ac.ir/browse.php?a_id=1797
[31] Nekooyi Moqaddam M, AmirEsmaeili MR, Izadi A. Competitive Analysis of Private Hospital Industry Using Diamond Porter Competitive Model. J Qual Res Health Sci. 2016;5(1):29-46. Available from: https://www.sid.ir/paper/215566/fa
[32] Haracoglou I. Competition Law and Patents: A Follow-on Innovation Perspective in the Biopharmaceutical Industry. Cheltenham: Edward Elgar Publishing Limited; 1981.
[33] Yamani N, Shater Jalali M. Integration in Curricula with Emphasis on Integration in Medical Education. Iran J Educ Med Sci. 2011;11(9):1202-13. Available from: https://elmnet.ir/doc/110443-91111
[34] Seitz C. Healthcare Systems and Competition: Challenges and Boundaries for the Application of Competition Law in the EU Healthcare Sector. In: Nihoul P, van Cleynenbreugel P, editors. The Roles of Innovation in Competition Law Analysis. Cheltenham: Edward Elgar Publishing; 2018. p. 131-54.
[35] European Commission. Update on Competition Enforcement in the Pharmaceutical Sector (2018-2022). Work Report. Brussels: European Union; 2024. Available from: https://competition-policy.ec.europa.eu/system/files/2024-01/kd0223117enn_pharma_report_2018-2022_e-version_en.pdf
[36] National Competition Center. Study of Competitiveness of Iran's Economy. Tehran: Presidency; 2016.
[37] Hosseini M. Ethics and Competition Law in the Pharmaceutical Industry. Ethics Med Hist. 2016;9(1):1-10. Available from: https://www.sid.ir/paper/135419/fa
[38] Jafarzadeh M, Rahbari E. Competitive Analysis of Prohibited Restrictions in Technology License Contracts. Q J Priv Law Res. 2012;1(1):65-104. Available from: https://jplr.atu.ac.ir/article_2217.html
[39] McClellan FM. Medical Malpractice; Law, Tactics, and Ethics. Philadelphia: Temple University Press; 1994.
[40] Ghamami SMM, Esmaeili M. Comparative Study of Competition Legal System in Iran and France. Islam Law Res J. 2010;11(2):153-88. Available from: https://www.sid.ir/paper/229424/fa
[41] Sadr SS. Ethics and Medical Law. Sci J Med Counc Organ. 2011;29(1):93-5. Available from: https://www.sid.ir/paper/457185/fa
[42] Arabshahi M, Azad A, Haghbejaneb M. The Charter of Medical Ethics in Imami Jurisprudence and Law and Its Role in Reducing Medical Violations (Case Study of Imam Reza Hospital in Bojnurd). Q J Bioethics. 2015;5(16):113-42. Available from: http://uctjournals.com/farsi/archive/socials/1396/autumn/3.pdf
[43] FTC & DoJ. Improving Health Care: A Dose of Competition. New York: Federal Trade Commission and the Department of Justice; 2004. Available from: https://www.ftc.gov/sites/default/files/documents/reports/improving-health-care-dose-competition-report-federal-trade-commission-and-department-justice/040723healthcarerpt.pdf
[44] Bajanowski T, Rabi W, Fracasso T. Medical Responsibility and Liability in German-Speaking Countries: Austria, Germany, and Switzerland. In: Ferrara SD, Boscolo-Berto R, Viel G, editors. Malpractice and Medical Liability; European State of the Art and Guidelines. London: Springer; 2013. p. 111-29. Available from: https://www.uems.eu/__data/assets/pdf_file/0003/19614/Item-3.2.7-pringer_Monograph_Table-of-Contents.pdf
[45] Parsapur MB, Ghasemzadeh SR. Jurisprudential Study of Patient Informed Consent and Physician Information Task (with Comparative Study in British and French Law). J Med Ethics Hist.

2011;5(1):39-50. Available from: https://ijme.tums.ac.ir/browse.php?a_id=140&sid=1&slc_lang=fa

[46] Saghafi M, Yazdanian A, Jalali M. The Nature of Safety Commitment and Its Application in Physician Civil Liability in Iranian and French Law. Comp Law Res. 2017;21(3):1-36. Available from: https://clr.modares.ac.ir/article-20-11460-fa.html

[47] Abdollahnejad M. Reviewing the Effect of Patient Satisfaction on Physician's Guarantee in Iranian and Lebanese Law. Q J Soc Sci Stud. 2017;3(3):32-44. Available from: http://uctjournals.com/farsi/archive/socials/1396/autumn/3.pdf