# THE THEORETICAL FOUNDATIONS OF THE DOCTOR'S COMMITMENT TO ENLIGHTENMENT AND ITS EFFECTS ON THE SAUDI HEALTH SYSTEM

**Dr. Anis Mamdouh Shaheen**
Assistant Professor of Civil Law
University of Bisha - Kingdom of Saudi Arabia

**Abstract**

This research is concerned with briefly studying the general health legislative situation in in the Kingdom of Saudi Arabia, with a focus on the doctor's commitment to enlighten the patient. It relies on the provisions of the health professions practice system with a review of the legislative and jurisprudential situation prevailing in the comparative systems. It starts with a review of the legal basis for the commitment to enlightenment, followed by the legal nature of the commitment to enlightenment and the limits and stages of that right. Then, we ended up by pointing out the shortcomings that were not covered by the current legislative texts, so that we finally recommend solutions and treatment for those uncovered issues.

**Keywords:** Health system - doctor's commitments - patient's rights - patient enlightenment.

**1. Introduction:**

All praise be to God, who says in His Holy Book: “Have We not given him two eyes, (8) and a tongue and a pair of lips, (9) and shown him the two paths? (10)” (Surah Al-Balad, verses (8), (9), (10)). Our Lord, your blessings are abundant for us that we cannot count, nor can we count our praise. Glory be to You, as You have praised Yourself, and You, Glory be to You, are undependable of the worlds, and prayers and peace be upon our master Muhammad, the Seal of the Messengers.

Patient rights, or medical commitments can be divided into six important or major rights - or commitments - three of which are more related to the medical ethical aspects, and the other three are more related to the medical technical aspects. The rights associated with the technical medical aspects are the patient’s right to care, the patient’s right to treatment, and the patient’s right to physical safety. As for the rights related to the medical ethical aspects, they are the patient’s right to enlightenment, the patient’s right to consent, and the patient’s right to keep the medical secrets.

Based on these previous details and as an introduction that paves the way for us to deal with the topic, our research will be restricted to only one of these six basic rights or commitments, which is the patient's right to enlightenment postponing the other rights for subsequent research, God willing.

**2. The study problem:**

The commitment of the doctor to the enlightenment of the patient in our Arab society in general and in Saudi society, as the focus of our research, is surrounded by a lot of ambiguity. It is a relatively recent legislative phenomenon that needs further interpretation and analysis, and it is an issue that is the subject of jurisprudential disagreement as its frameworks have not yet been clearly defined. It is directly related to the contemporary man, who is now suffering from many diseases surrounding him from all sides and which our ancestors knew nothing about, which necessitates shedding more light on this topic due to the legislative and jurisprudential ambiguity that surrounds it despite its importance to modern man, and perhaps what played a major role in all of these aspects is the novelty of this topic. Thus, the study will address this issue by trying to answer the following questions:

1 -What is the legal basis on which the commitment to enlightenment is based?

2 - What is the legal nature of the commitment to enlightenment?

3 - What is the framework and limits of the commitment to enlightenment?

4- What are the different stages that the commitment to enlightenment must be met?

**3. The study methodology:**

To achieve our goal, which is to explore the depths of the commitment to enlightenment and to reveal all its aspects that are ambiguous, we followed the descriptive and analytical approach, as well as the comparative approach to describe and analyze the commitment to enlightenment in the Saudi system and sometimes compare it with other systems. The study seeks disclosing the aspects of ambiguity that marred the commitment to enlightenment into the Saudi legislation, comparing that with solutions in legislation and comparative jurisprudence, so that we can finally come out with recommendations through which practical solutions can be taken for any subsequent legislative amendments to the Saudi health professions practice system.

**4. The application framework:**

Since ancient times, the rules of the medical profession have generally been concerned with ethical aspects (Lahwal, Samia et al.: 2015, p. 46). In this study, we will deal with the patient's right to enlightenment, as medical intervention in the human body undoubtedly requires the patient's consent, a satisfaction described as enlightened (Hussein, Anwar: 2014, p. 99). This is what we are dealing with, that the patient must first be informed of his condition and the appropriate treatment, and then his consent is obtained based on that enlightenment. This clear and simple matter was not the subject of agreement in Western jurisprudence, as is the case now. Rather, the complete opposite prevailed in an earlier period, where the prevailing view was what is called the medical dominance. According to that view, the doctor's relationship with the patient was viewed as an unbalanced relationship, as the doctor is superior to the patient with medical knowledge and technical specialization, and the other party becomes more vulnerable because of the ignorance of medical data. Therefore, those with this view do not consider the necessity for the doctor to obtain the patient's consent. Rather, they support the idea of the possibility of forcing the patient to receive the treatment that the doctor deems necessary (Qasim, Muhammad: 2001, p. 136).

Some jurisprudence uses the term "medical paternalism" to express this trend, and whether we use the term medical dominance or medical paternalism, the content is the same, as this trend assumed that "facing an ignorant patient, the doctor cannot feel that he is dealing with a free and equal human being. The patient here is like a child. His guidance, and the patient's consent cannot be imagined at every stage of the medical intervention, and that is nothing but an unimaginable myth where the patient is nothing but a legal minor, so we cannot expect valid consent from him (Mushattat, Alia: 2020, p. 524).

However, as this was an affront to the patient's human dignity, it quickly vanished to be replaced by an ethical view that linked the doctor's relationship with the patient. The doctor had to see the patient in order to obtain valid satisfaction from him within the framework of what might be called the moral or non-technical commitments of the doctor.

The sources of commitment to enlightenment in the Kingdom are represented in the Islamic Shariaa, as it is the main source of the legislations applied in the Kingdom of Saudi Arabia, and it is the origin of legitimacy and its source in all its systems from which the principles of all organizations are derived (Al-Fawzan, Muhammad: 2008, p. 10).

The second source that regulates the doctor's commitments in the Kingdom of Saudi Arabia, including the commitment to enlightenment, is the health systems, foremost of which is the system for practicing health professions by Royal Decree No. M / 59 dated 4/11/1426 AH.

There are multiple definitions of the doctor's commitment to enlightenment, including "the doctor giving his patient a reasonable and honest idea of the health situation in a way that allows the patient to make his decision of acceptance or rejection, and he is aware of the possible results of treatment or surgery." Saeed: 2000, p. 136).

Others define it as the "commitment to continuous dialogue between the patient and the doctor during the period of the medical contract with the aim of obtaining informed satisfaction" (Khalil, Majdi: 2000, p. 51).

Some believe that the commitment to enlighten the patient and receive his consent with medical actions finds its basis in the necessity of respecting the moral entity of a person before affecting his physical entity, which is also inviolable, so that the integrity of the human body must not be compromised, except for the medical necessity of the person, and it is noted that the term medical necessity has become used instead of the therapeutic necessity of the French legislator since 1999 AD, because it is possible to harm the human body for the therapeutic benefit, such as cutting off organs from the living, (Hajj Azzam, Suleiman: 2017, p. 525).

**The first topic: the legal basis for the doctor's commitment to enlightenment:**

Some jurisprudence attribute the commitment to enlightenment to the authority of the legislator in regulating the consensual contract in general, including the medical treatment contract (Raziq, Musa: 2016, p. 9).

Others believe that the commitment to enlightenment, along with the legislative basis, is also due to the medical contract, where the basis here is the contractual liability when the breach of enlightenment is due to something that the medical contract necessitates enlightenment about , and sometimes the basis is the tort liability, as the commitment to enlightenment here finds its basis in a legal obligation prior to the contract conclusion and independent of it (Maamoun, Abdul Karim: 2005, p. 79).

In order to shed light on all the sides of this topic, which treats the legal basis for the patient's right to enlightenment, we will deal with it by treating two different directions of jurisprudence, the first of which attributes the basis of this right on the theory of will defects, which is the first approach, while the second of them assigns the basis of this right to the principle of good faith, which is what we will deal with it in the second approach, as follows:

**The first tendency: the theory of will defects as a legal basis for the doctor's commitment to enlightenment:**

According to this approach, the will of the patient must be - as is the case in all contracts, including the medical treatment contract that we are discussing in this research - free from the will defects, so that both consent and foresight are described as enlightenment as they complement each other and are based on each other, the enlightenment must also be like consent free from defects of the will to ensure the freedom and safety of the will of the patient from falling into error, coercion or fraud. Therefore, according to this approach, the will of the patient is afflicted with a defect of will if he is exposed during the enlightenment to a mistake that mars that enlightenment, or fraud or exploitation by the doctor, or material or moral coercion against his will. Regarding the criterion used to measure the behavior of the doctor, according to this approach, it is necessary for the doctor to make his commitment to enlightenment according to a personal criterion, but it is linked to the enlightenment of the patient's will. This framework, in accordance with this approach, obliges the doctor to determine the extent of the patient's need for information that achieves the enlightenment of his will, and he also needs to ensure that this enlightenment is achieved (Ruzeeq, Musa: 2016, p. 9).

**The second tendency: the principle of good faith as a legal basis for the doctor's commitment to provide enlightenment:**

The requirement of the principle of good faith in contracting is that each party to the contract informs the party of the data he has so that he can accept the contract with good will (Savatier, J: 1947, p. 180).

On the contrary to what is required by the principle of the authority of the will and as an exception to it, here according to the principle of good faith, each party is preoccupied with defending the interest of the other contracting party, and the basis for this exception and the reason for it here is the exceptional situation of one of the parties, which is here the professional debtor. Financially, it becomes clear how important this exception works by placing this commitment on the shoulders of this professional person (Abdul Rahim, Fathi: 1999, p. 15).

This commitment in the professional selling is a commitment to enlighten. Some attribute the basis of the commitment of the professional seller to enlighten to the general commitment to safety that is the responsibility of the professional seller here (Abdul Rahim, Fathi: 1999, p. 36)

As for the medical treatment contract, the commitment of the professional doctor is a commitment to inform, and some add details to that, as they see that the commitment to inform is less than the commitment to enlighten, as the latter is superior to it because the debtor's position is more positive, as he is required to make the other contracting party do or refrain from doing. Thus, enlightenment, according to this view, is a comprehensive meaning that includes information, advice, and warning (Sobh, Alaa: 2020, p. 191).

According to this approach, the doctor is required to inform the patient of his health condition and the available treatment. The criterion for that is the ordinary man, and enlightenment is achieved with the availability of that amount of knowledge about the state of health and the available treatment that achieves the enlightenment of the ordinary man. This approach does not extend the commitment of enlightenment to include the effects and precautions related to the condition or treatment due to the weakness of the non-specialized patient who may be prompted by knowledge of the effects or precautions to make an inappropriate decision not to accept the therapeutic intervention that may negatively affect his health. They also see that giving adequate explanations may be difficult. It is achieved due to the doctor's time and preoccupation, and perhaps - according to their point of view - that enlightenment to a non-specialist needs simplification that may change the meaning - no matter how skillful the simplification is - in what may mislead the patient instead of guiding him. This trend adds that as the doctor himself is not aware of all expectations so how does he enlighten the patient about results that may not be taken into account (Hussein, Anwar: 2014, p. 110).

Whatever the case, some prefer to adopt the principle of good faith as a basis for the doctor's commitment to enlightenment, given that this is better for the benefit of the patient who is informationally, economically, and psychologically weaker in the contractual relationship, and in a way that restores balance between the two parties, as the doctor is treated as a professional party who is required to implement strictly his commitments - including the commitment to enlightenment - compared to the normal contracting conditions between two equal parties (Razik, Musa: 2016, p. 10).

**The situation in the Kingdom:** The system of practicing health professions did not favor one of the previous tendencies over the other. As for the jurisprudential point of view, it is possible to refer to the opinion of some people about the commitment to enlightenment stating that the Islamic Shariia prohibited fraud and forgery, and since the medical contract is based on an unequal relationship between the doctor and the patient, then the jurists unanimously agreed on the professional commitment to provide enlightenment to the weaker party in the contractual relationship, whether that was before contracting as an independent legal commitment or during the implementation of the contract as a contractual commitment (Al-Qurashi, Muhammad: 2019, p. 134).

**The second topic: the legal nature of the doctor's commitment to enlightenment:**

Reviewing the legal nature of the doctor's commitment to provide enlightenment requires dealing with two approaches, the first which considers the doctor's commitment to provide enlightenment to the patient as a commitment to exercise care, and the second approach considers that the doctor's commitment to provide enlightenment to the patient is a commitment to achieve a result, and we discuss that as follows:

**The first tendency: the doctor's commitment to enlightenment is a commitment to achieving a result:**

The ethical aspects of medical work transcend it and show its extent of nobility, and in this regard, Al-Shafi'i says, "I do not know of knowledge after the forbidden and the permissible that is more noble than medicine" (Ibn Hamad, Khaled: 2010, margin p. 4597)

One of the first manifestations of this ethical aspect of the medical profession is the commitment to enlightenment. And considering the commitment to enlightenment is a commitment to a result that leads to the inevitability of enlightened insight so that the doctor avoid being responsible, which is what pushes the doctor to strive to achieve this formally, so in order for the doctor to fulfill his commitment according to this direction, the result must be achieved, and here is the enlightenment of the patient's will, and this inner enlightenment is inferred by an apparent matter, which is the patient's consent to the treatment after being informed of the disease and its treatment (Al-Jubouri, Ibrahim: 2022, p. 55).

Therefore, it is noted that this attitude may prompt the doctor to strive to raise his responsibility to seek by all means to obtain that acknowledgment of enlightenment and consent, even at the expense of the reality in which there may be a deficiency in the actual enlightenment on the part of the doctor or a lack of understanding on the part of the patient, which ultimately leads to defective satisfaction. (Penneau, J: 2008, p 1129).

**The second tendency: the doctor's commitment to enlightenment is a commitment (by a means) to exert care:**

The implication of this is that the doctor's commitment is represented in striving to achieve enlightenment of the patient's will, meaning that the doctor strives to clarify and inform the patient about the conditions of the disease and the methods of its treatment. The doctor's behavior in this is measured by the standard of the common man, and the doctor has fulfilled his obligation if two things are available. The first of them relates to the patient, which is the attainment of enlightenment in proportion to the person of the patient. The second is related to the doctor, which is that he exerts the effort expected from the usual doctor of his category. The rule in this is that the obligor - who is here the doctor - has fulfilled his commitment if he exerts in its implementation the care that the usual person exerts from doctors of the same category (Al-Muhairat, Ghalib: 2018, p. 268).

After this discussion and due to the different attitudes, as we have explained about the legal nature of the doctor's commitment to enlightenment, we will discuss this in more detail in our following section, which we devoted to dealing with the practical aspects of the right to enlighten, God willing. It can be said here briefly that the commitment to enlightenment is generally governed by the general rule of the doctor's commitments, given that his commitment is a commitment to exercise care, taking into account the change in this commitment according to the applied cases that may be emphasized or mitigated.

**The situation in the Kingdom:** The doctor's commitments in general are considered a commitment to exercise care, as Article (26) of the Law of Practicing Health Professions states, and in the chapter dedicated to professional responsibility it states that "the commitment of a health practitioner subject to the provisions of this Law is a commitment to exercise vigilant care consistent with the known scientific principles."

However, in cases where doctors are committed to strict enlightenment towards patients, such as the case of medical experiments, operations to extract and transplant human organs, non-therapeutic plastic surgeries, and non-therapeutic abortions, we find it necessary to consider the doctor's commitment to enlightenment here as a commitment to a result, because it involves serious risks on human health and most of them are devoid of a therapeutic goal. The doctor's commitment to enlightenment is a commitment to a result, but the activity that the doctor exerts in enlightenment to achieve the result is only a means, because enlightenment here is not what is meant by itself, but rather it is a means to ensure the safety of the patient (Al-Qurashi, Muhammad : 2019, p. 140).

This brings us to the third topic of this study, through which we will deal with the framework and restrictions of the doctor's commitment to enlightenment, which we address as follows:

**The third topic: the framework and restrictions of the doctor's commitment to enlightenment:**

Jurisprudence was divided on the limits of commitment to enlightenment into two directions, the first of which is tight as it confines the doctor's commitment to enlightenment to narrow elements, including the appropriate treatment as well as the expected risks, and the second is an expanding tendency that expands the doctor's commitment to enlightenment to include expanded elements, including therapeutic alternatives as well as unexpected risks. But we must clarify before that, and as an introduction to the framework of this right, its elements through the first tendency, and then clarify in the second tendency about the standard of measurement by which we judge that it is expected or unexpected from these medical risks, which we will address as follows:

**The first tendency: the elements of commitment to enlightenment:**

Through this section we try to clarify the elements of this commitment in order to put a complete image of the subject and then follow it up in the following sections with some specificities that dealt with parts of those elements with some discussion, disagreement, and detail. In fact, the picture regarding the doctor's commitment to insight is not complete by reviewing the elements of this commitment only, nor by reviewing the narrow and broad directions only - which we will discuss later - but by addressing all those points. Therefore, we review each of them in addition to the criteria for distinguishing between risks, beginning with the elements of commitment to enlightenment, as follows:

The French legislator dealt with clarifying the elements of the commitment to be informed in the law of March 4, 2002 AD (Art.L111-2) as it stated that "Everyone has the right to be informed about their state of health. This information relates to the various investigations, treatments or preventive actions that are proposed, their usefulness, their possible urgency, their consequences, the normally foreseeable frequent or serious risks that they entail as well as the other possible solutions and the foreseeable consequences in the event of refusal...."

Accordingly, it is required that the enlightenment should include the following elements:

- **The patient's condition and the diagnosis of the disease:** the patient's enlightenment into his condition may require simple intervention by simply examining the patient with or without simple tools, and he may need analyzes or the use of accurate and dangerous tools, and he may need surgical intervention and perhaps all those complex procedures together, just to find out the condition. There is no doubt that this element is an obligatory and necessary element of correct enlightenment for the patient.

- **The nature of the proposed treatment:** This means clarifying the type of treatment proposed from the doctor's point of view, as it is the most appropriate for the patient's condition, and this also includes the period that this type of treatment takes.

**- The risks of the proposed treatment:** These are the risks that usually occur as a result of the proposed treatment (the narrow direction) or those risks that occur exceptionally (the broad direction), which we will address in more detail in the third and fourth tendencies of this topic.

**- Alternatives and other therapeutic options:** Some jurisprudence advocates that enlightenment must be expanded to include not only the treatment that the doctor deems appropriate, but also to include all available therapeutic alternatives, and the patient has the right to choose the appropriate one for him, which we will discuss in more detail also in the third and fourth sections from this tendency.

**- Effects of refusing treatment and remaining without it:** Originally, the refusal of treatment is a right of the patient, as we will explain later, but in that case in which the patient refuses treatment, the doctor must inform his patient with the effects of that refusal, and in this regard, the patient's desire to refuse must be respected, as well as his right to privacy, so it is not permissible to disclose his medical secret, where sometimes the refusal of treatment is due to the patient's desire to keep his medical secret from his social environment, which will be revealed by undergoing treatment, and therefore his desire is respected unless it is likely that this will endanger other parties such as AIDS (Armelle, B & Pierre, B: 2006, P113).

**The situation in the Kingdom:** According to Article (15) of the Health Professions Practice Law, "the health practitioner must … provide the patient with reports on his health condition and examination results, taking into account accuracy and objectivity." In the same regard, Article ( 18) of the same law states that "the health practitioner is obligated to alert the patients or his family to the need to follow the instructions he sets for them and warn them of the serious consequences that may result from not considering them after explaining the treatment or surgical situation and its effects." From these two texts, it is clear that the Saudi legislator was interested in clarifying the elements of enlightenment, and singled out among them the statement of the patient's condition, which was shown in the reports and examinations, as well as the treatment and its effects, as well as the effects and risks of not following the treatment instructions in addition to refusing the treatment itself or staying without it, and this did not include alternatives and other treatment options.

**The second tendency: the criterion for distinguishing between risks:**

Jurisprudence has differed regarding the criteria used in differentiating between types of risks into several directions, which we explain as follows:

**The first criterion: the inclusion of risks in the medical references:** Mentioning the medical risks that the patient may be exposed to as a result of the medical intervention in the medical references makes the matter to be expected, and vice versa. This criterion has been criticized because it makes the dangers not mentioned in the medical references non-existent, and it may contradict logic as it limits the restrictions of reality to the limits and framework of medical books, and the reality is much broader than that. As a remedy for this, some have said that the expected danger is what its realization is familiar and rationally imagined (Hussein, Anwar: 2014, p. 127)

**The second criterion: a statistical criterion for risk:** Based on this trend, the risk is expected if it is a frequent occurrence with a rate exceeding 2%. What is less than that are exceptional and unexpected risks and therefore cannot be predicted in the circumstances of the time and place in which the medical work takes place (Mushattat, Alia : 2020, p. 530).

**The third criterion: the criterion of the severity of the risks:** the risks that may be described as exceptionally recurring may have a huge impact on the patient if they occur, such as paralysis, loss of an organ, or loss of its benefit, and vice versa when one of the symptoms of the therapeutic intervention is the occurrence of some temporary headaches for the patient, and perhaps that prompted this trend to consider the risks within the circle of expectation, and they must be considered whenever they are of a high degree of seriousness, regardless of the frequency of those

risks, and this trend believes that the doctor is not exempt from commitment to enlightenment just because the risks of intervention do not occur except in an exceptional way, the doctor is committed to enlightenment as long as the surgical intervention can lead to risks such as death or disability of the patient even if the surgical intervention was carried out in accordance with professional rules (Abdul Latif, Muhammad: 2004, p. 64).

Some believe that the last two criteria can be taken together, the danger degree standard and the statistical criterion, so the risks are considered expected and should be considered whenever they occur frequently according to the aforementioned statistical criterion, and besides that, the severity criterion works, so the doctor must not neglect serious risks, even if they are rare, as long as it is possible and probable to occur (and it can be predicted). As for what cannot be predicted (the medical accidents), the doctor is not asked about it unless the severity of the damage reaches a certain limit, which is that the resulting disability percentage reaches 25% or more, as the French legislator allocated in the legislation of March 4, 2002 a large part of its provisions to compensate victims of serious damage that cannot be predicted under the name of a medical accident (Mushattat, Alia: 2020, p. 533).

**The situation in the Kingdom:** As is the case with most legislation, Saudi health legislation did not adopt a specific criterion to differentiate between risks, leaving that to jurisprudence and judicial rulings that strive in such cases to adopt a legal reality that is more appropriate for each case separately.

After this review of the different criteria that are used to differentiate between medical risks, we go on to review the jurisprudential trends that vary into two different directions regarding the patient’s right to enlightenment.

**The third tendency: the narrow trend in the doctor's commitment to enlightenment:**

The first tight approach states that the doctor's commitment to enlightenment is limited to the expected risks surrounding his illness, which occur according to the normal course of things during medical intervention, and some tighten that right to the fact that the doctor only has the right to inform the patient with the appropriate treatment and determine the technical means to implement it, aiming from that to achieving the patient’s interest first (Ruzeeq, Musa: 2016, pg. 7)

Others express the same narrow trend, with some expansion, as they add the expected risks, along with the treatment and methods of implementing it adopted by the previous trend, by saying that the doctor's commitment to enlightenment is limited to the risks expected to be encountered, which usually occur during medical intervention (Al-Jarrah, Jihad: 2006, p. 18).

Some jurisprudence differentiates with regard to expected risks between simple expected risks and serious expected risks, as they consider that the simple expected risk is that usual risk, whether it occurs frequently or rarely, and the doctor is required to inform the patient of it despite its simplicity (Shukry, Eman: 2018, p. 122).

As for the serious expected risks, they define them as those risks that by their nature affect the patient’s decision to accept or reject the intervention or treatment proposed by the doctor, which by nature lead to death, disability, or leave a disfigurement in the patient’s body due to its psychological and social effects (Boughriet.N. : 2013, p50)

This trend suggests that the doctor is committed to enlightenment with an expected simple danger equally with the expected serious danger, and therefore this distinction may not be feasible in terms of reality, as there is no difference between them in the final outcome.

After this review of the narrow approach to the patient's right to enlightenment, we move to the second approach in this regard, which is the broad approach, as follows:

**The fourth tendency: the broad trend in the doctor's commitment to enlightenment:**

The second trend, according to the expanded concept of enlightenment, believes that the doctor must inform the patient with all the risks that he may face, whether these risks are expected or exceptional (Al-Jarrah, Jihad: 2006, p. 19).

The clarification of some of the expansion of enlightenment was limited to informing the patient about the different methods of treatment and their effects, as it is believed that the patient's right to that includes introducing the patient to all therapeutic alternatives as well as the effects that result from those alternatives, and then leaves the patient free to choose the appropriate one, as that approach deals with the distinction between the two directions expanding and narrowing not on the basis of risks, but rather on the basis that the restriction is in the doctor's offering the patient one treatment that is suitable from the doctor's point of view, with an explanation of its effects. As for the expansion of informing, it is in presenting many different treatments with an explanation of all their effects, and the choice between them is left to the patient (Ruzeeq, Musa : 2016, p. 7).

This last trend shows that there is a difference between the treatment and the technical means used in the implementation of the treatment, as the patient's right to enlightenment extends according to the expanded trend to knowing the different treatments that can be used in his condition, and the patient chooses among them the appropriate for his situation, condition and circumstances, and that is to achieve the interest of the patient and also his personal freedom. As for the technical methods that the doctor will use in implementing these treatments of all kinds, they are not covered by the commitment to enlightenment, both according to the narrow or broad directions, because they remain within the authority of the doctor by virtue of specialization and the absence of the patient's interest in that (Ruzeeq, Musa: 2016, p. 7).

This distinction between the treatment and the means of its implementation may lead to a disagreement between the patient and the doctor, which ultimately leads to the fact that the doctor is not able to direct the alternative treatment that the patient may choose, and the doctor is eventually forced to abandon the treatment (Penneau, J: 2008, p 1129).

Probably, the orientation is towards the severity of the risks and the necessity of the patient's awareness of them, whether they are expected or unexpected, in addition to the statistical standard, so that the patient is informed by everything that is frequent in addition to everything that is serious. This is a balance between two conflicting interests, as this protects the basic rights of patients and does not hinder the movement and development of medicine.

**The situation in the Kingdom:** By reviewing the texts of the system for practicing health professions in the Kingdom, it becomes clear that the legislator obligated the health practitioner to explain the therapeutic or surgical situation and its effects to the patient or his family as a general principle of enlightenment, and sometimes he expands on that as some jurisprudence assumes in the specificity of some cases, as we will see later in our research.

At this level, and after our review of the wide and narrow trends regarding the patient's right to enlightenment, and after clarifying some of the trends that built the broad and narrow visions of risks, and some of those that built the same two trends on the basis of the one appropriate treatment or the different treatments that the patient can choose between and the effects of each of them, we will move to the stages of the patient's right to enlightenment so that the image becomes clearer, and this is what we will address through the fourth topic, as follows:

**The fourth topic: the stages of the doctor's commitment to enlightenment:**

In this section, we will try to deal with enlightenment through the different stages of the therapeutic intervention in three tendencies as follows:

**The first tendency: the enlightenment of the patient at the stage of diagnosis:**

The diagnosis stage is almost the most important, as it is the first building block on which all the following stages in the patient-doctor relationship are based. In this stage, the doctor studies both the disease and the patient's condition and is not satisfied with only one of them until he builds a good treatment plan or plans that can lead to the targeted results of the intervention. The doctor then presents it to the patient to choose from among the alternatives presented to him that are suitable for his circumstances. Some individuals may prefer surgical interventions due to their speed compared to drug treatment, and others may prefer medications that may be defective in the long term rather than undergoing surgical interventions due to their seriousness.

In this regard, the doctor's commitment to enlightenment is not limited to informing the patient of the results of the diagnosis that has been made, but rather the commitment to enlightenment extends to include the previous medical procedures necessary to carry out this diagnosis before it is made (Al-Jarrah, Jihad: 2006, p. 37).

Whereas, those pre-diagnostic procedures can be as simple as the apparent diagnosis, or as complex as the surgical interventions that are used to diagnose the disease, such as medical endoscopes, which necessitates enlightening the patient with them and their risks as previously presented.

Some research indicated that the commitment to enlightenment in the diagnosis stage is an independent commitment in itself and is not linked to the rest of the treatment stages, as the patient may resort to a specific doctor to carry out the diagnosis only and stand on his condition without having to continue with him to start the treatment stage. And since the commitment to enlightenment is an independent commitment, and since it may also involve surgical intervention for the sake of diagnosis, which makes the diagnosis process in itself a violation of the patient's right to the safety of his body, the doctor must inform the patient of the nature of the examination he intends to perform and the nature of the risks that may be associated with it. (Maamoun, Abdul Karim: 2005, pg. 79).

As we have made clear, the commitment to enlightenment at the stage of diagnosis is not limited to clarifying the necessary procedures for making the diagnosis - whether external or surgical - as it certainly also includes the result that the doctor has reached with regard to determining the disease and its degree of simplicity or seriousness as clarified previously.

**The situation in the Kingdom:** Article (15), as we mentioned earlier, stipulates that "the health practitioner must make the diagnosis with the necessary care … and provide the patient with the reports he requests about his health condition and the results of the examinations." It is clear from that article that the Saudi legislator is interested in making the patient have sufficient enlightenment from the beginning and not only in the important stages such as the stage of therapeutic intervention.

**The second tendency: the patient's enlightenment into the treatment phase:**

After the end of the diagnosis stage and complete enlightenment, comes the next stage that is the stage of treatment in order to reach the desired goal of the medical intervention, which is recovery and the end of the patient's pain. For this, the patient may accept some of the symptoms and temporary pains if they are the only way to get rid of the pain of the ongoing disease, and in order for that acceptance of the therapeutic intervention and its symptoms and risks to be correct, it must be preceded by an enlightenment that illuminates the way for the will of the patient, so that if he chooses to accept treatment, his acceptance will be enlightened. (Al-Atrushi, Muhammad: 2007, pg. 96). The patient's enlightenment into the treatment stage requires the his enlightenment into the nature of the medical intervention (Hussein, Nour: 2014, p. 121), (Al-Maghrabi, Taha: 2014, p. 91), This intervention could be by using drugs, surgeries, or radiological intervention, and sometimes it may be the necessary intervention - even if as a stage of medical intervention - using physiotherapy for example.

This also requires informing the patient of the duration of the medical intervention required for treatment and the cost of that medical intervention. This also includes the necessity of clarifying the purpose of the medical intervention, whether it is for diagnosis or for treatment - which we are dealing with - or with the intention of carrying out medical experiments (Maamoun, Abdul Karim: 2005, p. 79) until the patient becomes comprehensively informed and takes the decision to undergo treatment or not based on full enlightenment.

The issue is not restricted to enlightenment into the nature of the treatment, its duration, costs, and purpose, but it extends to include, in addition, enlightenment into the benefits of treatment such as its effectiveness and success rate, and its defects such as the risks that may occur or appear during the medical intervention itself or those risks that may result as effects after the implementation of that intervention. Moreover, the effects and risks are not limited to those that may appear directly on the patient's body – whether expected or unexpected risks as we explained previously – as some believe that they also include those bad effects that the patient may be exposed to from an economic point of view or his situation and his continuation of work. (Hussein, Nour: 2014, p. 122).

Some add that enlightenment in the treatment stage also includes enlightenment into therapeutic alternatives, as it may be that only one treatment is offered to the patient with an indication of its risks, the patient chooses that one treatment, assuming that enlightened insight has occurred. Perhaps there is some fallacy in it, since the entire picture was not seen by the patient, as he chose only what he saw from it.

In this regard, it should be noted that the enlightenment of medical alternatives is a matter of disagreement between the Latin systems and the Anglo-Saxon systems. In the latter, jurisprudence agrees that information about therapeutic alternatives is necessary for the patient in order to make the right decision regarding the future of his health, while this is a matter of disagreement in Latin jurisprudence and justice systems, although it clearly contains the trend calling for leaving this to the medical staff as long as it seeks to achieve therapeutic goals (Maamoun, Abd al-Karim: 2005, p. 81).

Therefore, some jurisprudence believes that the doctor should explain the therapeutic alternatives to the patient, and the doctor may advise the patient on one of the methods that he deems appropriate, and in the end the patient remains the final decision-maker in choosing the treatment method, provided that it is not obsolete or new, nor its usefulness has not yet been proven. The doctor may choose between continuing the treatment if he deems that the patient's choice is appropriate, or to step down and abandon the treatement, provided that this is under appropriate circumstances (Al-Jarrah, Jihad: 2006, p. 23).

It is worth noting, in the framework of our discussion of the implications of the therapeutic intervention, what may be encountered by the doctor when he is aware of a medical condition other than the one from which the patient suffers and for which the intervention was carried out, such as finding a tumor inside the patient's body other than the condition that the patient knows that he is suffering from. Here, jurisprudence was divided into two groups, the first of which believes that prior enlightenment is required before intervention and removal of the tumor, and the second believes that the doctor may complete the treatment he started with and treat the condition that was not taken into account as long as the patient's condition requires that, provided that he returns and informs him of the situation that occurred during the treatment (Shukry, Iman: 2018, p. 131).

**The situation in the Kingdom:** The Saudi legislator was concerned with full enlightenment in all stages of the medical intervention, as it stipulated in the aforementioned Article (18) that "the health practitioner is obligated to alert the patients or his family to the need to follow the instructions he sets for them and warn them of the serious consequences that may result from not considering them after explaining the condition or surgical situation and its effects." As usual, the Saudi legislation did

not address some of the points under discussion in jurisprudence that we presented above, so as not to be widely interdicted before the Saudi judiciary.

**The third tendency: the patient's enlightenment into the post-treatment stage:**

The patient's enlightenment is not limited to the stages of diagnosis and treatment, but rather extends to the post-treatment stage. The doctor's commitment remains to provide insight at that stage, whatever the result of the medical intervention, whether it was successful or failed, and some believe that the main goal of enlightenment at that stage is to preserve the patient's condition, as he is informed of the outcome of the treatment and informed of the necessary precautions in the future to avoid possible harmful effects. This is in contrast to the situation in the previous two stages, where the main goal of enlightenment is to obtain informed satisfaction from the patient (Hussein, Akram, and Al-Obaidi, Zeina: 2006, p. 15).

The matter is represented by the precautions suggested by the doctor to protect the patient from exacerbating the disease again - taking into account that the prevention and precautions that we are talking about may start before the therapeutic intervention to avoid the disease and may be subsequent to the treatment to allow the patient to recover quickly, and the last case is the one we are dealing with here.

The essential commitment at that stage is to inform the patient of what his health situation has become after the completion of the treatment stage. In this regard, the doctor's commitment is valid whether the treatment results are positive or negative, and some stressed the importance of the doctor's commitment to informing the patient of all the negative incidents that occurred during the medical intervention so that the patient can search for a treatment for the new emergency and complications in his health condition as a result of the therapeutic intervention. They believe that the doctor's commitment here is a commitment to achieve a result and not a commitment to provide care (Ben Sagheer, Murad: 2019, p. 269).

Regarding the recent trend of shifting the doctor's responsibility from a commitment to provide care to a commitment to achieve a result, some added that the French judiciary tends to narrow the scope of the commitment to provide care for the doctor under the treatment contract, to shift little by little to a commitment to achieve a result on his shoulders. The purpose of that for them is to compensate the injured party for the damages incurred within the scope of the medical treatment contract (Bin Sagheer, Murad: 2019, p. 269).

In defining the framework of the doctor's responsibility for enlightenment, some pointed out that it is not sufficient to exempt the doctor from responsibility when his behavior is in conformity with the professional habits as those habits may conflict with the rules of enlightenment in the stages of the medical work (Hussein, Akram and Al-Obeidi, Zeina: 2006, p. 16).

**The situation in the Kingdom:** The Saudi health legislator paid attention to enlightenment in the post-treatment stage to complete the picture. The doctor's commitment to enlightenment covers all the stages of the medical work, as stipulated in Article (18) that "the health practitioner is obligated to alert the patient or his family to the need to follow the instructions he sets for them." " and that illustrates the interest of the legislator in the enlightenment in its final stage, which is represented here in the instructions given by the doctor to the patient or his family in order to follow the necessary precautions in the future to avoid possible harmful effects, and enlightenment here comes according to the aforementioned article in the last stage after the completion of the treatment stage as the article ends by saying, "after explaining the therapeutic or surgical situation and its effects."

**5. Findings and recommendations:**

The research concluded that the Saudi legislator was interested in referring to the commitment to enlightenment in all the stages of the medical intervention, whether in the diagnosis stage, in the

treatment stage, or in the last stage, the post-treatment stage, and this was also adopted by previous studies in the commitment to enlightenment.

**The results:**

1 - The jurisprudence dealing with the commitment to enlightenment was extended to all aspects, which built very detailed theoretical foundations in contrast to legislation in general and to the Saudi health legislation in relation to our study, as it focused on the important aspects from the practical point of view.

2 - In most controversial cases, the Saudi legislator chose the narrow framework of responsibility in order to give more freedom to medical development.

3 - The legislator did not contradict the interest of the patient in order to achieve the interest of medicine in the development, as it established the responsibility of the doctor to provide enlightenment in all stages of medical intervention, starting from diagnosis, through treatment, and ending with the post-treatment follow-up stage.

4 - Despite all the previous legislative jurisprudence, it did not set detailed and firm rules that regulate the doctor's relationship with the patient, especially with regard to the commitment to enlightenment, as it came in most cases with brief texts.

5 - Despite the novelty of the Saudi health professions practice system, which was issued in 1426 AH, it may have missed the modern legislative trend that tends in many practical applications to consider the doctor’s commitment to achieving a result and not a commitment to exercise care, as Article (26) of the professions practice system stipulates. In the chapter dedicated to professional responsibility, it states that “the commitment of a health practitioner subject to the provisions of this system is a commitment to exercise care…”.

**The recommendations:**

1- Issuing a unified medical rationing that brings together all the different health systems in force in the Saudi health field to avoid repetition and fix the shortcomings.

2 – Paying more attention to the texts regulating the commitment to enlightenment, as they were brief in most cases and succinct, which created aspects of legislative deficiency, as concision neglected many aspects and kept them without legislation, such as the necessity of emphasizing enlightenment in various aspects such as natural therapy, plastic surgery, and so forth.

3 – Paying more strictness in the doctor's obligations to enlightenment, taking into account the interest of the patient, where the doctor is not obligated, according to the current legislation, to indicate the alternatives or the different treatment methods that the patient can choose from among what suits him and his circumstances.

4- The legislator should adopt a clear criterion with regard to determining the risks that must be considered, as the Saudi legislator did not adopt a specific criterion in this regard.

**Arab references:**

- **Ibn Hamad, Khaled. (2010).** The Doctor's Error: A Foundational Study. The Second Islamic Jurisprudence Conference (Contemporary Medical Issues). Imam Muhammad Bin Saud Islamic University .

- **Al-Atrushi, Muhammad. (2007).** Civil liability resulting from blood transfusions. Dar Al-Hamid for publication and distribution.

**-Al-Jubouri, Ibrahim. (2022).** Commitment to patient enlightenment: a comparative study. International Journal of Humanities and Social Sciences. College of Humanities and Social Sciences.

**-Al-Jarrah, Jihad (2006).** The responsibility of the civil medical team in accordance with the provisions of the Jordanian legislation. A dissertation to obtain a doctorate degree in law. Graduate School of Legal Studies - Amman Arab University for Postgraduate Studies.

- **Al-Fawzan, Muhammad. (2008).** Commenting on the new Saudi labor system. Law and Economics Library.

- **Qurashi, Muhammad. (2019).** The Doctor's commitment to enlighten the Patients "In Light of the Provisions of the Health Professions Practice System". King Saud University Journal. King Saud University - College of Law and Political Science. Vol. 31. P1.

**- Al-Maghrabi, Taha (2014).** Criminal responsibility for medical errors in obstetrics. Dar al-Fikr wa al-Qanun for publication and distribution.

- **Al-Mahairat, Ghalib. (2018).** The commitment of the producer to be informed before contracting electronic contracts. Yazouri.

**- Bin Sagheer, Murad (2019).** Modern trends of doctors' civil responsibility and their implications for tightening their professional commitments. Journal of Shariia and Law. UAE University Journal of Legal Research. P. 77.

- **Hajj Azzam, Suleiman. (2017).** The consumer's right to information and satisfaction in the medical field: Obliging the doctor to inform the patient and receive his satisfaction as an example. Journal of Rights and Freedoms - M'sila University. P4.

**- Hussein, Akram, and Al-Obeidi, Zina (2006).** Enlightenment of the patient in the medical contract. Al-Rafidain Law Journal. Mosul University - College of Law. P. 30.

**- Hussein, Anwar (2014).** The element of error in the civil liability of the doctor, Dar al-Fikr wa al-Qanun.

**- Khalil, Magdy. (2000).** The effectiveness of patient satisfaction in the medical contract. Arab Renaissance House.

**- Razik, Musa. (2016).** Commitment to patient enlightenment. International Journal of Law - Qatar University - College of Law.

**- Shukri, Iman (2018).** The objective scope of the physician's commitment to the patient's enlightenment. Journal investigator ornaments for legal and political sciences. College of Law - University of Babylon, Volume 10, P1.

**- Sobh, Alaa (2020).** The civil liability of the notary. Arab Center for Publishing and Distribution.

**- Abdel-Salam, Saeed (2000).** Commitment to disclosure in contracts. Arab Renaissance House.

**- Abdel Rahim, Fathi (1999).** The system of compensation for damages to the security and safety of the consumer in the Egyptian and comparative civil law. Journal of legal and economic research. Mansoura University - Faculty of Law.

**- Abdul Latif, Muhammad. (2004).** Medical liability issues. Journal of Legal and Economic Research. 36. Mansoura University - Faculty of Law.

- **Qasem Mohamed . (2001).** Proof of error in the medical field. (Special issue). Journal of the Faculty of Law for Legal and Economic Research. Alexandria University - Faculty of Law.

**- Lahwal, Samia et al. (2015)** The Role of Medical Ethics in Protecting Patient Rights through Adherence to Shariia Controls. International Journal of Islamic Marketing. International Islamic Marketing Authority.

**- Maamoun, Abdul Karim (2005).** Patient satisfaction with medical and surgical procedures. Thesis to obtain a state doctorate degree in medical law. Faculty of Law - Abi Bakr Belkaid University, Tlemcen.

**- Mushattat, Alia Zamil. (2020).** The development of medical risks and the approved standard in informing the patient of them. Middle East Research Journal. Ain Shams University, p. 53.

**Foreign references:**

- **Armelle, B & Pierre,B.(2006).** Questions éthiques en médecine predictive**.** John Libbey and company Ltd.

- **Boughriet.N. (2013).** Essai sur un paradigme d'alliance constructive entre droit et médecine : L'accès du médecin à la connaissance juridique. These du doctorat en droit. Université du Droit et de la Santé - Lille II.

- **Savatier, J. (1947).** Étude juridique de la profession libérale. Thèse, LGDJ.

- **Penneau, J. (2008).**mentionnée dans «Corps humain». Rép. pén. Dalloz.

- **Penneau, J. (2008).** Rep. pen. Dalloz.