

From Factual Causation to Legal Attribution: The Normative Structure of Liability for Medical Harm

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Abstract

Establishing causation remains one of the most complex problems in medical liability, particularly where an adverse outcome results from multiple contributing factors, pre-existing conditions, recognised treatment risks and probabilistic medical processes. In such circumstances, demonstrating a factual connection between medical conduct and patient harm does not necessarily determine whether, or to what extent, that harm should be legally attributed to the healthcare professional. This article examines the relationship between factual causation and legal causation in medical liability and considers how causal uncertainty affects the transition from causal involvement to legal attribution.

Using a doctrinal and comparative legal method, the article analyses the limitations of the conventional but-for test in multifactorial medical outcomes and examines the role of foreseeability, remoteness and the scope of risk in defining the boundaries of civil responsibility. It also considers counterfactual causation in cases of inadequate disclosure, focusing specifically on the causal significance of the hypothetical decision a patient might have made if adequate information had been provided.

The article argues that these dimensions should neither be treated as isolated causal problems nor collapsed into a single test. Instead, causation in medical liability is better understood as a structured progression in which factual causation establishes causal involvement, counterfactual reasoning reconstructs relevant alternative events or decisions, and legal causation determines whether the resulting harm falls within the proper scope of civil responsibility. This integrated approach preserves the evidential discipline of factual causation while recognising the normative function of legal attribution and provides a coherent framework for distinguishing an adverse medical outcome from legally attributable harm under conditions of causal uncertainty.

Keywords: medical liability; factual causation; legal causation; counterfactual causation; causal uncertainty; scope of liability; legal attribution.

Introduction

Establishing causation remains one of the most difficult aspects of civil liability for medical harm. An adverse outcome following medical treatment does not, by itself, establish that the conduct of a healthcare professional caused the harm in a legally relevant sense. Medical outcomes commonly arise from an interaction between the patient's underlying condition, the natural progression of disease, individual physiological characteristics, recognised complications of treatment, and the intervention itself. The causal inquiry is therefore rarely confined to identifying a single event that preceded the injury. It requires a distinction between harm attributable to the medical intervention and harm that would have

¹ Received: 15/01/2026; Accepted: 20/05/2026; Published: 08/10/2026

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occurred independently of it. This distinction is fundamental to the structure of medical liability, since negligence without a sufficient causal connection to the alleged injury cannot, as a general rule, justify the imposition of civil liability.

The conventional starting point for this inquiry is factual causation, ordinarily examined through the counterfactual logic of the but-for test. The test asks whether the harm would have occurred in the absence of the defendant's conduct and thereby provides a basic mechanism for excluding events that made no causal difference to the outcome. Its apparent simplicity, however, becomes problematic in medical disputes involving multiple or competing causes. Clinical medicine operates within conditions of probability rather than certainty, and the available scientific evidence may establish that particular factors increased the likelihood of an outcome without demonstrating that any one factor was independently sufficient to produce it. Recent judicial and academic developments continue to expose this difficulty, particularly where courts must translate probabilistic medical evidence into the binary structure of legal proof. The resulting tension between scientific uncertainty and the requirements of legal attribution demonstrates why factual causation, although indispensable, cannot always provide a complete account of responsibility for medical harm.

The limitations of factual causation reveal a second and conceptually distinct stage of the inquiry. Establishing that medical conduct contributed to an adverse outcome does not necessarily determine whether the resulting harm should be attributed to that conduct for the purposes of civil liability. Legal causation performs this further normative function by defining the scope within which factual consequences become legally relevant consequences. Questions of foreseeability, remoteness, the nature of the risk created by the defendant's conduct, and the protective purpose of the rule that has been breached therefore operate not merely as supplementary considerations, but as mechanisms for delimiting responsibility. This distinction is particularly significant in medicine. If every adverse consequence factually connected with treatment were attributed to the healthcare professional, causal analysis could become indistinguishable from liability for outcome. Legal causation accordingly performs a limiting function: it determines which consequences of medically relevant conduct fall within the proper scope of civil responsibility and which remain outside it.

The limits of a purely physical account of causation become still more apparent in cases involving informed consent. A medical intervention may be technically appropriate and competently performed, yet liability may arise from an alleged failure to disclose a material risk or a reasonable alternative to treatment. In such cases, the causal inquiry changes in character. The relevant question is no longer confined to whether the intervention produced the physical injury. It may also require a counterfactual assessment of whether adequate disclosure would have altered the patient's decision to undergo the intervention. Causation therefore becomes connected to patient autonomy and decision-making, requiring courts to reconstruct a hypothetical course of conduct that never occurred. This form of inquiry illustrates a distinctive feature of medical liability: legally relevant causation may concern not only the production of physical harm, but also the relationship between deficient information, patient choice, and the subsequent materialisation of risk.

Although these dimensions of medical causation are well recognised, they are frequently examined through distinct doctrinal categories. Factual causation is commonly addressed through the limitations of the but-for test and the problem of multiple causes, while foreseeability and remoteness are considered within the scope of liability, and causation following inadequate disclosure is generally examined through the separate doctrine of informed consent. This article approaches these questions as interconnected stages of a broader process of legal attribution. Its contribution lies in examining the transition from factual connection to legally attributable harm and in identifying the common function performed by these apparently distinct causal inquiries. On this account, factual causation establishes whether the defendant's conduct made a relevant difference to the occurrence of harm, while legal causation determines whether, and to what extent, that harm should be attributed to the defendant for the purposes of civil liability. Informed consent adds a further dimension to this structure by demonstrating that attribution may also depend upon the counterfactual relationship between adequate disclosure, patient choice, and the risk that ultimately materialised.

Against this background, the article asks how factual causation, legal causation and consent-based causation should interact in determining the legally attributable scope of harm in medical liability cases characterised by causal uncertainty. It argues that causation in this field is better understood as a structured progression from factual connection to legal attribution rather than as a single inquiry into the physical production of harm. The analysis adopts a doctrinal and comparative legal method, drawing on established scholarship on causation alongside recent legal literature and relevant judicial developments. It first examines the distinction between factual and legal causation and the particular difficulties created by multifactorial medical outcomes. It then considers foreseeability and remoteness as mechanisms defining the scope of liability, before turning to the distinctive counterfactual inquiry generated by failures of informed consent. Finally, it considers whether these elements can be understood within a coherent model of legal causation capable of maintaining an appropriate balance between patient protection and the proper scope of civil liability.

I. From Factual Causation to Legal Attribution in Medical Liability

The distinction between factual causation and legal attribution is central to determining the boundaries of liability for medical harm. Factual causation is concerned with whether the conduct of a healthcare professional made a difference to the occurrence of the alleged injury. Legal attribution addresses a further question: whether the harm that is factually connected with that conduct falls within the scope of consequences for which civil liability should be imposed.² The two inquiries are closely related, but they perform different functions. A finding of factual causation identifies a connection between conduct and harm; it does not, without further analysis, determine the legal extent of responsibility.

The conventional method for establishing factual causation is the but-for test.³ Expressed counterfactually, the inquiry asks whether the claimant would have suffered the same harm if the defendant had acted in accordance with the required standard of care. Where the answer is no, the defendant's conduct may be regarded as a factual cause of the injury. The test performs an important exclusionary function because it removes from the field of potential liability conduct that made no difference to the claimant's position. In relatively simple causal sequences, this method may provide a sufficiently clear basis for determining causation. Medical disputes, however, frequently resist such a straightforward counterfactual reconstruction.

The difficulty arises because an adverse medical outcome may have more than one medically plausible explanation.⁴ The progression of an underlying disease, pre-existing vulnerability, delayed diagnosis, the effects of treatment, subsequent complications and independent biological processes may operate simultaneously or successively. In such circumstances, the question of what would have happened in the absence of the defendant's conduct cannot always be answered with the degree of certainty suggested by the apparent simplicity of the but-for formula. Medical evidence may establish probabilities, identify competing explanations or demonstrate that a particular act increased the likelihood of an adverse outcome, while remaining unable to isolate a single sufficient cause. The problem is therefore not simply evidential. It exposes a structural tension between the probabilistic character of medical knowledge and a legal inquiry that ultimately requires a determination as to whether the causal requirement has been satisfied.

This tension becomes particularly visible in cases involving multiple sufficient or contributing causes. If the but-for test is applied mechanically, conduct that genuinely contributed to the occurrence of harm may escape causal recognition merely because another factor was also capable of producing the same result. The development of doctrines such as material contribution reflects an attempt to respond to this difficulty without abandoning the requirement of a meaningful connection between breach and

² H.L.A. Hart and Tony Honore, *Causation in the Law*, 2nd edn (Oxford University Press 1985); Gemma Turton, 'Causation and Consent to Medical Treatment: The Risks and Benefits of a Consent-Based Approach to Causation in Negligence' in *Research Handbook on Medical Consent* (Edward Elgar Publishing 2026) 163-184.

³ Richard W. Wright, 'Causation in Tort Law' (1985) 73 *California Law Review* 1735; Hart and Honore (n 1).

⁴ Patricia de Moraes Paisani Matthey Claudet, 'Michael Holmes v Poeton Holdings Ltd [2023] EWCA Civ 1377: A Necessary Clarification for a Non "de minimis" Discussion in Causation' (2024) 32(3) *Medical Law Review* 410-420, 410-412.

injury.⁵ Such approaches do not make causation irrelevant. Rather, they demonstrate that the law may require a more differentiated account of causal involvement where conventional counterfactual reasoning cannot adequately represent the medical circumstances of the case.

At the same time, relaxation of the conventional factual inquiry creates a different risk. The inability of medical science to identify a single cause cannot itself justify the attribution of every uncertain outcome to a healthcare professional. An increase in risk, a temporal sequence and a factual contribution are not necessarily equivalent propositions.⁶ Their legal significance depends upon the nature of the harm, the evidential standard applicable to the claim and the particular causal doctrine invoked. It is therefore necessary to distinguish uncertainty concerning what occurred from the normative question of who should bear legal responsibility for its consequences. Without this distinction, doctrines developed to address evidential or causal complexity may gradually become substitutes for proof of causation itself. For this reason, factual causation should be understood as the beginning rather than the conclusion of causal analysis in medical liability. Once a sufficiently relevant factual connection has been established, the inquiry moves from causal involvement to legal attribution.⁷ The existence of a factual contribution does not answer whether the resulting injury is sufficiently connected to the risk created by the defendant's conduct, whether the consequence is too remote, or whether imposing liability for that consequence would extend responsibility beyond the function of the breached duty. These questions belong to the scope of liability and require a normative assessment that cannot be derived from medical evidence alone.

The transition from factual causation to legal attribution is therefore not a rejection of causal reasoning, but a clarification of its limits. Medical expertise may assist the court in determining whether a particular intervention, omission or delay was capable of contributing to the claimant's condition and how probable that contribution was. It cannot, however, determine by itself the boundaries of civil responsibility.⁸ That determination remains legal in character. The role of legal causation is to identify, among the consequences connected with the defendant's conduct, those that may properly be attributed to that conduct for the purposes of liability. In this sense, the movement from factual causation to legal attribution marks the point at which causal explanation becomes a question about the scope of responsibility.

II. Foreseeability, Remoteness and the Scope of Medical Liability

Once factual causation has been established, the existence of a causal connection does not by itself determine the full extent of civil responsibility. A consequence may be factually linked to negligent medical conduct and yet fall outside the legally attributable scope of the defendant's liability. The inquiry therefore shifts from whether the conduct contributed to the harm to whether the particular harm is sufficiently related to the risk created by that conduct. Foreseeability and remoteness traditionally perform an important role at this stage, limiting liability for consequences that, although causally connected with the defendant's conduct, should not be attributed to it without further normative justification.⁹

Reasonable foreseeability provides one method of drawing this boundary. Its function is not to require a healthcare professional to predict the precise sequence of events that ultimately produced the injury. Rather, the inquiry concerns whether the type of harm that materialised was sufficiently foreseeable in the circumstances in which the relevant duty was performed. This distinction is particularly important in medicine, where serious complications may be statistically uncommon without being clinically irrelevant. A low probability of occurrence does not necessarily place a risk outside the scope of

⁵ Claudet (n 3) 413-419; Richard W. Wright, 'Causation, Responsibility, Risk, Probability, Naked Statistics, and Proof: Pruning the Bramble Bush by Clarifying the Concepts' (1988) 73 *Iowa Law Review* 1001.

⁶ Claudet (n 3) 414-419; Gemma Turton (n 1) 163-184.

⁷ Hart and Honoré (n 1); Jane Stapleton, 'Legal Cause: Cause-in-Fact and the Scope of Liability for Consequences' (2001) 54 *Vanderbilt Law Review* 941.

⁸ Hart and Honoré (n 1); Stapleton (n 6).

⁹ Jane Stapleton, 'Legal Cause: Cause-in-Fact and the Scope of Liability for Consequences' (2001) 54 *Vanderbilt Law Review* 941.

reasonable anticipation, especially where the potential consequence is severe and forms part of the risks that competent medical decision-making is expected to take into account.¹⁰

Foreseeability, however, does not provide a complete explanation of the scope of liability. A consequence may be foreseeable at a sufficiently general level while remaining unrelated to the reason why the defendant's conduct was wrongful. This difficulty becomes clearer when the inquiry is framed in terms of the scope of the risk. Under this approach, the relevant question is whether the injury suffered by the patient represents the materialisation of a risk against which the breached duty was intended to provide protection.¹¹ The focus therefore moves from the abstract predictability of harm to the relationship between the purpose of the duty, the risk created or left uncontrolled by its breach, and the injury that subsequently occurred.

The distinction is significant in medical liability. Consider a failure to diagnose a condition at the appropriate time. The breach may expose the patient to the risk that the untreated disease will progress and reduce the effectiveness of later treatment. If that risk materialises, the resulting deterioration may fall within the scope of liability because it corresponds to the danger that timely diagnosis was intended to prevent. By contrast, the mere fact that some subsequent injury would not have occurred but for the patient's continued presence in a healthcare setting does not necessarily make that injury attributable to the diagnostic failure. The factual sequence may remain intact while the normative relationship between the breach and the particular harm is absent.¹²

Remoteness performs a related limiting function. Its relevance lies in preventing factual causation from expanding liability indefinitely through an increasingly extended chain of consequences. Yet remoteness should not be reduced to a mechanical inquiry into physical or temporal distance.¹³ An injury occurring shortly after negligent treatment may nevertheless fall outside the relevant scope of risk, while a later consequence may remain attributable where it constitutes the development of the very danger created by the breach. The decisive consideration is therefore not simply how many events separate the defendant's conduct from the claimant's injury, but whether the connection between the breach and the type of harm retains sufficient legal significance.

This approach also helps distinguish the scope of liability from the evidential difficulties examined in relation to factual causation. Scientific uncertainty concerns whether and to what extent particular conduct contributed to the medical outcome. Foreseeability and remoteness address a different problem: assuming the necessary factual connection can be established, which of its consequences should be treated as falling within the defendant's responsibility? Keeping these inquiries distinct prevents uncertainty in medical proof from being used either to eliminate legitimate claims or, in the opposite direction, to justify liability for consequences that fall outside the risk associated with the breach.

The scope of liability in medical cases should therefore not be understood as a secondary or merely technical restriction imposed after causation has already been established. It forms part of the causal analysis through which factual consequences are converted into legally attributable harm. Foreseeability remains relevant to that process, but its function is more convincing when considered together with the nature and purpose of the breached duty and the risk that made the defendant's conduct negligent.¹⁴ This combined inquiry permits the law to recognise the particular uncertainties of medical decision-making without transforming every medically connected adverse outcome into a compensable consequence.

¹⁰ *Zweigel v North Atlanta Obstetrics & Gynecology, LLC*, 374 Ga App 579, 913 SE2d 719 (Ga Ct App 2025).

¹¹ Jane Stapleton, 'Cause-In-Fact and the Scope of Liability for Consequences' (2003) 119 *Law Quarterly Review* 388-425; Marco Cappelletti, 'Remoteness in Negligence: A Critique and Reconstruction' (2026) *Oxford Journal of Legal Studies*, gqag027, doi:10.1093/ojls/gqag027.

¹² Stapleton (n 10) 388; Stapleton (n 8) 941.

¹³ Marco Cappelletti, 'Remoteness in Negligence: A Critique and Reconstruction' (2026) *Oxford Journal of Legal Studies*, gqag027, doi:10.1093/ojls/gqag027; Stapleton (n 10) 388.

¹⁴ Stapleton (n 10) 388; Cappelletti (n 10).

III. Counterfactual Causation in Cases of Inadequate Disclosure

Causal analysis assumes a distinctive form where the alleged breach consists of a failure to provide information before medical treatment. The relevant causal question is not simply whether the medical intervention physically produced the injury. Where the treatment itself has been performed competently but an undisclosed risk subsequently materialises, the causal inquiry concerns the relationship between the omission of information and the patient's decision to undergo the treatment. The analysis therefore depends upon a counterfactual proposition: what would the patient have decided if adequate information had been provided?¹⁵

This counterfactual inquiry differs from the conventional but-for analysis examined in relation to physical injury. In an ordinary medical negligence claim, the hypothetical comparison generally concerns the likely medical outcome had the healthcare professional acted without negligence. In a disclosure case, however, the counterfactual intervenes through human decision-making. The court must reconstruct not only an alternative sequence of medical events, but also a decision that the patient did not in fact make under conditions that did not in fact exist. The causal chain consequently contains an additional hypothetical element between the defendant's conduct and the resulting harm: the patient's response to information that was never provided.¹⁶

The difficulty is not eliminated by asking whether a reasonable patient would have proceeded with the treatment. Such an inquiry may provide an objective reference point, but the causal proposition ultimately concerns the decision of the particular patient. Conversely, reliance exclusively on the patient's retrospective assertion that treatment would have been refused creates an obvious evidential difficulty, since that assertion is made after the adverse risk has already materialised. Counterfactual causation in this context therefore requires a reconstruction based on evidence capable of connecting the omitted information with the individual patient's likely decision, while avoiding both an entirely abstract objective standard and an uncritical acceptance of hindsight.¹⁷

A further complication arises where adequate disclosure would not necessarily have resulted in the permanent rejection of treatment. The patient might instead have postponed the procedure, sought another medical opinion, selected an alternative intervention or accepted the same treatment at a different time. These possibilities demonstrate why the counterfactual cannot always be reduced to a binary choice between consent and refusal. The relevant hypothetical sequence may involve several possible courses of action, each of which may alter the relationship between the omission and the injury that ultimately occurred. The more dependent the causal conclusion becomes upon assumptions about these unobserved choices, the more carefully the evidential and legal dimensions of the inquiry must be distinguished.¹⁸

This difficulty also exposes the limits of describing the problem exclusively in terms of factual causation. Even where a court accepts that adequate information would have affected the patient's decision, a further question remains as to whether the injury that occurred should be attributed to the informational omission. The omission did not physically produce the medical complication in the same manner as a negligent surgical act might produce physical injury. Its causal relevance lies instead in the alleged alteration of the decision-making process through which the patient became exposed to the risk that subsequently materialised. The analysis therefore moves from a hypothetical reconstruction of patient choice to the legal significance that should be attached to that reconstructed choice.¹⁹

Counterfactual causation in cases of inadequate disclosure consequently illustrates the broader distinction developed throughout this article between causal connection and legal attribution. The counterfactual inquiry remains necessary because liability cannot be based solely on the fact that information was omitted and an adverse outcome followed. Yet the reconstruction of what the patient

¹⁵ Gemma Turton, 'Causation and Consent to Medical Treatment: The Risks and Benefits of a Consent-Based Approach to Causation in Negligence' in *Research Handbook on Medical Consent* (Edward Elgar Publishing 2026) 163-184; *Chester v Afshar* [2004] UKHL 41, [2005] 1 AC 134.

¹⁶ *Chester v Afshar* [2004] UKHL 41 [40]-[41], [60]-[61]; Turton (n 14) 163-184.

¹⁷ Gemma Turton (n 14) 163-184; *Duce v Worcestershire Acute Hospitals NHS Trust* [2018] EWCA Civ 1307 [48]-[50].

¹⁸ *Chester v Afshar* [2004] UKHL 41 [8]-[9], [39]-[41]; *Chester v Afshar* [2002] EWCA Civ 724 [19]-[20].

¹⁹ Daniel Ugarte Mostajo, 'Causation and Attribution in Medical Liability for Breach of the Duty to Inform in Risky Medical Interventions' (2024) 68 *IUS ET VERITAS* 189-208, doi:10.18800/iusetveritas.202401.013; Turton (n 14) 163-184.

would have decided does not, by itself, resolve the scope of responsibility.²⁰ It identifies the possible causal significance of the informational omission, after which the law must determine whether the materialised harm is sufficiently connected with that omission to justify its attribution to the defendant. In this respect, disclosure cases provide a particularly clear example of the transition from factual and hypothetical causal reasoning to the normative determination of legally attributable harm.

IV. Legal Causation as a Normative Mechanism of Attribution

The preceding analysis demonstrates that causation in medical liability cannot be reduced to the identification of a factual sequence between medical conduct and patient harm. Factual causation establishes whether the defendant's conduct made a relevant difference to the occurrence of the injury, but the existence of such a connection does not determine the full extent of legal responsibility. Questions concerning the scope of risk, remoteness and counterfactual patient choice reveal a further stage of the inquiry in which the law must determine which consequences of medically relevant conduct are properly attributable to the defendant. Legal causation therefore performs a normative function within the broader structure of causal analysis.²¹

This function is particularly important in medical liability because the circumstances in which harm occurs are frequently characterised by uncertainty and causal complexity. A patient may already be exposed to a significant risk of deterioration before any medical intervention takes place. Treatment may reduce one risk while simultaneously introducing another, and an adverse outcome may result from the interaction of several factors rather than from a single independently sufficient cause. If factual involvement alone were treated as sufficient for the attribution of responsibility, the boundary between liability for negligent conduct and liability for an adverse medical outcome would become increasingly difficult to maintain. Legal attribution prevents that expansion by requiring a relationship not merely between conduct and harm, but between the legally relevant risk created or left uncontrolled by the breach and the injury for which compensation is sought.²²

The limiting function of legal causation should not, however, be understood solely as a mechanism for protecting healthcare professionals from excessive liability. Causal requirements also protect the coherence of the claimant's right to compensation. Where negligent medical conduct has exposed a patient to a legally relevant risk and that risk has materialised in the form of the harm against which the relevant duty was directed, an excessively restrictive approach to causation may leave a genuine injury without an effective legal response. The normative function of causation therefore operates in both directions. It restricts liability where the connection between breach and harm is legally insufficient, while permitting responsibility to attach where the injury represents the materialisation of the risk that gave the breached duty its protective significance.²³

This dual function becomes especially visible when factual uncertainty is unavoidable. Medical science may be unable to reconstruct the biological history of an injury with complete certainty, but uncertainty does not eliminate the need for a principled legal determination. At the same time, the existence of uncertainty cannot itself supply the missing causal connection. The task of legal causation is therefore not to replace scientific proof with an unrestricted appeal to fairness, but to determine the legal significance of the causal findings that can properly be established.²⁴ Normative attribution begins where factual explanation reaches its legal limits, but it remains dependent upon a sufficiently grounded connection between the defendant's conduct, the relevant risk and the harm suffered by the patient.

The same structure is visible in the counterfactual analysis of inadequate disclosure. There, the causal inquiry cannot be confined to the physical mechanism by which treatment produced an injury. It also requires consideration of whether adequate information would have altered the patient's decision and,

²⁰ Turton (n 14) 163-184; Ugarte Mostajo (n 18) 189-208; *Chester v Afshar* [2004] UKHL 41 [8]-[9], [60]-[61].

²¹ H.L.A. Hart and Tony Honore, *Causation in the Law*, 2nd edn (Oxford University Press 1985); Jane Stapleton, 'Legal Cause: Cause-in-Fact and the Scope of Liability for Consequences' (2001) 54 *Vanderbilt Law Review* 941.

²² Jane Stapleton, 'Cause-In-Fact and the Scope of Liability for Consequences' (2003) 119 *Law Quarterly Review* 388-425; Marco Cappelletti, 'Remoteness in Negligence: A Critique and Reconstruction' (2026) *Oxford Journal of Legal Studies*, gqag027, doi:10.1093/ojls/gqag027.

²³ Stapleton (n 21) 388-425; Cappelletti (n 21).

²⁴ Hart and Honore (n 20); Stapleton (n 20) 941.

if so, whether the resulting harm should be attributed to the omission of that information. The example is significant not because disclosure claims require a separate theory of causation, but because they make particularly visible the transition from factual and hypothetical reasoning to normative attribution. The law must first identify the causal significance of the omitted information and then determine the legal consequences that may properly follow from it.²⁵

Legal causation can therefore be understood as the stage at which the different dimensions of medical causation converge. Factual causation identifies causal involvement; counterfactual reasoning tests alternative courses of events or decisions; foreseeability, remoteness and the scope of risk delimit the consequences for which responsibility may extend. These inquiries should not be collapsed into a single test, since each performs a distinct analytical function. Their relationship is nevertheless sequential and complementary. Together, they provide a structure through which the law moves from the existence of a causal connection to the attribution of legally relevant harm.²⁶

On this account, the balancing function of causation does not consist in an abstract compromise between the interests of patients and healthcare professionals. It is achieved through the disciplined application of causal and normative criteria to the circumstances of the individual case. The protection of patients requires that genuine causal complexity should not become an automatic barrier to recovery. The proper limits of civil liability require, with equal force, that medical uncertainty should not be transformed into a presumption of responsibility for every adverse outcome. A coherent approach to legal causation must accommodate both concerns by maintaining the distinction between factual involvement and legal attribution while explaining the relationship between them. In this sense, causation operates not merely as a condition of liability, but as a structural mechanism for defining its legitimate scope.

Conclusion

Causation in medical liability cannot be adequately explained through a single inquiry into whether medical conduct physically contributed to an adverse outcome. The analysis developed in this article demonstrates that the legally relevant causal inquiry involves distinct but interconnected stages. Factual causation identifies whether the defendant's conduct made a difference to the occurrence of harm. Counterfactual reasoning reconstructs the course that events, or in certain cases patient decisions, would have taken in the absence of the relevant breach. The scope of liability then determines whether the resulting harm may properly be attributed to the defendant. Causation in medical liability is therefore best understood as a progression from factual connection to legal attribution.

This distinction assumes particular importance in conditions of medical uncertainty. Multiple contributing factors, pre-existing disease, recognised treatment risks and probabilistic scientific evidence may make it impossible to describe an injury through a simple linear causal sequence. Such uncertainty does not justify abandoning factual causation, nor should the conventional but-for test be expected to resolve every case irrespective of the causal structure of the medical outcome. The appropriate approach is to preserve the distinction between factual proof and normative attribution, recognising that each addresses a different question within the determination of responsibility.

Foreseeability, remoteness and the scope of risk further demonstrate why factual contribution cannot define the limits of liability by itself. Once a sufficient factual connection has been established, the law must still determine whether the injury represents the materialisation of a risk legally connected with the defendant's breach. This prevents liability from extending automatically to every consequence within the factual history of medical treatment, while allowing responsibility where the injury corresponds to the danger against which the relevant duty was intended to provide protection. Legal causation therefore operates neither as a purely technical restriction on recovery nor as an unrestricted appeal to fairness, but as a mechanism for defining the legally relevant scope of causal responsibility.

Counterfactual causation in cases of inadequate disclosure confirms the same structural point from a different perspective. Here, causal reasoning may require the reconstruction of a hypothetical patient

²⁵ Daniel Ugarte Mostajo, 'Causation and Attribution in Medical Liability for Breach of the Duty to Inform in Risky Medical Interventions' (2024) 68 *IUS ET VERITAS* 189-208, doi:10.18800/iusetveritas.202401.013; Gemma Turton (n 14) 163-184.

²⁶ Hart and Honoré (n 20); Stapleton (n 20) 941; Stapleton (n 21) 388-425; Cappelletti (n 21).

decision rather than merely an alternative sequence of physical events. The inquiry concerns whether adequate information would have altered the patient's course of action and what legal significance should attach to that hypothetical difference. The counterfactual remains necessary, but its establishment does not by itself determine the ultimate scope of responsibility.

Factual causation, counterfactual reasoning and legal causation should therefore neither be collapsed into a single test nor treated as unrelated doctrinal inquiries. They perform different functions within a common structure of attribution. Factual causation establishes causal involvement; counterfactual analysis tests whether the relevant conduct or omission made a difference to the course of events or decisions; and legal causation determines whether the resulting harm falls within the proper scope of civil responsibility. Foreseeability, remoteness and the scope of risk contribute to this final determination by defining the boundaries within which factual consequences acquire legal significance.

This integrated approach avoids two opposite distortions. Causal uncertainty should not become a reason to deny recovery whenever medical science cannot provide a complete reconstruction of the injury, but neither should uncertainty weaken the causal requirement until adverse outcome becomes a substitute for proof of responsibility. A coherent approach requires a sufficiently grounded factual connection together with a separate assessment of whether the harm falls within the legally attributable consequences of the relevant breach.

The movement from causal connection to legal attribution thus provides a coherent framework for understanding causation in medical liability. It preserves the evidential discipline of factual causation without assuming that scientific explanation alone can determine the boundaries of civil responsibility, while recognising the normative character of legal causation without detaching attribution from the causal foundation of the claim. The resulting framework accommodates the uncertainty inherent in medical decision-making while maintaining a principled distinction between an adverse medical outcome and legally attributable harm. That distinction defines the proper function of causation in medical liability: not merely to explain how harm occurred, but to determine when and why that harm may properly become the subject of civil responsibility.

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