Evidential Gaps in Primary Care Communication: When "Usual Practice" Is Not Enough — Expert GP Analysis of Shaheen and Ahmed v Daish

by Dr Samah Boulis, GP Expert Witness.

Clinical negligence cases in primary care rarely turn on dramatic errors. More often, they hinge on small, easily overlooked moments within routine consultations. The High Court decision in *Shaheen and Ahmed (Executors of the Estate of Mr Ajaz Ahmed) v Dr Joanna Daish* is a clear illustration of this reality.

At its core, this case is not about diagnostic failure in the traditional sense. It is about communication—what was said, what was not said, and, crucially, what cannot be proven to have been said. For those of us practising as GP expert witnesses, it represents a clear and instructive example of how workflow, documentation, and patient-led systems intersect to create medicolegal risk.

Factual Background and Chronology

Mr Ahmed, aged 49, consulted his GP, Dr Daish, on 11 February 2019 with worsening breathlessness following a respiratory infection. At consultation, he was assessed as having an asthma exacerbation, treated with inhalers and oral steroids, and a chest X-ray was requested via the ICE system. This operated as a walk-in service requiring the patient to attend radiology independently.

The key chronology is as follows:

- 11 February 2019: Consultation recorded examination, diagnosis, treatment, and the X-ray request. However, there was no documentation of any discussion with the patient about the investigation or how to access it. Audit data indicated that parts of the management plan, including prescribing, were completed after the patient had left, and the record was then closed.
- 11 February 2019 (later): A text message was sent regarding medication changes only; no communication was sent about the X-ray.
- 27 February 2019: A nurse follow-up appointment was scheduled but not attended, with no clear link to imaging.

- 2019–2022: No chest X-ray was undertaken. There is no evidence that Mr Ahmed was aware of an outstanding investigation.
- January 2022: Mr Ahmed stated in a witness statement that he had not been told to attend for an X-ray.
- February 2023: Mr Ahmed died from lung cancer.

The Claimants alleged failure to communicate the X-ray request and its process. The Defendant relied on usual practice but had no specific recollection. The court was asked to determine breach, causation, and contributory negligence.

The court was asked to determine three preliminary issues:

1. Whether the Defendant failed to inform Mr Ahmed of the X-ray request;
2. If so, whether Mr Ahmed would have attended had he been informed;
3. Whether Mr Ahmed was contributorily negligent in failing to attend subsequent follow-up appointments.

The Judge's Conclusion and Reasoning

Christopher Kennedy KC, sitting as a Deputy High Court Judge, found for the Claimants on all preliminary issues. The court held, on the balance of probabilities, that Dr Daish did not inform Mr Ahmed of the need to attend for a chest X-ray, despite being described as a "caring and competent" clinician.

1. Communication of the X-ray

The court relied primarily on the contemporaneous record:

- No documentation of discussion: The record confirmed the X-ray request but contained no evidence that it was explained to the patient, unlike other investigations in the same notes.
- Clinical context: Given Mr Ahmed's anxiety about his symptoms and recent urgent attendance, the court found it unlikely he would have ignored a cancer-excluding test if informed.
- Audit trail evidence: Post-consultation prescribing and record closure supported an inference that key actions may have occurred after the patient left, without communication.

2. Causation

The court found Mr Ahmed would have attended the X-ray if informed, relying on:

- prior compliance with walk-in investigations;
- clear concern about his health;
- expected engagement with serious pathology exclusion.

There was no evidence of informed non-attendance.

3. Contributory Negligence

The defence failed.

The court found no evidence that Mr Ahmed knew about the X-ray or understood any risk in not attending follow-up. Non-attendance could not therefore be characterised as negligent, and the burden of proof was not met.

GP Expert Witness Perspective

The facts will be immediately recognisable to any practising GP. Speaking as a GP who also works in medico-legal cases, what stands out in this case is how ordinary it all is. There's nothing exotic here clinically. No diagnostic outlier. No missed red flags in the traditional sense. The dispute turns on something far more familiar in general practice: communication, timing, and what the record does—or doesn't—show.

The key issue isn't diagnosis, it's communication

What the court was really trying to establish wasn't whether the GP acted competently in clinical terms. It was much narrower and, in some ways, more unforgiving: was the patient told about the chest X-ray, and did he know how to act on it?

That's a question every GP recognises. It's the "I'm sure I told them" problem, which in day-to-day practice is usually true—but legally, it has to be demonstrable.

The record tells the story, not memory

When you step back and look at the audit trail from 11 February 2019, it essentially reconstructs the consultation more reliably than any recollection could. This chronology allowed the court to reconstruct events with a high degree of precision. It also reinforces an important medicolegal principle: primary care records are best understood as time-stamped datasets rather than narrative recollections.

You can see the consultation itself: assessment, examination, clinical reasoning, and a decision to request imaging. Then you can see the subtle but crucial timing issue—the X-ray request appears to have been generated after the patient had left the room. The same applies to later prescribing and administrative updates.

None of this is clinically unusual. It's how general practice actually runs: decisions made in real time, paperwork completed immediately afterwards.

But legally, that gap between "decision" and "documentation" becomes very important.

What is missing, though, is the one thing that matters most in this scenario: any clear, contemporaneous evidence that the patient was told about the X-ray and what to do next.

Communication vs "Usual Practice"

The GP defendant, described as a competent and conscientious clinician, had no independent recollection and relied on her usual practice of explaining investigations and access arrangements.

This is a familiar evidential position in primary care litigation. However, the court preferred contemporaneous documentation.

From an expert witness perspective, this reflects a consistent judicial approach: contemporaneous clinical records are given greater weight than reconstructed accounts based on habitual practice.

Usual Practice: Evidential Weight and Its Limits in Clinical Negligence Claims

Where records are silent, and particularly where other entries demonstrate that similar discussions are routinely documented, courts are entitled to infer that the communication did not occur. This is not a criticism of clinical care; it reflects evidential hierarchy.

The Consultation Extends Beyond the Consultation Room

One of the most important practical points this case highlights is something GPs know but often underestimate in its legal significance: a consultation doesn't finish at the end of the face-to-face encounter.

Ordering the test, coding it, sending the text, finishing the notes—all of that often happens after the patient has gone. This is operationally efficient but legally significant.

If an investigation is generated post-consultation, or not explicitly communicated before the patient leaves, a critical step remains incomplete: patient understanding.

The court, in essence, separated two things we often blur together in practice:

- initiating care (ordering the X-ray), and
- delivering care (ensuring the patient understands and can act on it).

Patient-Led Systems Increase Risk

The ICE walk-in model is widely used and efficient, but it quietly shifts responsibility onto the patient.

That only works safely if one condition is met: the patient knows what has been requested and what they are supposed to do next.

When that step fails, the system doesn't visibly break. It just quietly fails downstream.

From a GP perspective, that makes communication not a "soft skill", but a safety-critical step. The greater the reliance on patient initiation, the greater the importance of explicit explanation and documentation.

Documentation isn't defensive - it's functional

There's a tendency in primary care to think of documentation as something we do for medico-legal protection. That's not really the right way to think about it.

The more accurate framing is this: if it isn't documented, it's very difficult to prove it happened.

In this case, a single line such as:"CXR requested, patient advised to attend walk-in radiology" would likely have changed the evidential picture entirely.

That's not about defensive medicine. It's about closing the loop.

Behaviour matters more than we sometimes admit

One of the more subtle aspects of the judgment is how much weight is placed on what the patient was likely to do, not just what was recorded.

This wasn't a disengaged or chaotic patient. He was health-aware, proactive, and had already sought assessment. In that context, the court found it unlikely he would have ignored a potentially serious investigation if he had been told about it properly.

Whether one agrees or not, this reflects a broader trend: courts increasingly test clinical narratives against realistic human behaviour, not just paperwork.

Contributory negligence remains a high bar

Attempts to argue contributory negligence in cases like this usually struggle, and this one was no exception.

Missing an appointment or not following up isn't enough on its own. There has to be evidence the patient understood:

- that further action was needed, and

- what the consequences of inaction might be.

In routine GP consultations, that level of explicit understanding is often assumed rather than confirmed—and that assumption rarely holds up well in court.

The reality of a routine GP consultation

What's striking is how unremarkable this all is from a clinical point of view.

This is standard general practice:

- a busy clinic with limited time,
- a reasonable clinical decision to investigate,
- the usual flurry of admin after the patient has left,
- and a system that depends on the patient taking the next step

There's nothing unusual in any of that. It's how most of us work every day.

The risk sits in a very small space—the gap between deciding to act and making sure the patient knows what to do.

In a system where investigations are often patient-led, that gap matters more than we sometimes think. If the patient leaves without a clear understanding of what's been arranged and what they need to do, the pathway is already vulnerable.

So the practical lesson is simple, if slightly uncomfortable:

If an investigation depends on the patient doing something afterwards, then the communication needs to be explicit, and the record needs to reflect it.

Not because GPs are failing to do their job—but because in a digitised, fragmented system, the record is often the only thing that survives the passage of time intact.

Why This Case Matters for Instructing Solicitors?

For practitioners in clinical negligence, the case highlights recurring evidential themes:

- Chronology is decisive: audit trails often determine factual findings;
- Internal consistency matters: variation within records can undermine "usual practice" evidence;
- Communication failures are highly litigable: particularly in patient-led pathways;
- Expert evidence must reflect real practice: not retrospective idealisation.

Expert Witness Role

Acting as a GP expert isn't just about reading the notes and commenting on clinical decisions. It's about understanding how general practice really works:

the pace of consultations,
the habit of completing tasks after the patient has gone,
the way electronic systems shape workflow,
and the points at which communication can realistically break down

That context is essential when forming an opinion on what is, and isn't, reasonable.

Final Reflection

From a GP standpoint, this isn't a case about getting the medicine wrong.

It's about something much more familiar—communication in a system that assumes patients will understand and act, but doesn't always make that understanding explicit.

The reality is simple, but not always easy in a busy clinic:

If the next step depends on the patient, the job isn't finished when the test is ordered. It's finished when the patient knows about it, understands it, and there is a clear record of that.

That's why this case feels so close to home.

There's nothing unusual here:
a routine consultation,
a sensible decision to investigate,
and just a small gap in communication.

And that small gap is exactly where the risk sits – a small omission which proved pivotal.

From an expert witness point of view, this isn't really about knowledge or clinical judgment. It's about what happens at the join between the GP, the patient, and the system we're all working in.

Modern general practice is busy, digital, and increasingly reliant on patients to take the next step themselves. Most of the time that works fine—but when communication isn't clear, or isn't documented, that's where the risk sits.

None of this is new. It's the sort of thing we've all been told before.

But cases like this show how little room there is now for things to be left assumed rather than said—and written down.

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As a GP expert witness, I prepare independent reports in clinical negligence cases, with a focus on informed consent, standards of care and decision-making in primary care.

My overriding duty is to the Court. All reports are prepared in accordance with CPR Part 35, Practice Direction 35, and the Guidance for the Instruction of Experts in Civil Claims (2014).

I welcome instructions from clinical negligence solicitors and counsel in England, Scotland and Northern Ireland.

If you would like to discuss a potential instruction or expert witness query, please feel free to get in touch: spboulis@doctors.org.uk