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Navigating ‘not doing’ in primary care: could more explicit guidelines on record-keeping help to ease clinician anxiety?

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Introduction

Electronic health records (EHRs) serve several key purposes: they remind healthcare professionals (HCPs) of consultation details, support continuity of care by sharing information, and provide evidence of care quality or potential deficiencies should clinical practice be scrutinised (1). As primary care (PC) professionals develop record-keeping skills, they may be influenced by preregistration training, advice from peers and mentors, observing others’ record entries, audit feedback, and published guidelines. Given the various ways these skills are acquired and the lack of a widely adopted gold standard, documentation practices differ across UK PC. This inconsistency may complicate record interpretation for multidisciplinary healthcare teams (MDTs), complaint investigators, and patients who view them.

There are increasing concerns about medical overuse, including over-prescription, overdiagnosis, unnecessary referrals, and a recognition of the harm it could cause patients. Medical overuse is complex, driven by time pressures, care discontinuity, patient expectations, team culture, misuse of guidelines, fear of complaints and peer criticism (2). HCPs often worry more about being criticised for ‘not doing’ than unnecessary interventions, despite the risks associated with both scenarios (2). Anxiety over patients’ decisions to ‘not do’ something, along with fear of reprisals, may fuel defensive practices. Robust record-keeping could be an important facilitator in reducing clinician anxiety and decreasing medical overuse.

The concept of ‘not doing’ in PC is more nuanced than it might initially appear. While it suggests inaction, consultations are inherently active. For example, advising patients to watch and wait is rarely passive; it ideally encompasses careful consideration, communication, and shared decision-making (SDM), offering patients the opportunity to voice their concerns and nurturing therapeutic relationships. In this article, ‘not doing’ refers to decisions that do not involve contemporaneous prescriptions, treatments, referrals, tests, or diagnoses, acknowledging that these decisions are a complex, active therapeutic process.

Exploration of the current record-keeping guidelines within the UK

Accurate record-keeping is considered a cornerstone of good clinical practice. Some clinical information, such as chronic disease management, diagnosis, and prevention, can be recorded in EHRs using coding (3). However, the free-text element is essential for capturing details of decision-making and treatment plans (3). It documents actions taken and decisions not to act, such as not prescribing, ordering tests, or referring patients; however, guidance on documenting these kinds of decisions remains limited and subject to interpretation.

The GMC regulates medical standards (4), including education and training, and promotes best practices. It does not provide a specific document on recording

decisions of ‘not doing’; it offers two relevant resources: *Decision-making and Consent* (1) and *Good Medical Practice* (5). These documents emphasise the importance of discussing what matters to the patient, the benefits and harms of treatment, and alternatives, including the option to refrain from action; they also advocate for ensuring accurate, proportionate records to justify the decisions made, indicating that variations in documentation are acceptable. *Good Medical Practice* advises that agreed actions, including decisions of non-intervention along with the individuals involved in making and agreeing to them, ‘must’ be included in the patient's records (5). Following the GMC's advice could provide a comprehensive account of treatment decisions, including ‘not doing’. Nonetheless, this may rely on what the clinician considers proportional to the encounter. NICE guidelines support the GMC's emphasis on incorporating patient values in their SDM advice but lack detailed instructions on documentation (6).

The GMC's general principles for documenting decisions may provide sufficient guidance for some professionals; however, a more structured approach could benefit others. This gap might be addressed by the PRSB, which offers a directive approach to recording SDM in EHRs, incorporating intervention decisions and ‘not doing’. *The PRSB standards for shared decision-making* offer a detailed list of what should be included in EHRs (7). Although the PRSB standards for recording SDM are not explicitly designed to capture ‘not doing’, they are comprehensive enough to address most types of shared-decisions. Integrating this standard into the digital systems of PCNs could reassure clinicians and patients by ensuring a comprehensive consultation record. Nevertheless, criticisms were raised during the consultation process regarding this PRSB standard; the practicality of completing this record within the allotted appointment time and some patients' ability to engage in the SDM process as indicated by the standard were questioned (8). Furthermore, implementing the PRSB standards is not mandatory; this could limit their adoption and bring their purpose into question.

HCPs with concerns about complaints or litigation may seek advice on record-keeping from medical defence organisations. Despite attempts to access published guidelines from five such organisations, the MDU was the only one that freely provided relevant guidelines. The MDU's guidance highlights that well-maintained records can serve as evidence to address future complaints (9). By following this advice, HCPs may reduce the likelihood of complaints being upheld while alleviating any anxiety associated with maintaining accurate records (9). The MDU advice aligns with the GMC's proportional approach to documentation and includes a record-keeping checklist of do’s and don’ts. This resource appears helpful in reflecting on current practice; however, it significantly emphasises recording interventions, with a minimal direct focus on ‘not doing’ (9). Therefore, this presents the question of whether the balance of guidance on record-keeping weighs in favour of providing interventions. Could this unintentionally guide clinicians towards providing interventions and away from ‘not doing’?

The HCPs that support GPs also make entries in EHRs and experience similar challenges. Little comprehensive record-keeping advice is available among the guidelines created for nursing, allied health professionals, physician associates and

pharmacists. An exception to this is the Chartered Society of Physiotherapy (CSP), which provides the SOAP method of record-keeping as an example (10). More generally, resources for non-GP professionals offer limited guidance on recording decision-making; the main focus is on maintaining event logs, e.g., time, date, patient consent, the scope of practice of the HCP and maintaining GDPR standards (see Table 1).

Reviewing professional guidelines can offer valuable insights into suggested record-keeping practices across PC MDTs; however, further consideration is required as to what extent they are or should be implemented.

Table 1- Summary of retrieved documents containing relevant guidance.

Institution	Document	Does it offer guidance on accurately recording event logs?*	Does it offer guidance on discussions regarding non-intervention?	Does it offer guidance on documenting the decision-making process?	Does it specifically guide the recording of non-intervention?
National Institute for Health and Care Excellence (NICE)	Shared decision-making NICE guideline [NG197](6)	No	Yes	Yes	No
General Medical Council (GMC)	Decision-making and consent (1)	Yes	Yes	Yes	Yes
General Medical Council (GMC)	Good medical practice (5)	Yes	Yes	Yes	Yes
Medical Defence Union (MDU)	Effective record-keeping (9)	Yes	No	Yes	Yes
Royal College of General Practitioners (RCGP)	No relevant document was found.				
The Professional Record Standards Body (PRSB)	Shared Decision-Making Standard (7)	Yes	Yes	Yes	Yes
Royal Pharmaceutical Society (RPS)	A competency framework for all prescribers (11)	Yes	Yes	No	No
Health & Care Professions Council (HCPC)	The standards of proficiency for paramedics (12); The Standards of proficiency for physiotherapists (13)	Yes	No	No	No
Health & Care Professions Council (HCPC)	Standards of conduct, performance and ethics (14)	Yes	No	No	No
College of Paramedics (CoP)	Practice Guidance for Paramedics - Independent & Supplementary Prescribers (15)	Yes	Yes	Yes	No
The Chartered Society of Physiotherapy (CSP)	Record Keeping Guidance (10)	Yes	No	Yes	No
The Nursing and Midwifery Council (NMC)	The Code (16)	Yes	Yes	No	No
Royal College of Nursing	Record Keeping: The Facts (17)	Yes	No	No	No
General Medical Council (GMC) Interim guidance for Physicians Associates	Achieving good medical practice for PAs and AA students (18)	Yes	No	No	No

*A record of time, date, people present, actions agreed, review date, legibility, accuracy, integrity, contemporaneousness etc

Are guidelines for primary care record-keeping a double-edged sword?

Guidelines for record-keeping in PC have the potential to offer significant benefits for some HCPs. They may also raise concerns about their impact on professional autonomy and the quality of patient care for others. At their best, guidelines can provide a framework that ensures EHRs are consistent, comprehensive, and translatable across the healthcare system. Increased uniformity could support continuity of care by enabling PC team members to quickly understand a patient's history, treatment plan, and shared decisions. Clear and structured documentation can enhance communication, minimise errors, and improve patient outcomes while meeting legal and regulatory requirements. In disputes or complaints, well-maintained records guided by standardised practices could serve as a robust defence for HCPs, providing the records demonstrate good clinical practice. Conversely, if the care does not meet the required standards, it can help patients uphold their complaints.

With patients now able to access their EHRs, a standardised structure for free-text entries could enhance patient understanding by providing consistency in where and how information is presented. Familiarity with this format may help patients navigate their records more effectively. Additionally, could standardised documentation alleviate HCPs' concerns about patient access? It could encourage accountability with consistent documentation of key details, reducing the risk of omissions and providing greater confidence in clinical decision-making. This could help mitigate anxiety among HCPs while supporting transparency and patient engagement.

Guidelines intended for broader HCPs transitioning into PC have notable gaps in advice. Improved guidelines for these professionals could enhance learning and development of record-keeping skills. Encouraging the appropriate documentation of the decision-making processes, including capturing patient values, goals, and preferences currently omitted from resources. This may support HCPs new to PC choosing 'not doing' approaches with their patients.

Rigid guidelines could also present significant challenges, particularly in fast-paced clinical environments. The demand for exhaustive documentation may detract from meaningful patient interactions if clinicians feel pressured to meet bureaucratic standards rather than focusing on the human elements of care. A tick-box approach could encourage defensive practice and make professionals more likely to opt for an active approach to care rather than consider not doing it. Excessive and irrelevant details may overshadow the key elements of the narrative of a patient's clinical journey and their preferences for their health.

Critics warn against the tyranny of guidelines, noting their potential to stifle professional judgment (19). This may be especially prevalent among less experienced HCPs who may lack the confidence to support patients in deviating from prescribed processes. There is a risk that rigid implementation of guidelines could lead to a formulaic approach to record-keeping, eroding the flexibility and nuance required for individualised patient care. It could diminish the richness of clinical documentation and alienate patients by prioritising procedure over engagement.

Instead of fostering professionalism, standardisation of record-keeping might create documentation fatigue and contribute to burnout and a loss of focus on clinical priorities. Ambient artificial intelligence (AI) could solve some of the concerns raised. Balloch and Sridharan et al. demonstrated that AI technology could capture simulated outpatient consultations and produce good-quality patient records without impacting patient interaction time while reducing the task load for clinicians (20).

Conclusions

We have explored the need to support HCPs in documenting ‘not doing’ in PC. While comprehensive guidelines can enhance consistency, promote SDM, and protect against litigation, they must remain flexible to preserve professional judgment and adapt to unpredictable patient consultations.

Addressing current gaps, particularly for those transitioning into PC, could build confidence and competency in recording clear and translatable ‘not doing’ decisions across MDTs. Striking a balance between thorough, translatable records and the realities of clinical practice is key. An effective approach might combine training, mentorship, and reflective record-keeping practices, supported by guidelines that guide but do not constrain. Integrating ambient AI tools could ease documentation burdens, allowing clinicians to focus on patient care while reducing hesitation around ‘not doing.’ Such a strategy could maintain high care standards and reduce medical overuse.

Future research could examine the effectiveness of comprehensive record-keeping in increasing clinician confidence and minimising medical overuse. Interdisciplinary practices, patient perspectives on ‘not doing’ documentation, and challenges in implementing standardised guidelines warrant further exploration. Additional research into the effects of employing AI tools to document consultations and their influence on decision-making could also enrich the discussion regarding patient records.

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