The medical record is a powerful tool that allows a physician to track the patient's medical history and identify ongoing or recurrent problems or patterns. The primary purpose of the medical record is to enable physicians to provide quality health care to their patients. The quality of documentation should allow any clinician to review the chart and continue to provide care for a given patient. Physicians are encouraged to review this assessment standard to help guide their day-to-day medical record keeping.

The intent of this Physician Practice Enhancement Program (PPEP) is to provide more detail on what is required for documentation and what a peer assessor will be looking for in a medical record, to increase transparency of the

This assessment standard does not apply to independent medical examinations (IMEs). Physicians conducting IMEs must refer to the College of Physicians and Surgeons of British Columbia practice standard *Independent Medical Examinations*. When assessing IMEs, a peer assessor will review the letter of instruction, IME report, notes, and fulfilment of the expert witness Duty to Court. The report is expected to include the facts and assumptions made to substantiate the opinions rendered by the expert.

This assessment is Outpatient Setting

	The medical record is the patient chart in its entirety. meets the requirements as set out in section 3 -5 of the Bylaws. The medical record must contain comprehensive documentation of the clinical care provided to the patient, including the f ollowing.	
ADM 1.1.1	The medical record is written in readable English and well organized.	1, 2
ADM 1.1.2	The medical record contains detailed description of all medical patient encounters, with dates (including those made in person or by virtual care. *Guidance: Virtual care is defined as any interaction between patients and registrants, occurring remotely, using any mode of communication or information technologies, with the aim of facilitating or maximizing the quality and effectiveness of patient care. See*	

ADM 1.3.6	Evidence-based and/or standard pharmacological treatment with consideration of patient characteristics, interactions, and current practice guidelines. *Guidance: If any therapies, used are employed (including alternative or complementary therapies), the details of the informed consent process including rationale must be documented in the medical record. Physicians who choose to practice complementary or alternative therapies in combination with conventional medicine do so in accordance with their professional, ethical and legal obligations. See the College practice standard* Complementary and Alternative Therapies .	8, 9, 11
ADM 1.3.7	Education regarding management	

ADM 1.3.14	For virtual care enco unters, ensure that the identities of all other participants involved in a virtual care encounter are disclosed to and approved by the patient, and documented in the patient record.	10
ADM 1.3.15	For virtual care encounters, explain the appropriateness , limitations, and privacy risks related to virtual care to the patient in plain language during the initial virtual care visit, and document their consent.	10
ADM 1.4.1	*Need for continuing specialist care is communicated to the referring physician in a written update D>BDC ,36*	

2002 Jun 1 [revised 2021 Apr 7; cited 2021 Oct 28]; 2 p. Available from: https://www.cpsbc.ca/files/pdf/PSG -Prescribing-Practices-Countersigning -Prescriptions-Internet-Prescribing.pdf

11. Cameron S, Turtle-Song I. Learning to write case notes using the SOAP format. J Co uns Dev. 2002; 80(3):286-92.