SUMMARY

DR. RUBENS F.H.C. BARBOSA (CPSO# 83909)

1. Disposition

On July 12, 2017, the Inquiries, Complaints and Reports Committee ("the Committee") required general practitioner Dr. Barbosa to appear before a panel of the Committee to be cautioned with respect to supervising two patients undergoing procedural sedation at the same time, and his method of drawing up medications from vials.

2. Introduction

The College considered a public complaint raising concerns about aspects of Dr. Barbosa's clinical care. Subsequently, the Committee approved the Registrar's appointment of investigators to conduct a broad review of Dr. Barbosa's practice.

3. Committee Process

As part of this investigation, the Registrar appointed a Medical Inspector (MI) to review a number of Dr. Barbosa's patient charts, interview Dr. Barbosa, and observe Dr. Barbosa's practice. The MI submitted a written report to the Committee.

A General Panel of the Committee, consisting of public and physician members, met to review the relevant records and documents related to the investigation. The Committee always has before it applicable legislation and regulations, along with policies that the College has developed, which reflect the College's professional expectations for physicians practising in Ontario. Current versions of these documents are available on the College's website at www.cpso.on.ca, under the heading "Policies & Publications."

4. Committee's Analysis

The Committee accepted the MI's conclusions that Dr. Barbosa failed to meet the standard of practice in that he re-used needles when drawing up medication, and that he provided procedural sedation for two patients in separate endoscopy suites. The MI was of the view that the former practice exposes patients to a potential risk of harm from the transmission of infectious diseases and sepsis. The Committee shared this concern.

In the Committee's view, Dr. Barbosa's actions in covering two endoscopy cases at the same time, where significant amounts of sedation were administered and only nurses were available to assist in monitoring, also presented a potential risk of harm to patients and was a significant deviation from the relevant guidelines (the College's *Out-of-Hospital Premises Standards,* 2013).

The Committee stated that while Dr. Barbosa indicated that he has changed his practice around vial management and he has not repeated the instance of covering two endoscopy suites at the same time, these deficiencies were significant. In particular, the Committee was concerned about Dr. Barbosa's actions in monitoring the anesthesia of two patients simultaneously, and the substantial risk this posed for patients. The Committee noted that Dr. Barbosa had told the MI he had covered procedural sedation in two rooms "a couple of times in the past."

In light of these concerns, the Committee decided to require Dr. Barbosa to attend to be cautioned about these two deficiencies.