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6/28/2023

[redacted]
I have concerns about negative trends that have not improved, and our present policies and practices are putting our patients and mission at risk.

The attitudes of doctors, management, physics and therapy within our team(s) have incorporated practices and policies which are obfuscating a clear path & objective focus necessary respond to urgent and planned service requests. We need to systematically address routine repairs, upgrades, system replacements and decommission systems in a responsible manner. A tactical approach to resolving our issues such as system service needs, upgrades, system replacement and decommissioning of obsolete systems will require prompt and actual resolution instead of a political excuse and delay. A political excuse to circumvent obvious immediate repairs and system replacement will not help us achieve our SPIRIT values but instead put our patients and organization at risk of failure on many levels.
If we cannot safely accomplish our service needs with in-house maintenance and management then we should promptly seek OEM contract services to adequately mitigate our present circumstances as well as decommission systems that are not able to be adequately repaired.

I have included a copy of the HR reprimand I received when I had to intervein on an [redacted] did not report to site to do a visual assessment, nor did he attempt a repair but simply told therapy to continue treatment. I found out about Jason's issue by [redacted]
Therapy allowed a moment between patients for me to see the loose hardware but NOT fix obvious other loose parts which I showed [redacted] I needed to address the parts which had already been collected that had fallen off but therapy and [redacted] disregarded by concern.

I had called [redacted] explained the matter to him, [redacted] the door to the vault was closing for patient treatment to commence and apparently the patient was about to be treated with a system that had parts falling off if it. I did not hit the emergency off but decided to go to the doctor's office to persuade whoever was there to stop the treatment due to the patient safety risk since all my options were not working other than hitting an emergency off.

Later I requested [redacted] was told by [redacted] to not attend the repair. [redacted] visit that the issues were not a safety risk despite it being so, Reference HF Final Warning, [redacted]

The system should have been placed in a down status by engineering until Jason could arrive and assess the system and the loose parts. If he was not able to immediately respond, then [redacted] contacted me-Carl Phillips to assess in person [redacted] before therapy proceeded.

Since I am not getting a reasonable or appropriate response to my concerns from [redacted] it is incumbent for me to seek out the next step to address essential issues we need to understand and rectify before more unreasonable patient risk is put into play by continuing to operate under inappropriate practices and procedures.

The privilege of having a trained and experienced in-house engineering team is and should be an objective credible source of reliable & accurate essential/critical repairs.

In-house service should never be circumvented from taking essential measures to immediately cease treatment if risk to patient and/or operator MAY-BE possible. The basis for establishing the need for immediate therapy system down status at ANY time should always be an option that in-house engineering has at it's disposal to keep our patients, students and staff safe from danger.

In-house engineering should not be considered an adjunct to external third-party authorized service that can be misused by management to excuse wrong practices & legitimize neglect for the sake of expediency, expense avoidance etc.
Our Medstar practices should NEVER be used as a tool to obfuscate and legitimize wrongful attitudes, policies and practices that disregard essential services and practices the OEM organization of the therapy product publishes and recommends.

[redacted] all share in the consorted lack of respect for engineering's recommendations to stop treatment and all are foundational to the evidence and ingrained decay the inner reasoning process has become in Radamerica and must be reversed to avoid imminent risk and harm to our patients.

Thank you for your attention to this matter and I hope to hear from you soon on resolving this matter, so I do not have to take it to the next level.

Sincerely,

Carl Phillips, Medstar/LandAmerica Radiological Engineering
[redacted]

[redacted]

o 5/31/23 at 9:23 AM

Carl:

FSROC TB 5-31-23 loose detector adapter hardware-in pics attached but no part number.

[redacted] called and should be here on 6/1 at 8am

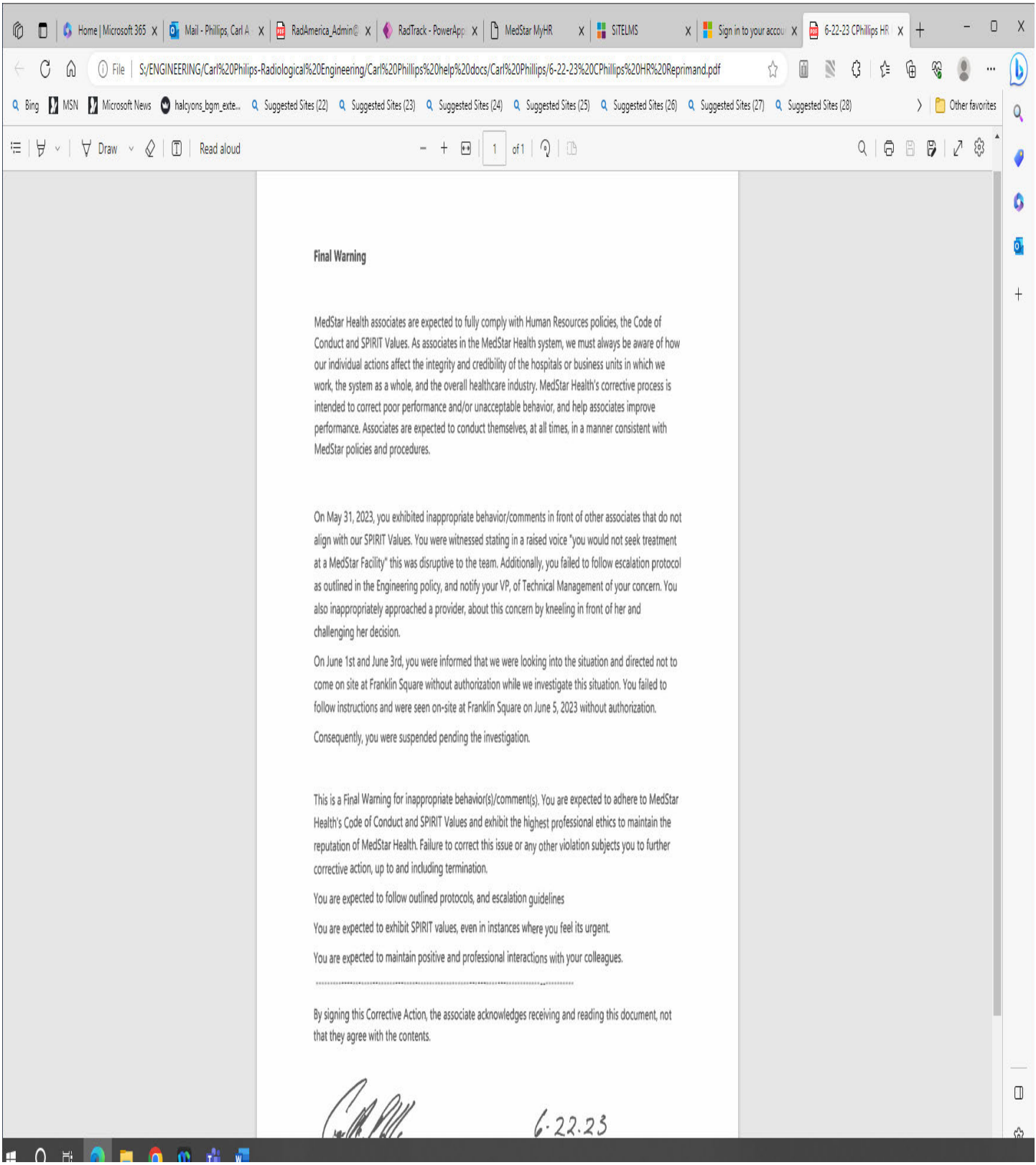
Case # 04090100

The loose detector may contribute to the artifacts in the KV images.

6/1/23(Jason Reed)

[redacted] arrived on site and verified that the panel was not in any risk of falling. It was found that the loose hardware had not come from the imaging arm but instead from a mounting bracket inside the gantry. That unit is held onto the frame of the gantry by more than one fastener. It was not a safety issue and was not contributing to the artifact issues. It was found that the artifacts were being caused by an issue with the [redacted]. Replacement of the pcb resolved the artifact issues.

Patient Safety Concerns-Carl Phillips



Final Warning

MedStar Health associates are expected to fully comply with Human Resources policies, the Code of Conduct and SPIRIT Values. As associates in the MedStar Health system, we must always be aware of how our individual actions affect the integrity and credibility of the hospitals or business units in which we work, the system as a whole, and the overall healthcare industry. MedStar Health's corrective process is intended to correct poor performance and/or unacceptable behavior, and help associates improve performance. Associates are expected to conduct themselves, at all times, in a manner consistent with MedStar policies and procedures.

On May 31, 2023, you exhibited inappropriate behavior/comments in front of other associates that do not align with our SPIRIT Values. You were witnessed stating in a raised voice "you would not seek treatment at a MedStar Facility" this was disruptive to the team. Additionally, you failed to follow escalation protocol as outlined in the Engineering policy, and notify your VP, of Technical Management of your concern. You also inappropriately approached a provider, about this concern by kneeling in front of her and challenging her decision.

On June 1st and June 3rd, you were informed that we were looking into the situation and directed not to come on site at Franklin Square without authorization while we investigate this situation. You failed to follow instructions and were seen on-site at Franklin Square on June 5, 2023 without authorization.

Consequently, you were suspended pending the investigation.

This is a Final Warning for inappropriate behavior(s)/comment(s). You are expected to adhere to MedStar Health's Code of Conduct and SPIRIT Values and exhibit the highest professional ethics to maintain the reputation of MedStar Health. Failure to correct this issue or any other violation subjects you to further corrective action, up to and including termination.

You are expected to follow outlined protocols, and escalation guidelines

You are expected to exhibit SPIRIT values, even in instances where you feel its urgent.

You are expected to maintain positive and professional interactions with your colleagues.

By signing this Corrective Action, the associate acknowledges receiving and reading this document, not that they agree with the contents.

6.22.23

MedStar RadAmerica

SECTION: TECHNICAL POLICIES AND PROCEDURES

POLICY TITLE: ENGINEERING POLICIES

NEW REVISED X **RENEWED**

POLICY COORDINATOR:
Chief Medical Physicist

EFFECTIVE DATE (LATEST REVIEW):
June 21, 2023

NEXT REVIEW DATE:
June 21, 2023

POLICY:
Follow outlined procedures in the management of linear accelerators.

SCOPE:
This policy applies to all MedStar RadAmerica clinical engineering, physics and therapy associates.

RESPONSIBILITIES:
All MedStar RadAmerica employees are responsible for becoming familiar with the provisions of this and all MedStar RadAmerica policies and procedures.

EXCEPTIONS:
None.

PROCEDURE:

A. MACHINE DOWN POLICY

1. A physicist, the Chief Physicist or the VP of Technical Management can declare a machine "down" status with or without a recommendation from engineering, when they deem this could otherwise pose a risk to patients, staff or to the integrity of the equipment. The physicist is required to immediately discuss this determination with the Chief Physicist or the VP of Technical Management.

2. A credentialed member of the engineering department shall recommend declaring a machine in "down" status only when they have sufficient reason to believe use of the machine could otherwise pose a risk to patients, staff or to the integrity of the equipment. The engineer is then required to discuss the situation with a physicist onsite, the Chief Medical Physicist, or the VP of Technical Management.
3. If a repair is needed, but the required timing is not deemed immediate by the physicist and engineer, this will be presented by the physicist to the physician. The final determination of a down status, pending service or repair and approval to treat will be conveyed by the physicist to the therapist staff, so treatments may continue or to reschedule appointments.
4. If a machine is in a state of repair and should not be used, one of the two following situations must exist.
    a. An engineer will be present physically working on the treatment unit, or
    b. A sign should be clearly posted on the Linac console stating "Linac down for maintenance, contact physics".

B. NOTIFICATION OF MACHINE DOWN STATUS AFTER HOURS

When a member of engineering is working on a treatment unit after normal working hours and determines the treatment unit will not be operational for treatment the next day, they must notify the Physicist, Chief Physicist or VP of Technical Management. The Physicist, Chief Physicist or VP of Technical Management will communicate the final status to the physician and therapy team so changes can be made to patient schedules, if those are needed.

Thank you for the privilege of sharing my apology/defense in regard to this issue. There was an urgent incident that developed and I had to immediately persuade Dr. Orwat to cease treatment regarding a patient on the table in the closed true beam vault (treatment was moments from commencing). On 5/31/23, at approximately 330pm, Therapy had advised me (prior to the next patient being treated) of the loose hardware on the FS True beam; therapy also stated that they had informed Jason Reed earlier that morning around 930am that hardware was loose on the machine and that it had fallen out. Therapy further advised that Jason approved treatments to continue without an on-site visual inspection or repair. The conversation with Therapy occurred in passing while I was checking the True beam chiller performance that is in close proximity to the True beam console. After becoming aware of the shortcomings of Jason's resolution and imminent safety risk involved, I had to process the danger of the situation and consider my options to intervene immediately. I told therapy at the TB console to please stop treatment due to the unsafe nature of the True beam. I promptly called Fritz Lerma and described the safety risks, the present TB status was to patients already treated today and further risk to patients yet to be treated. I thought I was clear in speaking to Fritz stating that the system should by no means be used for any more treatments until it was repaired. Prior to calling Fritz, I was able to go into the True beam vault and inspect the loose KV detector assembly and hardware on the in room counter that had fallen off earlier in the day. I remained in the back hallway next to the True beam vault door when I noticed to my shock that the vault door was closing and the next patient was about to be treated. I had no time remaining to intervene other than hitting the emergency off or immediately speak to Dr. Orwat (just a few steps away) who was in close proximity to the machine in her office. I then walked promptly in to the doctor's conference area and tried to urgently advise and persuade her to immediately intervene and stop treatment on the patient in the TB vault. We made eye contact as I approached Orwat directly as I entered the doctors conference area. I wanted confidentiality, but the conference area was open and conversation could be heard by anyone passing. I had no time to rehearse the urgent plea to request Dr. Orwat to stop treatment but I knew that I needed to speak with her about the urgent matter. I knelt down no closer than four feet of where she was sitting, due to the fact that I was trying to minimize my stature since I'm 6'5 and I wanted to be less imposing on her personal space while still remaining confidential in the doctors conference area. I informed her that the patient was in treatment and needed to stop due to a safety risk and that this type of risky practice was a negative trend/habit that must stop and that this type of practice was why I had no confidence in our center and would not personally choose to be treated here. Orwat stated that I could not speak to her like that and she stood up and walked out of the room. I had no time to coif my urgent plea to persuade her to stop treatment since she presumably heard my warning indirectly through her received message from Fritz. All loose hardware failures such as what occurred at FSROC on the morning of Wednesday 5/31/23 should always render the system down until a properly trained service engineer can in person visually inspect and repair the system to regain system stability. The loose hardware failure always requires inspection to ascertain if the system has more damage due to assemblies already effected by hardware found that may have fouled the close tolerances of items like the MLC and other components that if jammed could collapse and cause a risk of breaking and creating more debris that may fall on the patient who is immobile on the couch. Additionally, once hardware becomes loose enough to completely fall off it becomes nearly impossible to be assured that all of the hardware has been found

and it exacerbates the difficulty of finding the true purpose and origin of a loose fastener since the machine is so complex. This circumstance should be an obvious and well know down-status to anyone operating, servicing, or managing Rad Onc Ops. See attached pictures. Furthermore the obvious loose hardware renders a large portion of the accelerator targeting accuracy, beam delivery, quality and many other essential aspects of the patients' treatment into question. Since this incident became evident in the morning, the situation could have even impacted accuracy and safety for many days prior to the time I intervened; this is a problem given that the loose hardware is a gradual failure. In conclusion, my estimation of Dr. Orwat's response to my plea for her help was highly unprofessional, misdirected and she was completely unapproachable. (After this situation occurred, Fritz advised me that he stands 10-15ft away from Orwat to not offend or affect her personal space). I had no time to coif a message suitable to her hypersensitive demeanor as she chose to weaponize her prerogative to become offended and abandon her obligation to listen and act responsibly to assist our patient in need of help. Orwat was unable to process and intervene on behalf of the patients' safety; she attacked the messenger and disregarded the urgent message. Her improper response obfuscated the necessary intervention in the patients' treatment and further negatively impacts our mission since I have been placed on administrative leave and cannot perform my duties. I now have to rely on Jason's faulty service/support.

Respectfully,

Carl A. Phillips

Patient Safety Concerns-Carl Phillips

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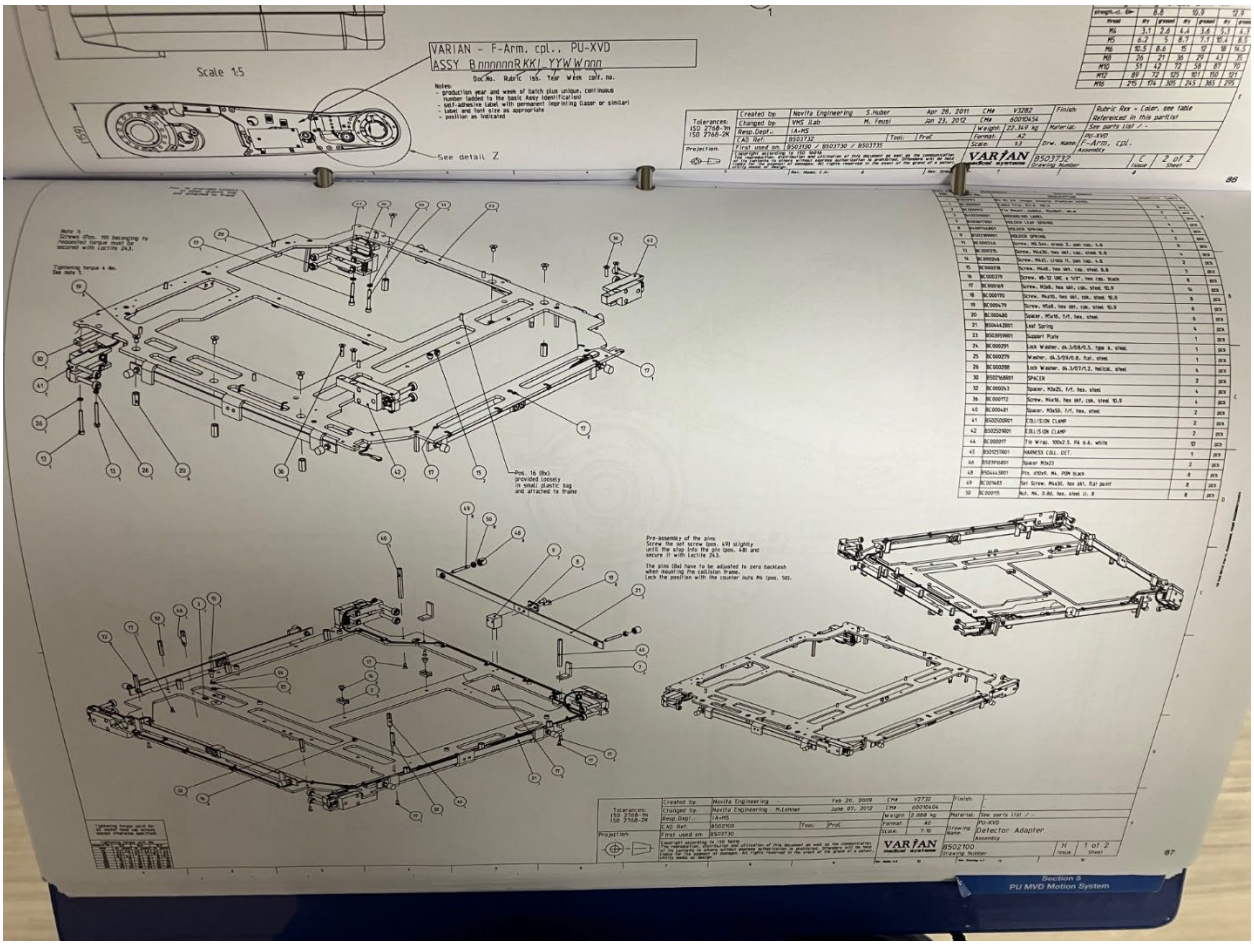

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