JANE SCHARF

[redacted]

mjslegalservices@oyahoo.com

Mrs. Valerie Amorosi
Intensive Care Unit
Civic Campus, Ottawa Hosptial
1053 Carling Ave.
Ottawa, Ontario

By Fax: 613-761-5418

Date: September 24, 2022

Dear Mrs.Valerie Amorosi:

RE: Stop Sedation of Farro [redacted] Immediately

I Jane Scharf have a power of attorney for personal care for Farro [redacted] who is currently receiving treatment at the Intensive Care Unit of the Civic Hospital

I was told on September 21, 2022, by Heather Gallie social worker that Farro was in the hospital in ICU unconscious since September 19, 2022. She did not know what his condition was. She asked me to send a copy of the power of attorney for personal care for Farro Braun by fax and I did so. She also asked me to come in and see him.

Then the next day September 22, 2022, a nurse who I did not record her name called me and said he was in very poor condition with a poor prognosis. She also asked me to come in and visit and speak with the staff.

I went in to visit Farro at 3:00 pm on September 22, 2022. When I arrived and saw him, he seemed to be sedated. I spoke with Farro's nurse she would only say her name was Racheal and she would not give her last name. She said he had been under sedation since Monday, and they had only reduced it somewhat that day. I was concerned about him being sedated because this would prohibit him from walking up. Then I spoke with Dr. Kyrementent and he told me that it is unlikely that Farro will wake up because he has had such a severe brain injury. He said they could not do any operation because it was too late as too much damage had occurred. He said he knew this for sure because of the cat scan that showed severe brain damage. He said if by some remote chance he woke up he would be so brain injured that he would have to be taken care of in a care home for the rest of his life. He asked me would he want to live like this. And he also asked me other questions about the quality of Farro life before the injury.

We discussed the sedation, and I said I wanted him to go off the sedation. Dr Kyrementent stated he could not go off the sedation because they needed to give it to him when he coughed because coughing was uncomfortable. I then said I wanted them to do other thing to relieve the cough first. He said it is not up to me it is up to him. I remined him that I had power of attorney and said this did not matter. I said I want them to encourage him to wake up. In the end after a heated discussion the Dr Kyrementent agreed to only give a small dosage of sedative only if all other methods of reducing cough were used first including moving him and administration of a prescription for coating the throat. Then shortly after Farro woke up. Another doctor called me on September 23, 2022, and said he woke up and they tested him for neurological damage and found none. And they told me they wanted to give him an operation to remove some blood. They said it was a noninvasive operation and the only risk was for infection. They

said they were going to remove the blood from the outside of the skeleton and take a tiny piece of bone out to explore if any blood had seeped into the brain tissue area.

The surgeon called after the operation to report success. All blood was removed no brain damage discovered. Prognosis very good. I asked if he was awake, and he said no he will be out a few more hours until the anesthetic wears off.

Then I went in to visit Farro on September 24, 2022, to find him still unconscious and appearing to be sedated. I had a problem with the staff who were rude and abrasive with me, but I will not express this complaint here. I left the hospital shortly after I arrived because of the treatment by the nurse on duty.

Then I attempted to contact the patients advocate and learned they did not work on the weekend. I asked to speak to an administrator and was told I would get a call within 2 hours from the ICU admin which never happened. I called back in three hours and was told that they would not speak to me because they could not override the doctor's instructions. They asked me if I wanted to speak with Farro's nurse and I said yes. The nurse was very cold and abrupt and told me yes Farro was being sedated and that this was the doctor's orders, and it would be continued. I advised that I have power of attorney and I had instructed the doctor not to sedate on going. This nurse gave a different reason for sedating him and that was that if he coughed this would cut off his oxygen supply and Dr Kyrementent had told me on Sept 22 that the reason was because coughing was uncomfortable, and he must make him comfortable.

I sent a message for the doctor to call me, and he did not call and left a message on his answering machine that I did not want Farro sedated any longer. He did not return my call. I looked up the protocols for brain surgery of the type Farro had and they say unconscious for up to 5 hours where he has been unconscious for a minor brain surgery well over 24 hours because of sedation and no end in sight for this sedation.

And when I spoke with Dr. Kyrementent he indicated that Farro health care decision where not up to me they were up to him even though I told him I had power of attorney for personal care. How is it that a doctor working in ICU for 20 years does not know the relevant treatment laws in regard to informed consent and substitute decision making i.e. the law concerning power of attorney for personal care.

Substitute Decision Act: Power of attorney for personal care
46 (1) A person may give a written power of attorney for personal care, authorizing the person or persons named as attorneys to make, on the grantor's behalf, decisions concerning the grantor's personal care. 1992, c. 30, s. 46 (1).

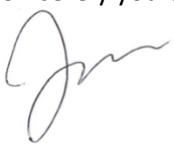
Health Care Consent Act: **10** (1) A health practitioner who proposes a treatment for a person shall not administer the treatment, and shall take reasonable steps to ensure that it is not administered, unless,

(a) he or she is of the opinion that the person is capable with respect to the treatment, and the person has given consent; or
(b) he or she is of the opinion that the person is incapable with respect to the treatment, and the person's substitute decision-maker has given consent on the person's behalf in accordance with this Act. 1996, c. 2, Sched. A, s. 10 (1).

I did not give consent for ongoing sedation in fact I instructed not to give ongoing sedation and therefore the hospital has broken the law.

I am reiterating again here that Farro is to be taken off on going sedation immediately. And that he only be given a small temporary dosage of sedation if he is coughing and all other measures including moving him to free airways and the application of the medication that soothes the throat be given first. And I want to be advised any time sedation is given including the type of sedation and the quantity and the reason. If this matter remains unresolved passed tomorrow morning I intent to report publicly that the Civic does not respect the law with regard to informed consent and substitute decision making. At 12 noon September 25, 2022, I will be picketing the hospital regarding the treatment of your patients. I am not going to stand by and do nothing while your Dr. Kyrementent extinguishes the life of Farro [redacted] because he believes he doesn't have a live worth living. This is not morally or legally acceptable.

Sincerely yours,



Jane Scharf

JANE SCHARF

[redacted]

mjslegalservices@oyahoo.com

Mr. Kyle Ganter
Intensive Care Unit
Civic Campus, Ottawa Hospital
1053 Carling Ave.
Ottawa, Ontario

By Fax: 613-761-5418

Date: September 24, 2022

Dear Mr Kyle Gantner

RE: Stop on Going Intubation of Farro [redacted] Immediately

I Jane Scharf have a power of attorney for personal care for Farro [redacted] please find attached. Farro is currently admitted to and receiving treatment at the Intensive Care Unit of the Civic Hospital.

I spoke with you, Heather Gallie, nurse Fran and Dr. Kyrementent and the surgeon yesterday with regard to the ongoing intubation of Farro. The position of the hospital was that there was some risk that Farro may stop breathing on his own and he might vomit when he gets his MRI test therefore, they would not respect my wishes to stop the intubation where there was immediate need.

My wishes for Farro's treatment was to stop the tracheal intubation and if he stops breathing on his own resume it. And for MRI remove it and use it for the test only.

The surgeon mentioned tracheostomy. Now based on his explanation after consideration I agree to tracheostomy if he stops breathing when the tracheal intubation is stopped.

My consultation with intensive care staff indicated that intubation should be stopped immediately under these circumstances as it possesses great immediate risks. And an excerpt from the Cleveland Clinic article outlines the risk which far out way the risks of stopping the intubation in Farro's case when he is breathing on his own. And I have agreed to a tracheostomy which reduces the risks caused by intubation and it addresses the risks involved in removing the intubation at this time.

"What are the risks of intubation?
Intubation is a common and generally safe procedure that can help save a person's life. Most people recover from it in a few hours or days, but some rare complications can occur:

- **Aspiration:** When a person is intubated, they may inhale vomit, blood or other fluids.
- **Endobronchial intubation:** The tracheal tube may go down one of two bronchi, a pair of tubes that connect your trachea to your lung. This is also called mainstem intubation.
- **Esophageal intubation:** If the tube enters your esophagus (food tube) instead of your trachea, it can result in brain damage or even death if not recognized soon enough.
- **Failure to secure the airway:** When intubation doesn't work, healthcare providers may not be able to treat the person.
- **Infections:** People who've been intubated may develop infections, such as sinus infections.
- **Injury:** The procedure can potentially injure your mouth, teeth, tongue, vocal cords or airway. The injury may lead to bleeding or swelling.

- **Problems coming out of anesthesia:** Most people recover from anesthesia well, but some have trouble waking or have medical emergencies.
- **Tension pneumothorax:** When air gets trapped in your chest cavity, this can cause your lungs to collapse.

A note from Cleveland Clinic
Endotracheal intubation is a medical procedure that can help save a life when someone can't breathe. The tube keeps the trachea open so air can get to the lungs. Intubation is usually performed in a hospital during an emergency or before surgery."

Most importantly the article states here that intubation possess a risk for patients to have trouble waking after anesthesia.

And the article indicates that intubation is for emergencies or before surgery.
Bottom line is under my authority as Power of Attorney for Personal Care I want Farro taken off tracheal intubation immediately and only be intubated on an as needed basis or conduct tracheostomy.
Here is the legal provision for me to make this decision for medical treatment:

Substitute Decision Act: Power of attorney for personal care
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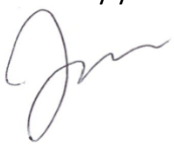
(b) he or she is of the opinion that the person is incapable with respect to the treatment, and the person's substitute decision-maker has given consent on the person's behalf in accordance with this Act. 1996, c. 2, Sched. A, s. 10 (1).

I trust my wishes will be respected for Farro Braun as per my legal authority under the POA of Personal Care made with what I believe Farro would want. Farro trusted me to make his medical decisions in the case of his incapacitation which can be seen in that he has appointed me as POA for Personal Care.

Sincerely yours,



Jane Scharf
CC patients advocates office
Media
Other interested parties

JANE SCHARF

[redacted]

mjslegalservices@oyahoo.com

Mrs. Michelle
Supervisor of Neoscience Acute Care Unit
Civic Campus, Ottawa Hospital
1053 Carling Ave
Ottawa, Ontario

By Fax: 613-4277

Date: October 6, 2022

Dear Michelle:

RE: Stop Nose Feeding and Use Intravenous Feeding Immediately

I Jane Scharf have a power of attorney for personal care for Farro [redacted] who is currently receiving treatment at the Neoscience Acute Care Unit please find attached.

On October 2 I was told by ICU nurse Rich that Farro was likely ready for the nose feeding to stop because he was very responsive. However, he said that the speech pathologist had to assess him first and that cannot be done on the weekend. I asked nurse Fran from ICU on Oct 3 and his NACU staff on Oct 4 when this would be going to happen and was told he was in the queue. I learned today that there was no requisition for speech pathology giving until late Oct 5. Now I am told today by the speech pathologist that he is not ready for the nose feeding to stop.

On Oct 3 Farro became despondent and on Oct 3 Farro it was discovered that Farro was experiencing very low sodium levels and likely became despondent because of it. And now Oct 6 I am told that he has a fever that could be the beginning of pneumonia because he cannot expel from his lungs easily because of nasogastric tube feeding.

The medical ligature indicates that the hyponatremia can be caused be excessive fluid which is a risk for persons on nasogastric tube feeding.

Also, on this method of feeding he is hindered from moving forward to expel from his lungs hence pneumonia is a risk. He currently has fever, and this may be the cause.

Guilherme F Gomes et al. Curr Opin Clin Nutr Metab Care. 2003 May.

Purpose of review: Aspiration is one of the most common complications in enterally fed patients. The source of aspiration is due to the accumulation of secretions in the pharynx of reflux gastric contents from the stomach into the pharynx. The true prevalence of aspiration is difficult to determine because of vague definitions, poor assessment methods, and varying levels of clinical recognition.

Recent findings: There is evidence in the literature showing that the presence of a nasogastric feeding tube is associated with colonization and aspiration of pharyngeal secretions and gastric contents leading to a high incidence of Gram-negative pneumonia in patients on enteral nutrition. However, other aspects may be equally important and should also be considered when evaluating a patient suspected of

having aspiration and aspiration pneumonia. The mechanisms responsible for aspiration in patients bearing a nasogastric feeding tube are (1). loss of anatomical integrity of the upper and lower esophageal sphincters, (2). increase in the frequency of transient lower esophageal sphincter relaxations, and (3). desensitization of the pharyngoglottal adduction reflex.

Summary: Sometimes it is possible to differentiate whether the aspirate is gastric or pharyngeal. The kind of bacterial contamination is, however, more difficult to establish. Oral or dental disease, antibiotic therapy, systemic illness or malnutrition and reduction of salivary flow are responsible for colonization of Gram-negative bacteria in oral and pharyngeal flora in nasogastric-tube-fed patients. The use of a nasogastric feeding tube and the administration of food increase gastric pH and lead to colonization of gastric secretions. It has also been suggested that gastric bacteria could migrate upward along the tube and colonize the pharynx.

As power of attorney for personal care I am instructing that Farro Braun have the nasogastric tubing removed immediately and be put on intravenous feeding straight away.

I have researched the risks of intravenous feeding and since he has already had low sodium levels and fever and is unable to cough freely, I feel the risk is reduced with intravenous feeding as the nasogastric tube feeding risks are life threatening.

The treating physician yesterday said he would remove him from the nasogastric tube feeding if I want them to. I said I would research and give my answer today. My answer is I want him removed from nasogastric tube feeding and put on intravenous feeding because the speech pathologist says she believes he cannot swallow yet.

May authority to make this decisions rests with a signed power of attorney please find attached and the following legislation.

Substitute Decision Act: Power of attorney for personal care
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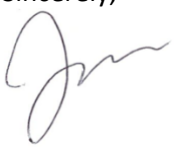
Sincerely,



Jane Scharf

JANE SCHARF

[redacted]

mjslegalservices@yahoo.com

Katherine Cotton Chair,
Board of Governors

Cameron Love
President and CEO

Dr. Virginia Roth
Chief of Staff

Dr. Kathleen Gartke
Senior Medical Officer

Ottawa Hospital Civic Campus
1053 Carling Ave.
Ottawa, Ontario

By Fax: 613-761-4462

Date: October 6, 2022

Dear Sirs and Madams:

RE: Systemic problem with illegal disregard for unconditional power of attorney for personal care

I, Jane Scharf have a power of attorney for personal care for Farro [redacted] who is currently receiving treatment at the Neoscience Acute Care Unit please find attached.

You will find attached a series of letters I have sent to hospital administrators over the past few weeks regarding the medical care received by Farro Braun. Two of your doctors Dr. A Sachs and Kyrementent indicated to me that they do not have to regard my instructions as POA for personal care.

Currently, I have asked for Farro to be taken off nasogastric tube feeding

1. Dr. Sachs refused to regard my request to take him off nasogastric tube feeding and put him on intravenous feeding

2. He did not address the research I provided
3. He did not indicate any other research or even if there was any other research that contradicted the research I gave
4. Nor did he provide any of his own information to challenge my request
5. He merely stated without qualifying his position that he is refusing to follow my instructions because he disagrees with taking him off the nasogastric tube feeding.
6. He also stated that the decision was his to make and he would not respect my power of attorney for personal care.
7. Dr Adam Sachs says he knows for sure the low sodium level was from the brain surgery not from the nose feeding without indicating how he knows that. This contradicts what the other doctor and nurses said. They agree it could be from the nose feeding and it might be complications from surgery

This is the second such experience I had with your doctors refusing to regard my wishes regarding care. The other doctor was Dr. Kyrementent, .also stated in a meeting with Kyle coordinator of ICU nurse Fran, Heather Gallie, social worker, and one of the surgeons that the decision to take Farro off intubation was his decision not mine.

Evidently, 2 of your doctors think they can undermine my legal right to make decisions and the decisions of the patient on treatment without even the need to explain other than to say this is their opinion.

There was also unnecessary delay in the request for speech pathologist assessment which was supposed to have been made on Oct 4 and was not made until late Oct 6 and assessment done Oct 7.

He is even more responsive than he was on Sunday and he needs to be reassessed by a speech pathologist ASAP.

At this point he either needs the nose feeding tube removed and normal feeding to begin or intravenous feeding which has less risks so he can sit up and lean forward and sleep on stomach to assist the expulsion of fluid in lungs. When he coughs now it ends up being re-swallowed.

Some Research on nose feed patients

Guilherme F Gomes et al. Curr Opin Clin Nutr Metab Care. 2003 May.

Purpose of review: Aspiration is one of the most common complications in enterally fed patients. The source of aspiration is due to the accumulation of secretions in the pharynx of reflux gastric contents from the stomach into the pharynx. The true prevalence of aspiration is difficult to determine because of vague definitions, poor assessment methods, and varying levels of clinical recognition.

Recent findings: There is evidence in the literature showing that the presence of a nasogastric feeding tube is associated with colonization and aspiration of pharyngeal secretions and gastric contents leading to a high incidence of Gram-negative pneumonia in patients on enteral nutrition. However, other aspects may be equally important and should also be considered when evaluating a patient suspected of having aspiration and aspiration pneumonia. The mechanisms responsible for aspiration in patients bearing a nasogastric feeding tube are (1). loss of anatomical integrity of the upper and lower esophageal sphincters, (2). increase in the frequency of transient lower esophageal sphincter relaxations, and (3). desensitization of the pharyngoglottal adduction reflex.

Summary: Sometimes it is possible to differentiate whether the aspirate is gastric or pharyngeal. The kind of bacterial contamination is, however, more difficult to establish. Oral or dental disease, antibiotic therapy, systemic illness or malnutrition and reduction of salivary flow are responsible for colonization of Gram-negative bacteria in oral and pharyngeal flora in nasogastric-tube-fed patients. The use of a nasogastric feeding tube and the administration of food increase gastric pH and lead to colonization of gastric secretions. It has also been suggested that gastric bacteria could migrate upward along the tube and colonize the pharynx.

Here is a list of the three risks for intravenous feeding from Stanford Medical Clinic:

Complications Associated with Total Parenteral Nutrition
Dehydration and electrolyte Imbalances. Thrombosis (blood clots) Hyperglycemia (high blood sugars)

As you can see clearly the risks are a lot less serious and are not life threatening as can be the complication of nose feeding.

As power of attorney for personal care I am instructing that Farro[redacted] have the nasogastric tubing removed immediately and be put on intravenous feeding straight away.

I have researched the risks of intravenous feeding and since he has already had low sodium levels and fever and is unable to cough freely, I feel the risk is reduced with intravenous feeding as the nasogastric tube feeding risks are life threatening.

The treating physician yesterday said he would remove him from the nasogastric tube feeding if I want them to. I said I would research and give my answer today. My answer is I want him removed from nasogastric tube feeding and put on intravenous feeding because the speech pathologist says she believes he cannot swallow yet.

May authority to make this decisions rests with a signed power of attorney please find attached and the following legislation.

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Health Treatment and Consent Act- No treatment without consent

10 (1) A health practitioner who proposes a treatment for a person shall not administer the treatment, and shall take reasonable steps to ensure that it is not administered, unless,

(a) he or she is of the opinion that the person is capable with respect to the treatment, and the person has given consent; or

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Sincerely yours,

Jane Scharf

Find attached letters regarding POA for personal care instructions and the POA

JANE SCHARF

[redacted]

mjslegalservices@yahoo.com

Katherine Cotton Chair,
Board of Governors

Cameron Love
President and CEO

Dr. Virginia Roth
Chief of Staff

Dr. Kathleen Gartke
Senior Medical Officer

Ottawa Hospital Civic Campus
1053 Carling Ave.
Ottawa, Ontario

By Fax: 613-761-4462

Date: October 9, 2022

Dear Sirs and Madams:

RE: Systemic problem with illegal disregard for unconditional power of attorney for personal care

I, Jane Scharf have a power of attorney for personal care for Farro [redacted] who is currently receiving treatment at the Neoscience Acute Care Unit please find attached.

As per my instruction on October 6, 2022 that Farro Braun be taken of nose tube feeding and placed on intravenous feeding my instructions have been ignored.

I visited Farro yesterday Oct 8 in the morning, and he asked for water. The nurse said he could try some water. I gave him some with a straw. He drank and swallowed easily with no difficulty whatsoever.

I spoke with his nurse at 10 PM after trying since 6:30 and she told me he is still on nose tube feeding and it was not being removed. She was uninterested that he drank and said

he will remain on nose feeding until after his speech pathologist assessment to see if he can swallow.

The tube is dangerous, and these procedures are putting him at risk of low sodium levels and pneumonia for no reason.

I will be visiting Farro this morning and if the nose tubing is not removed, I am going to:

1. Start to protest outside the hospital as you are unnecessarily putting Farro under risk
2. Make arrangements to move him to a safer place.
3. Looking to see if there is financial incentive for keeping Farro on nose tube feeding unnecessarily

I looked and I have proof of why you were keeping him intubated when there was no emergency with his breathing (in case he might stop breathing was reason given) and why you kept him on incubator post op with a risk of patient not waking after antiseptic. The reason is financial incentives.

I am going to investigate this morning whether there is also financial incentive to keep him on nose tube feeding which puts him at risk of serious harm for no reason.

Some Research on nose feed patients

Guilherme F Gomes et al. Curr Opin Clin Nutr Metab Care. 2003 May.

Purpose of review: Aspiration is one of the most common complications in enterally fed patients. The source of aspiration is due to the accumulation of secretions in the pharynx of reflux gastric contents from the stomach into the pharynx. The true prevalence of aspiration is difficult to determine because of vague definitions, poor assessment methods, and varying levels of clinical recognition.

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As power of attorney for personal care I am instructing that Farro Braun have the nasogastric tubing removed immediately and intravenous feeding or preferabley commence regular feeding.

I have researched the risks of intravenous feeding and since he has already had low sodium levels and fever and is unable to cough freely, I feel the risk is reduced with intravenous feeding or regular feeding as the nasogastric tube feeding risks are life threatening.

The treating physician on October 5, said he would remove him from the nasogastric tube feeding if I want them to. I said I would research and give my answer Oct 6. My answer was I wanted him removed from nasogastric tube feeding and put on intravenous feeding. Now he can swallow so preferably regular feeding.

May authority to make this decisions rests with a signed power of attorney please find attached and the following legislation.

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Sincerely yours,

Jane Scharf

Find attached letters regarding POA for personal care instructions and the POA