Warning the public about medical murder and the organ trade in Canada

Marked for Murder at the University Health Network (Toronto)

Organs cannot be "donated" in situations of entrapment. Those fully conscious patients who realize they have been kidnapped by a hospital never agree to their predicaments. Instead they desperately try to escape. Likewise, no one in a coma ever signs his donor card or gives his consent to be dismembered in that state. One cannot ethically agree to something which one cannot assess in the present tense. One must be informed in every possible way, especially as to how one feels at the time. For profiting third parties to hold someone to a promise based in theory, when the truth finally stares him in the face, is the boldest of crimes. Who is so far from the truth themselves that they would demean another so badly?

The idea that murder happens in a hospital is one we would rather not contemplate. Most people die there, apparently from natural causes, and the common belief is that hospitals are humane places where patients are never harmed. We believe that hospital personnel wouldn't work there if they weren't suited to the task. We believe that this task involves putting the sick person first and that nothing could ever violate this principle. We are wrong.

The following case provides graphic details of a hospital murder. The patient was imprisoned, tortured and killed since he fitted the statistical profile of someone whose family would likely donate his organs. The case serves as a warning to people seeking help in hospitals and is a good one to keep in mind when there. A discussion of its elements is encouraged. A list of cues and clues is also provided which help to detect if a family member is being terminated in the interests of the medical staff, hospital and government.

CASE STUDY: University Health Network (Toronto Western Hospital)*

"It's really important that the integrity of the process of assessing a patient's ability and altruistic willingness to donate is under a continuous assessment, right to the point where they're ready to enter into the operating room."
Robert Bell, President and CEO of University Health Network (UHN)
(CBC News, June 5, 2007)

The following case study refutes Dr Bell's assurances.

Around midday in late winter, a 33 year-old single, male patient presented himself to the emergency department of the Toronto Western Hospital with a relapse of a neurological problem. The treatment routine was familiar to him; he had experienced three prior episodes of his condition over 15 years. His illness was not life-threatening and was easily treatable. The patient had come to the hospital by taxi. He had come alone. He was fully competent and documented as such in the hospital chart. He described his history to the attending residents and what treatment had worked best for him in the past. He informed the staff that his medical records were available from his family doctor who worked on the premises of the Toronto Western Hospital. The patient stated he did not need unnecessary testing and that his main concern was to avoid delay. He provided his mother's name and number as his contact.

The patient was admitted to the neurology ward by a resident in nephrology. This medical specialty deals with

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patients on dialysis and those who receive kidney transplants. The resident was doing a rotation in the neurology ward to familiarize himself with the process of identifying, admitting and managing potential organ donors.

The resident omitted to tell the patient he wasn't going to give him the treatment he'd asked for and did not tell the patient that he was going to admit him to the neurology ward. After he interviewed the patient, he said he “would be back soon.” The resident did not return. Instead, two orderlies arrived who transported the patient against his will to the ward.

The resident had gone to notify the Trillium Gift of Life Network that someone had come into the emergency ward who fitted the profile of a possible donor. The TGLN requires that medical staff comply with its directive to increase the supply of replacement organs for the use of the transplantation industry. Without harvested organs from other people, this industry would not exist; the greater the number of organs it can procure, the more the industry can profit and expand.

In the neurology ward, the patient found out from a nurse that he had been admitted for numerous tests over two days even though he had specifically stated he did not wish to repeat non-critical tests he had undergone before. He was put into a room where he was alone. There was no phone next to his bed, or anywhere else in the room.

The patient became alarmed that his wishes were not being taken into account and asked to leave the Toronto Western Hospital. He expressed his intention to go to an alternate hospital where he had been treated five years prior. The patient dressed himself and walked to the elevator. While waiting for the elevator, a nurse apprehended him. She told him that he could not leave without first seeing a doctor.

The patient was taken to the nursing station and made to stay there until the nursing supervisor was called. The resident who admitted the patient was also called. The resident talked to the patient over the phone but was unable to persuade the patient to stay for tests[1]. The patient knew he was free to accept or decline his hospital admission and treatment plan, and insisted on leaving the Toronto Western Hospital[2]. He was polite and reasonable. He hung up the phone and again set out to leave.

This time, the nursing supervisor followed the patient. She apprehended him along with the nurse and threatened to call security if he did not go back to his room. Back in his room the patient was told by the nursing supervisor that he could not leave, and that he either voluntarily submit to psychiatric assessment or be deemed incompetent and forced to stay[3]. The patient had no option but to agree to psychiatric assessment. He decided to put his best foot forward, changed back into his hospital gown and asked for shaving supplies to make himself look as presentable as possible. He waited in his bed for the arrival of the psychiatrist to confirm his competence and his right to leave. A psychiatrist did not come.

The nurse was required by law to inform the patient's family if any mental incapacity was suspected. She did not.

The nursing supervisor had lied to the patient that she would call a psychiatrist. Instead of doing so, she asked the patient if he “would like something for his headache while waiting.” In this way, she was able to sedate the patient without his knowledge[4]. In his condition, sedation was especially dangerous since he was suffering from a brain lesion. CT scans showed that his brain was already prone to swelling and required immediate treatment.

The patient was correct in sensing something was wrong. What he did not know however, was that he had been profiled as a likely organ donor and marked for murder (See Trillium Gift of Life Network Continuum).

It is alarming to note that the profiling process had completely overridden the patient's preferences: he was firmly against organ donation and had a card to that effect in his wallet. Instead, the gamble was on among hospital staff that his family would be culturally susceptible to the idea of organ donation and that sweet-talking organ procurers could shock and pressure the family into doing so.

The possibility also existed that the patient's organs could be procured through denial of care and exacerbation of illness. The goal of ultimately getting their hands on his organs was simply a matter of encouraging his brain to swell until he suffered his first herniation. With the TGLN's continuum as their guide, the doctor and nurses were not going to let this patient get away.

Their decision to stop him from leaving became their commitment to kill him.

Their decision to stop him from leaving became their commitment to kill him. Their rationale was that the patient was irresponsible in wanting to leave the hospital, taking his organs with him, and not, himself, waiting to see if he

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was going to die.

In order to fulfill the next step of the continuum, the nurses left the patient to sleep throughout the night without monitoring and without specific waking to prevent prolonged periods of shallow breathing. The goal of the hospital was to provoke and rely on the deterioration of his condition so that he would be unable to leave the scene and ultimately die.

The next morning the patient's condition was very much worse. The overnight sedation had compromised his breathing and caused his brain to swell. The patient would have been in a better state had he gone home.

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No doctor came to see the patient in the morning. The team had agreed to avoid him since he was insisting to leave. According to an eyewitness, the patient eventually tried to force his way out. He was stopped by nurses and cleaning staff who blocked his way. He tried to use a phone on the nurse's desk but was prevented from doing so. For as long as he was able, the patient tried to refuse tests which were designed to prepare him for organ harvest.

The patient was crying out in pain. A nurse documented these cries for help as "complaints" and "moaning and groaning." The patient was denied all treatment. Instead, a drug toxicology test was ordered to check for IV drug abuse[5].

There were two main reasons for ordering the drug test in this case. One was to create a way to deflect attention from the issue at hand and waste time. The other goal was to justify detaining the patient against his will. The patient was clearly not an IV drug user. His skin was naturally pale and no sign of old or new needle marks appeared anywhere.

Obtaining urine for the test was postponed for as long as possible affording more time for deterioration[6]. This delay was not difficult to achieve since the patient was vomiting and intentionally denied an IV drip. The patient's dehydration had been engineered for a further purpose. Dehydration brings about seizures in brain-injured patients. Seizures increase ICP, which speeds up brain herniation and stroke.

Over the next 28 hours the patient was kept sedated and unmonitored. In this setting, CO2 builds up in the brain due to shallow breathing and worsens swelling. The patient's right-side limbs were now weak and he was having difficulty speaking. All told, the patient had been in the hospital for 36 hours without any treatment. His pain had been excruciating all day. He was nauseous. By this time he urgently required the attention of a neurosurgeon but no one heeded his urgency.

At 10 PM the results of the drug toxicology test were received. These results confirmed that the patient was not a drug user. The negative drug test was an important part of branding the patient as a potential organ donor. A neurology resident was informed of the results and came to see the patient for the first time. The resident then set about to cause herniation of the patient's brain, and to bring him to the earliest point where he could be pronounced "brain dead."

The timing of the drug test was arranged expressly so that harm to the patient could be brought about late at night. At that time there would be fewer interruptions and no visitors on the ward.

The neurology resident who handled the task was adept at concealment. His accompanying hospital notes are lengthy, flowery and neatly written. They read like a chatty monologue justifying every action with vague, protective, and optimistic language. It is clear this individual was relied on for his slick verbal skills and stream-of-consciousness charm.

Had the patient been a drug user, and unsuitable for organ donation, he would have been killed nevertheless. In his case, the patient had been sufficiently alarmed from the outset about denial of treatment and forcible detainment to know that he was the victim of foul play. He had tried repeatedly to leave the premises. His sense of intelligence and autonomy had proved to be a liability to the hospital and doctors. Had the patient survived he would have been a witness to the crime of kidnapping with the intention of forcibly extracting urine/blood samples from him and thereupon to kill him for his bodyparts.

The next step in damaging the patient's brain was to cause a seizure. The patient underwent a CT scan, an event which the neurologist used to persuade the patient that his situation was very serious. He drew him a picture on

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hospital stationery. The patient became very disturbed and afraid. He wrote down questions on the same piece of paper.

The neurology resident then offered to do the patient the “favour” of prescribing him the regular steroid treatment for his condition: the one the patient always received for flareups of his non life-threatening condition; the one which the patient had asked for upon admission but was refused; and the one for which the patient had earlier tried to leave the Toronto Western Hospital in order to find elsewhere.

At this point in the patient's situation, steroids were of no use to him. It was too late. The resident also made sure that he prescribed the weakest steroids available.

The neurology resident had offered the steroids as a way to obtain the patient's consent to medication. He then used the patient's desperate consent to the steroids to slip him morphine as well. Morphine served two purposes. First, it would conceal the patient's true condition by ceasing his cries of pain, and second, it would compromise the patient's respiration further and lead to more swelling of his brain. In the setting of proper medical care this patient would have been prevented from having a seizure, not provoked to have one.

It is important to note that the CT scan did not show imminent death. The patient's brain, although swelling, showed no signs of herniation. With the most basic of neurological care, this patient would have made rapid progress towards recovery. The neurology resident must certainly have known this basic care. He went on to pass his licensing exam two months later, and he knew which care to deny in order to kill.

With the patient unable to speak, sedated with morphine, and a seizure in the works, the neurology resident called the patient’s family for the first time. They lived out of town. The resident left a vague message on their answering machine. The message was worded in such a way that it sounded more like a hospital fundraising call than a personal one. The patient’s name wasn’t mentioned. The call was not made in response to the patient’s request. He had been continually trying to have his family called but in the interests of concealment, no one would do so.

When the call was eventually made it was done in order to fulfill the requirement of contacting a patient’s legal representative in an emergency situation. The call was made in preparation for this patient’s imminent death. The resident had asked the patient to identify his legal representative by writing it down. The resident then used the written name to give the impression that this was the first time the patient had asked to have his family called.

This is a false assertion since the paper shows that the patient first wrote “why” and then started to write, “who is legal rep” before the paper was taken away from him. The patient clearly did not understand why he would have to differentiate between the name he had provided upon admission to contact in case of emergency, and a “legal rep.”

An hour and a half later, the patient began to have a seizure brought on by the combination of a 38-hour sedation, dehydration and morphine. The neurologist was called back but he did not arrive until 15 minutes into the seizure. Hospital staff complied with the resident to allow the seizure to continue for 70 minutes without intubation or barbiturates.

Instead of being intubated, the patient was hooked up to a naso-gastric tube. This lesser device was chosen since it gave the impression that the patient was being protected from choking on his saliva. In fact, this device served to conceal the fact that the patient was vomiting from mounting intracranial pressure. Added to the effects of sedation the long, untreated seizure caused grave damage to the patient’s brain.

Due to the earlier dehydration inflicted upon the patient in order to help induce the seizure, his blood pressure was now very low. At this point, he was prescribed copious amounts of liquid. The hospital notes show numerous orders by the neurologist to maintain high fluid infusion. Since no neurosurgeon was consulted as to the patient's deterioration, it is obvious the fluids were intended solely to preserve the quality of the patient's organs for possible and imminent harvest.

The neurologist and hospital staff—anticipating the eventual arrival of the patient’s family—continued to conceal what they were doing. They transferred the patient to the ICU instructing the staff there to inform the family, when they arrived, that the patient was “sleeping off” a seizure. Ultimately it would also be easier to prompt organ donation from family members if the patient was dying in the ICU. The family could also be kept out of the way because of ICU visitor protocol.

At about 10 PM the following evening the patient’s mother arrived from out of town to the bedside. It had proven time-consuming to figure out that the cryptic message on her answering machine had to do with her son, to obtain accurate information as to where her son was, and to travel to Toronto. She had spoken to him over the phone two

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days before where he was well, and there was no indication yet of the relapse.

She found her son sleeping soundly. The nurse informed her that he had begun to awaken from his seizure an hour or so earlier, but that she had given him a shot of haldol to slow him down. An examination of the facts shows that the patient had actually been writhing around in pain from intracranial or head pressure well above the normal limit. The facts also show he had been very restless during an earlier EEG procedure, moving his head from side to side in agony.

By the time his family arrived, the patient’s suffering had been concealed with the sedating agent, haldol. Haldol does not relieve pain. It simply acts as a chemical “straightjacket,” also serving to maintain the quality of organs during suffering.

The nurse stated that the patient was doing so well he would be transferred to back to the neurology ward the next morning. This was untrue.

The brain is tricked at this time into seeing organ donation as a form of treatment which will save the loved one's life.

Critical care nurses are trained to give false assurances where brain injury/potential organ donation is concerned. These assurances lull the patient's family into a false sense of hope. That way when the patient's condition worsens, the family's high degree of shock makes for a higher likelihood of organ donation. When in shock, families will donate more readily since the feeling of donating the loved one's living organs provides a source of comfort. A shocked family, usually one who is not sufficiently helped by cultural or religious beliefs, will grasp at straws to lessen their pain and sense of hopelessness. The brain is tricked at this time into seeing organ donation as a form of treatment which will save the loved one's life. If too much time goes by, this effect wears off. Organ procurers know this.

The hospital’s priority was to prevent the patient from communicating the agony he was going through.

Having initiated the patient’s death with morphine, the neurologist and hospital staff discontinued the administration of the painkiller after the patient was rendered postictal (very sleepy) by the seizure. They wished to avoid questions of why the patient was in pain and why he was not being referred to a neurosurgeon for relief of his mounting intracranial pressure. The patient’s unimaginable pain at this point was disregarded. The hospital’s priority was to prevent the patient from communicating the agony he was going through.

Since it was difficult for the family to remain by the bedside in the ICU, they agreed to leave asking the nursing staff to inform them of any changes in the patient’s condition overnight. They would be close by and provided two phone numbers.

An hour after his family left, the patient suffered a further deterioration. One of his pupils became fixed and dilated. The neurology resident on call was paged. The hospital notes say the resident “did not answer his pager.”

A resident/fellow on duty in the ICU, Dr Natalie Wong, attended the patient’s bedside instead. This individual's field of interest is well-suited to managing potential organ donors. She is described as a specialist in dialysis, ICU, critical care, “end-of-life” and internal medicine. Like the “kidney” resident who helped imprison the patient in the hospital, Wong would have an interest in neurology as far as replacement organs were concerned. The case in point shows that her knowledge in this field is more attuned to ending lives than palliating suffering.

Natalie Wong contacted the staff neurologist on call, Dr Richard A. Wennberg. The patient had undergone a CT scan which showed he was experiencing a transtentorial herniation. Wennberg instructed Wong to “do nothing” although the patient could have easily been saved at this point. The pair then conspired to omit calling the waiting family for consent with respect to these doctors' decision to let the patient die.

Natalie Wong and the nurse then purposely caused the patient to vomit by sending food supplements down his naso-gastric tube. This event served to justify the administration of high dose gravol to the patient. The gravol caused further sedation and continued his brain damage. It was chosen as a medication which at this point would not have raised any questions as to the patient’s care.

Had the family known about the patient's condition... the hospital's bid to obtain organs unfairly would have been exposed. Moreover, the patient would have been a witness to kidnapping and attempted murder.

The patient’s family was not notified of the patient's serious turn for the worse. This omission by the hospital was

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intentional. Had the family known about the patient's condition they would have asked for immediate neurosurgical care. In that case, the patient's life would have been saved. The hospital's bid to obtain organs unfairly would have been exposed. Moreover, the patient would have been a witness to kidnapping and attempted murder.

When asked why she did not call the family after the patient's signifcant deterioration, Natalie Wong stated, “I didn't know they wanted to be notified right away, about every little thing... I planned to call them in the morning.”

Wong's response also sheds light on the growing practice of declaring targeted patients brain dead at the first sign of any brain damage whatsoever. Her actual reason for postponing her call to the family was that no one was around in the middle of the night to persuade the family into believing the patient was terminally ill.

Wong's specific task was to manage the patient's deterioration with respect to the arrival of the daytime shift. This way the family would be approached by neurosurgeons and organ procurers alike: first with bad news, and then with offers to “save” the patient through giving his living organs to others.

This young woman's stomach-to-kill effectively displays the effects of industry brainwashing on insecure and achievement-driven trainees.

After his pupil blew (a sign of massive head pressure) the patient was still not treated for his pain. Under the influence of yet more sedatives, his intracranial pressure worsened to about 8 times the norm. The level of suffering he endured at this point while chemically and physically prevented from expressing his pain, can only be described as the highest form of cruelty.

His brain was left to swell to such an extent that it had pushed itself hard against his skull and down into the top of his spine. Worse, the patient had suffered this abysmal damage without any pain relief at all.
At about 6 AM the patient’s second pupil became fixed and dilated. An MRI scan showed he had suffered brain herniation and two strokes as a result of excessive sedation and lack of treatment. His brain was left to swell to such an extent that it had pushed itself hard against his skull and down into the top of his spine. Worse, the patient had suffered this abysmal damage without any pain relief at all.

It is important to note that only at this point did the hospital staff hook the patient up to a ventilator. Honest medical care would have provided him with this life-saving help much earlier. At the very least he should have been ventilated at the 15-20 minute mark of his seizure. The reason for the ventilation after the patient's second pupil blew was not to save his life. It was too late for that. The plan was to hold him in limbo while discussions for organ donation took place.

Only now was the family called at one of the numbers they had provided. The neurology resident who had initiated the patient's death with morphine called the family. He had just started his shift. He described the deterioration as “unexpected.” He cited a “grim” prognosis and all further care as “futile.” He added that the patient had been intubated so as to give the family time to decide “what to do.”

This resident provided unsound and impossible medical explantions for the patient's condition. As he spoke, his face became flushed with two spots of red forming on his cheeks. His mandate was i) to bring the family to the point of accepting that their loved one was going to die, ii) refer them to organ procurers in order to be persuaded to donate the patient's organs and tissue, iii) have the patient harvested, iv) have the waiting recipients transplanted with the patient's organs and finally, v) deal with any complaints and suspicions by the family after there was no turning back.

The shocked family members asked to have heroic measures applied. At first they were firmly refused. When the family questioned the doctors' explanations of what had happened, a neurosurgeon was brought in to give the patient some help with his high ICP. When the family asked Dr Richard Wennberg why he hadn't called the family when the patient's first pupil blew, he just looked at them saying nothing[7].

Only now was the patient prescribed pain medication as he lay dying. Now fully deteriorated and unable to be saved, his condition no longer needed to be concealed.

Along with this medication he was prescribed drugs—further to earlier ones—in preparation for organ harvesting despite the fact that his family had not yet been approached regarding donation, The staff could see that they were distressed at not having been called during the night as they has asked. The staff planned to take it slow, appease the family by undertaking some heroic measures, and all along keep the patient harvestable in case the

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family was eventually persuaded to donate.

The drugs used to prepare the patient for possible harvest included: Heparin which increases blood flow and preserves organs. Nimbex, which is used in situations such as this one to prevent spinal reflex in a targeted donor and to assure access to his chest during the harvest flaying. Levophed and pentaspan were given to maintain the correct blood pressure for quality organs. The patient was undergoing a great infusion of fluids for the same purpose. Late morphine was prescribed in order to assist in intraoperative cardiovascular management. Despite being in a terminal state, he was also being vigorously tested for infection, HIV, etc so as to confirm his suitability as a potential donor. These drugs and tests can be made to seem part of regular treatment.

When the only treatment a patient receives concerns his ability to donate organs, it is clear he is being murdered for that purpose. In this case, the family was not aware of foul play until much later.

It is interesting to note that around this time the family bumped into the nurse who had attended the patient the night before. This nurse had promised to call the family in the event of change but did not do so. On seeing the family the next day, and after the patient's unrecoverable deterioration, the nurse stammered, “How is he doing today...? By the way, what's wrong with him anyways?”

With the patient now hooked up to an emergency shunt to relieve his intracranial pressure, his family envisioned a wait of a few days to see whether he would respond to the treatment. They left the hospital to check on the patient's apartment where they found he had left his computers running in the expectation of returning shortly to what he was working on.

While they were away, the family received a call from the hospital in which the caller demanded to know the wishes of the family. The reason given was that the bed was needed in the ICU.

The family returned to the hospital where a neurosurgeon explained to them the futility of any further treatment. His tone was pressured and impatient.

During this conversation, the family agreed to withdraw life support. They went to the bedside. A different individual entered. He appeared to be a member of the ICU staff. Unlike the neurosurgeon his demeanour was quiet and patient. He said nothing for about a minute while fumbling with a chair and then offered his regrets with respect to the outcome. He asked whether the family would like to donate the patient's organs. The patient's mother replied, “His wishes are in his wallet. Don't you have his personal effects?”

The individual offered no response forcing the family to reply that no, they did not wish to donate the patient's organs.

Embarrassed and humiliated she found herself having to apologize for her behaviour and her son's disapproval of organ transplantation.

The individual then asked, “Why not?” His eyes roved from one family member to another scanning for an answer. The patient's mother, awkward and distressed, searched for a way out. In order to counteract the pressure she felt from the organ procurer to donate her son's organs despite his wish not to do so, she launched into her son's philosophy on such matters. She began to cry. Embarrassed and humiliated she found herself having to apologize for her behaviour and her son's disapproval of organ transplantation.

Her defensive instinct was to keep talking over the procurer in order to preclude any further persuasion to donate her son's organs against his will. She did so for about 10-15 minutes until the organ procurer stood up, mumbled “Thank you” and left.

With life support removed from the patient, his mother held him to her heart. As her son took his last breath, her relief of having barely managed to carry out his final wishes rose above that offered by the end of his abysmal suffering. This is scarcely the way things should be.

The family left the bedside about 30 minutes after the patient's death. They exited the patient's room to see Dr Richard Wennberg standing at the nurse's station. A patient's death requires the supervising doctor to console the patient's family at this time. Wennberg made no gestures of sympathy towards the family. He lowered his head and raised it only after the family began to turn the corner. His only interest lay in seeing whether the family had left[8].

The patient's cause of death is listed as “brain mass.” The rationale for removal of life support is entered as

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"patient would not have wanted to live with speech impediment and right arm weakness."

The true cause of death in this case was "false imprisonment and murder for possible organs."

These statements are unabashedly false and insulting to the patient and his family. The true cause of death in this case was "false imprisonment and murder for possible organs." By the time life support was removed, the patient's disabilities were severe. His brain stem had shut down and he had suffered numerous strokes. These impressive injuries had been caused by intended injury and disregard on the part of his doctors, nurses and hospital. The methods used by these parties were stealthy and practised. It is clear they were no strangers to the crime of murder.

The reasons given by these healthcare providers for death and removal of life support here, reflect a standard approach which attributes the decision to terminate care to the family—as though they chose to kill their loved one for relatively minor reasons. This tactic is employed at the earliest opportunity to discourage legal procedures against the hospital and doctors.

The lengths to which the University Health Network goes in order to obtain organs are startling and disturbing. The dedication shown by their staff and doctors to the organ transplant industry is nothing short of evangelical. Had these parties been willing to show the same degree of dedication to the patient's needs, he would be alive and well today. There is no type of situation which compares to this one in terms of lack of respect for human life. The degree of malevolence shown surpasses even that which is found in the worst cases of hate.

The case study does not imply that this patient's fate was a one-time incident. Similar instances happen in hospitals across Canada, every day. These created deaths amount to crimes of the highest order.

MASHCan urges law enforcement authorities to do their part in stemming the tide of this cruel practice. While the public is encouraged to believe in the miracle of organ transplantation, it must also be warned of dangers to those patients who are deceived, imprisoned, tortured and murdered as potential donors of those organs. There are two sides to everything. In this scenario, one of them is particularly depraved.

All details in the case study and its sequence of events have been obtained by means of an exhaustive analysis of the hospital notes, medical history, eyewitness testimony, confessions, independent clinical assessment, literature reviews, litigation/complaint process, intimate knowledge of the patient's personality, sense of courage/autonomy, intelligence, previous hospital experiences etc.

* The civil action brought in this matter is as against Drs Richard Arnold Wennberg, Michael Joshua Angel, Manish Micheal Sood, Natalie Wong, The University Health Network (Toronto Western Hospital) and nurses, Jennifer Seeley, Trudy Maria Whiting. The addition of further parties was pending.

The cause of action was intentional tort (false imprisonment leading to death). The defendants refused to acknowledge the cause of action as filed stating that they would only defend against professional negligence. They did not move for a summary judgment on the basis that the cause of action was "improper." This move would never have survived the scrutiny of precedent in that it is illegal to shield any Canadian citizen from murder charges. Instead, the defendants relied upon court bias and corruption to maintain their position. Judges and court staff conspired to protect the defendants.

After two years of defendant and court misconduct, the plaintiff moved to have the case discontinued on the basis of escalating court corruption in favour of the doctors, nurses and hospital. She provided a long list of wrongdoing including bribery of court staff, conspiracy among judges and lawyers, theft of documents, and alteration of transcripts. The judge at the final hearing asked the plaintiff if she was willing to continue if the wrongdoing was corrected. She turned down the offer fearing yet more corruption. The discontinuance was granted without argument. The plaintiff was not ordered to pay costs which at this point were approaching $400,000[9].

The contents of the above case study are known and were to have been presented at the mandatory mediation session for all parties which forms part of the Canadian litigation procedure. The defendant parties refused to attend the required mediation despite the rule, and regardless of plaintiff's good faith efforts over the two year

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duration of the action to discuss and narrow the issues.

The defendants have chosen to let their above-cited personal crimes stand undefended, and rely upon their affiliation with the medical system for protection. The government does not wish to shake the public trust in the medical system. These parties continue to treat patients in this fashion where they work in hospitals throughout Ontario. Some of them have enjoyed rapid promotion for their "stomach" to imprison, torture and deny care to a brain-injured patient in order to obtain his organs for other people. The government allows for collateral death and injustice within its systems. It is important that the public be aware of this reality and protect itself.

As stated, "MASHCan frequently updates and improves materials on this website." These updates and improvements are drawn from journal articles on organ transplantation, the latest news and solicited public responses to articles provided. These articles reflect heartfelt beliefs as to the above patient's cause of death, and those of other patients whose situations are submitted and studied. These articles appear as regular features on this site. They are provided to inform the public, specifically the probable segment thereof which does not condone, or ask for, any medical killing.

This site is written in the omniscient voice in order to minimize the impression that a hospital murder is an anomaly or the opinion of a bereaved parent.

1. When a patient wishes to leave a hospital he does not have to see a doctor. The hospital asks patients to sign a form known as an AMA (wish to leave against medical advice) for its own protection. If a doctor wishes to obtain this form for the hospital, he is required to speak to the patient in person.
2. The Patient Consent Act provides for patient approval of treatment plans and consent to hospital admission.
3. The code for this illegal act will appear in hospital notes as, "Make a compromise to stay."
4. Sedation without the patient's knowledge is achieved by modifying an existing order and then having a doctor update it later. For instance, an aspirin can be replaced with codeine if the nurse wishes to sedate a patient.
5. Drug users are not desirable organ donors. Therefore, when potential donors are identified, the first step is to screen them for drug use. An order for a drug test also serves to incite feelings of hatred within an unsophisticated nursing staff towards a patient in their care.
6. A common tactic on the part of doctors and hospitals to worsen patients without arousing suspicion is to order tests which waste time.
7. Wennberg later told a colleague about his part in this wrongdoing. He was worried and had sought "peer support" after receiving a pre-litigation letter from the patient's family. He did not know that his colleague was personally acquainted with the family.
8. Dr Wennberg attends fundraising events for the UHN. Fundraising reports show he associates with wealthy people interested in the UHN neurology program. Organs for transplant come mostly from neurology patients whose lives are not saved in the hospital. The UHN performs the greatest number of organ transplants in Canada
9. Special circumstances for removing a losing plaintiff's obligation to pay court costs include defendant or court misconduct during the litigation process or when legal questions are novel (Judge John Gill).

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Many families beg me to refer their ill or injured relatives to Trillium [organ donation agency] regardless of the relative's suitability for harvest. These people have the idea that by donating their relative's organs they will make themselves feel better about the death. They see donation as a service provided to avoid the grieving process. To them this service keeps their relatives “alive” or doing some good.
—Ontario physician, 2007
Organ harvesting is a cause of death. It does not happen after death. Every family who chooses organ harvesting as the ultimate cause of death for their injured relative, should assess on a scale of 1 to 10 how much that relative felt the pain and degradation of the harvesting process. It's important to the souls of the dead that their families know this last fact about them.
Organ donors are organ “don't-knowers.” They are ignorant of physiology, they are ignorant of crime. They are ignorant of the soul. They have long abandoned any cultural values. Their only hope of appearing intelligent or to belong somewhere is their agreement to be killed or to kill their children. Body part profiteers target this ignorance.
MASHCan exposes the motive, means and opportunity for organ murder in Canada. This site categorically states that organ “donation” is an act of murder. It states that transplantation is used to conceal corporate responsibility for the effect of harmful products on public health by making recipients grateful for a new organ. MASHCan states that transplantation also serves to prolong the lives of corporate profiteers who, for their part, suffer the consequences of high-living. MASHCan does not dignify with debate such an exploitive practice.
The aim is to have the phrase “organ donation” become a colloquial term for “hassle-free euthanasia.” Eventually anyone who wants to euthanize themselves or their family members will know how it's done, and where to go. This pact however, forbids the use of the word “euthanasia.” We already do it with our pets and our garbage. We have them nicely “put to sleep" or “recycled.”
Organ transplantation is not compatible with an over-populated world. For every donor, there is a seven-fold increase of unnatural survival elsewhere. This trend is irresponsible and short-sighted.
There is only one difference between organ harvesting in China and Canada. China, politely, does not point a finger at Canada as a way to deceive and distract its population from the awful truth of transplantation.
It is urgent that the focus on organ harvesting move from the “definition of death” to the growing trend of imprisoning and killing curable patients whose family type would likely submit to organ donation. In real time, neurology wards have become casinos: hospitals are boutiques of harm.
Organ transplantation has to be stopped. We are looking at the most beautiful reasons for committing the most terrible crimes.
So it isn't the masses who are to blame for demanding rubbish but rather those who aren't capable of providing them with anything else.
—Cervantes
When a doctor goes wrong he is the first of criminals.
He has nerve and he has knowledge.
—Arthur Conan Doyle
All truth passes through three stages. First it is ridiculed, second it is violently opposed. Third it is accepted as self-evident.
—Arthur Schopenhauer
Organ harvesting is not “cadillac” medical treatment for a donor. Harvesting neither saves his body nor his soul. It murders both.
There would be no attention paid to clinical ethics unless the public demanded it.
—Sr. Hospital Exec. (Toronto)
If you see my fear, grief and rage as mere psychological phenomena, how do I view your greed and megalomania which like to blame ME for being human?
I was told not to enter the PICU because I felt that they were ordering DNRs much too quickly on kids with brain damage from accidents or stroke.
—Ontario pediatrician
I thought it was okay to harvest your wild mushrooms because there weren't any “No Trespassing” signs posted.
—Deli owner
The will to save the organs at all costs kills the will to save the patient at all costs.
—Prof. Dr. Massimo Bondì
The corporate promise now is health along with indulgence. There is no way to sell this anomaly without making organ replacement a part of popular culture.
These hideous killers will answer to my son himself in some form or another, at some point in eternity. They too will get ill and die. It is impossible for them to be sure that there is no place of reckoning.
—Mother of murdered patient

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