

# Ventilators May Increase Risk of Death From COVID-19

Analysis by [Dr. Joseph Mercola](#)

✓ Fact Checked

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## STORY AT-A-GLANCE

- › COVID-19 patients who are put on ventilators have an increased risk of death. It may turn out that ventilators are inappropriate for a majority of patients
- › Doctors at UChicago Medicine report “truly remarkable” results using high-flow nasal cannulas (HFNC) in lieu of ventilators. Of 24 COVID-19 patients who were in respiratory distress, only one required intubation after 10 days of HFNC
- › A more complicated treatment strategy that’s showing promise is membrane oxygenation (ECMO), in which the patient’s blood is oxygenated outside the body before pumped back into circulation. ECMO is recommended for relatively young patients with few comorbidities who fail to respond to ventilator treatment
- › Mechanical ventilation can easily damage the lungs as it’s pushing air into the lungs with force. Hyperbaric oxygen treatment (HBOT) may be a better alternative, as it allows your body to absorb a higher percentage of oxygen without forcing air into the lungs
- › Chinese doctors report “promising results” after treating five COVID-19 patients with HBOT and NYU Langone Health is currently recruiting COVID-19 patients for a study comparing HBOT to standard of care alone

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### From Dr. Joseph Mercola

Since COVID-19 first entered the scene, exchange of ideas has basically been outlawed. By sharing my views and those from various experts throughout the pandemic on COVID treatments and the experimental COVID jabs, I became a main target of the White House, the political establishment and the global cabal.

Propaganda and pervasive censorship have been deployed to seize control over every part of your life, including your health, finances and food supply. The major media are key players and have been instrumental in creating and fueling fear.

I am republishing this article in its original form so that you can see how the progression unfolded.

*Originally published: May 6, 2020*

In recent weeks, several doctors and published papers have noted that COVID-19 patients who are put on ventilators have an increased risk of death.<sup>1</sup> April 9, 2020, Business Insider reported<sup>2</sup> that 80% of COVID-19 patients in New York City who are placed on ventilators die, causing some doctors to question their use.

According to The Associated Press,<sup>3</sup> “Similar reports have emerged from China and the United Kingdom. One U.K. report put the figure at 66%. A very small study in Wuhan ... said 86% died.”

## **Updated New York City Statistics**

An April 22, 2020, study published in JAMA describing the outcomes for 5,700 patients hospitalized with COVID-19 in the New York City area reported:<sup>4</sup>

*“Mortality rates for those who received mechanical ventilation in the 18-to-65 and older-than-65 age groups were 76.4% and 97.2%, respectively. Mortality rates for those in the 18-to-65 and older-than-65 age groups who did not receive mechanical ventilation were 19.8% and 26.6%, respectively. There were no deaths in the younger-than-18 age group.”*

These numbers were amended shortly thereafter, though. April 26, 2020, CNN Health reported<sup>5</sup> that an average of 24.5% of patients placed on ventilators died, compared to about 20% of those who were not ventilated.

Karina Davidson, senior vice president of research at Northwell Health, told CNN her team had decided to “clarify the wording of the report,” and that the figures are being

updated to reflect “how many [patients] we know have had an outcome and how many remain in the hospital.” CNN explained:<sup>6</sup>

*“The original report in JAMA stated that 12% of patients required ventilation and of them 88% died – but those numbers only represented a minority of patients whose outcome was known, not the entire body of patients. The updated numbers include all of the patients, including those who remained in the hospital at the time the data was gathered on April 4.”*

In an April 8, 2020, article, STAT News reported:<sup>7</sup>

*“What’s driving this reassessment is a baffling observation about COVID-19: Many patients have blood oxygen levels so low they should be dead. But they’re not gasping for air, their hearts aren’t racing, and their brains show no signs of blinking off from lack of oxygen.*

*That is making critical care physicians suspect that blood levels of oxygen, which for decades have driven decisions about breathing support for patients with pneumonia and acute respiratory distress, might be misleading them about how to care for those with COVID-19.*

*In particular, more and more are concerned about the use of intubation and mechanical ventilators. They argue that more patients could receive simpler, noninvasive respiratory support, such as the breathing masks used in sleep apnea, at least to start with and maybe for the duration of the illness.”*

## **Oxygen Is Needed but Ventilation May Be Inadvisable**

Dr. Cameron Kyle-Sidell, whose video is featured at the top of this article, has noted their patients’ symptoms have more in common with altitude sickness than pneumonia.<sup>8</sup> Similarly, a recent paper<sup>9</sup> by Drs. Luciano Gattinone and John Marini describes two different types of COVID-19 presentations, which they refer to as Type L and Type H.

While one benefits from mechanical ventilation, the other does not. Dr. Roger Seheult discusses this paper, as well as the comparison of COVID-19 to high altitude pulmonary edema or HAPE, in the MedCram video above.

In the final analysis, it may turn out that ventilators are inappropriate for a majority of patients, and doctors at UChicago Medicine report<sup>10</sup> “truly remarkable” results using high-flow nasal cannulas in lieu of ventilators. As noted in a press release:<sup>11</sup>

*“High-flow nasal cannulas, or HFNCs, are non-invasive nasal prongs that sit below the nostrils and blow large volumes of warm, humidified oxygen into the nose and lungs.*

*A team from UChicago Medicine’s emergency room took 24 COVID-19 patients who were in respiratory distress and gave them HFNCs instead of putting them on ventilators. The patients all fared extremely well, and only one of them required intubation after 10 days ...*

*The HFNCs are often combined with prone positioning, a technique where patients lay on their stomachs to aid breathing. Together, they’ve helped UChicago Medicine doctors avoid dozens of intubations and have decreased the chances of bad outcomes for COVID-19 patients, said Thomas Spiegel, MD, Medical Director of UChicago Medicine’s Emergency Department.*

*‘The proning and the high-flow nasal cannulas combined have brought patient oxygen levels from around 40% to 80% and 90%, so it’s been fascinating and wonderful to see,’ Spiegel said ...*

*‘Avoiding intubation is key,’ Spiegel said. ‘Most of our colleagues around the city are not doing this, but I sure wish other ERs would take a look at this technique closely.’”*

## **Extracorporeal Membrane Oxygenation Technique**

Another less available and more complicated treatment strategy that's showing promise is known as extracorporeal membrane oxygenation or ECMO. The system involves a complex circuit of tubes, filters and pumps that oxygenate the patient's blood and remove waste products outside the body before pumping it back into circulation.

Guidance<sup>12</sup> for the use of ECMO in COVID-19 treatment was published March 30, 2020, in the ASAIO Journal. As a general rule, ECMO is recommended for relatively young patients with few comorbidities who are failing to respond to ventilator treatment. According to an April 24, 2020 press release by the University of Michigan:<sup>13</sup>

*"As of April 21 ... more than 470 patients with suspected or confirmed cases of COVID-19 have been treated at the ECMO centers that are sharing their data. Most were men in their 40s and early 50s. Nearly half had obesity and one-fifth had diabetes.*

*Most of those placed on ECMO for COVID-19 are still on the treatment, which can take weeks to allow the body to recover enough for the patient to function on their own. Every moment of that time, patients must be under the care of teams of trained nurses, respiratory therapists, technicians and physicians ...*

*Patients must get evaluated by an ECMO center and transferred before their condition worsens too much. They should not have been on a ventilator more than seven days before starting ECMO, which means that they should be considered for ECMO soon after the decision to intubate them is made.*

*'Despite the substantial resources required to care for patients on ECMO, we believe this is an appropriate strategy for selected patients that are otherwise at imminent risk of death,' says Jonathan Haft, M.D., medical director of U-M's ECMO program."*

## **Hyperbaric Oxygen Therapy**

Sadly missing from the conventional conversation is the use of hyperbaric oxygen therapy (HBOT) which I believe might be an excellent treatment method. As noted by Dr.

Andrew Saul, editor-in-chief of the Orthomolecular Medicine News Service, in “A Review of Helpful Antiviral Strategies”:

*“Making the oxygen available in a way that's appropriate to the severity of the patient is the answer. We have to remember that our body is singularly good at taking in oxygen or we wouldn't be here. And our lungs have a huge amount of absorptive space. I mean, that's what they do. It's just an extraordinary system that we have.*

*Oxygen goes in by diffusion. You don't push it in; the body sucks it in because if you have more oxygen outside than you do inside, it just goes through. All you do is give a lot of absorptive surface. And if you flattened out all the little alveoli in the lungs, you'd have an enormous area ...*

*So, by providing the oxygen and then see if the body will take it up, you've made the first step. That can be done preventively by fresh air and exercise and going out and playing ...*

*If somebody needs more oxygen, and you want to give them a little pressure, if that makes the patient better, then you do it. But the idea that you've got to ram this oxygen like a supercharger on a Mustang is, I think, a little bit, shall we say, industry friendly ...*

*[The alveoli] are tiny, tiny little sacks. They have some of the thinnest little membranes you've ever seen. Look at them under a microscope. They're very delicate. So, the last thing you want to do is add injury to insult.”*

Mechanical ventilation can easily damage the lungs for the fact that it's pushing air into the lungs with force. During HBOT, on the other hand, you're simply breathing air or oxygen in a pressurized chamber, which allows your body to absorb a higher percentage of oxygen.

There's no airflow being forced directly into the lungs. HBOT also improves mitochondrial function, helps with detoxification, inhibits and controls inflammation and

optimizes your body's innate healing capacity. You can learn more about this in "Hyperbaric Oxygen Therapy as an Adjunct Healing Modality."

## **HBOT Trials for COVID-19**

We may eventually hear more about this, however, as NYU Langone Health is currently recruiting COVID-19 patients for a study using HBOT. The study was posted April 2, 2020. As detailed on ClinicalTrials.gov:<sup>14</sup>

*"This is a single center prospective pilot cohort study to evaluate the safety and efficacy of hyperbaric oxygen therapy (HBOT) as an emergency investigational device for treating patients with a novel coronavirus, disease, COVID-19 ...*

*The patient will receive 90 minutes of hyperbaric oxygen at 2.0 ATA with or without air breaks per the hyperbaric physician. Upon completion of the treatment the patient will then return to the medical unit and continue all standard of care ...*

*After the intervention portion of this study, a chart review will be performed to compare the outcomes of intervention patients versus patients who received standard of care."*

Chinese doctors also report "promising results" after treating five COVID-19 patients with HBOT. Two were in critical condition and five were severe. As reported by the International Hyperbarics Association:<sup>15</sup>

*"Hyperbaric oxygen was added to the current comprehensive treatments being performed at the hospital for COVID-19 affected patients, with a dose of 90-120 minutes at treatment pressures of 1.4 to 1 fi.ATA.*

*The results were very encouraging as these five patients received significant therapeutic benefits, including rapid relief of symptoms after the first session.*

*The rationale for adding this procedure is to help combat the progressive hypoxemia (low blood oxygen levels) that COVID-19 can cause. Hyperbaric oxygen has the ability to add a substantial supply of extra oxygen into the bloodstream ...”*

## **Hospitals Are Major Transmission Sites of SARS-CoV-2**

In this video, taped April 17, 2020, Dr. John Ioannidis discusses results from three preliminary studies. Importantly, he points out that nosocomial infections – infections that occur in hospital settings – appear to be part and parcel of why the COVID-19 mortality rate is so much higher in certain areas, such as Italy, Spain and the New York metropolitan area.

A common denominator between these areas is a massive number of hospital personnel who are infected with SARS-CoV-2 and spread it to patients who are already in an immune-compromised state.

*“Hospitals are the worst place to fight the battle with COVID-19,” he says. “We should have done our best to keep people away from the hospitals if they had COVID-19 symptoms, unless they had really severe symptoms.”*

In essence, by having so many people unnecessarily going to the hospital out of fear, a hospital-chain of infectious transmission was allowed to develop. Many could simply have been treated at home.

These findings highlight the need for very stringent infection control measures in hospitals, to avoid transmission from asymptomatic personnel to patients. They also highlight the need to more carefully assess your need for medical care.

Ioannidis stresses that people experiencing mild to moderate symptoms of COVID-19 should not rush to the hospital, as they simply increase the risk of infectious transmission to personnel and other more vulnerable patients.

He also cites data showing hospital personnel have an estimated 0.3% chance of death from COVID-19, which is significantly lower than the 3.5% originally cited by the World Health Organization. He also points out that this and other data point to COVID-19 having a fatality rate very close to that of seasonal influenza.

This, he says, is good news for hospital personnel who have been working under very distressing conditions, many fearing for their lives. As it turns out, such fears appear to be vastly exaggerated and uncalled for.

## **Sepsis Is a Common Complication in COVID-19**

While treating mild to moderate symptoms at home may be advisable, it's important to stay vigilant to signs of sepsis.<sup>16</sup> If COVID-19 symptoms worsen and signs of sepsis develop – described in [“Recognizing the Signs and Symptoms of Sepsis”](#) – immediate medical care is required.

Unless promptly diagnosed and treated, sepsis can rapidly progress to multiple-organ failure and death. [Sepsis is responsible for 20% of deaths worldwide](#) each year, and the cytokine storm response associated with sepsis also appears to be a primary way by which COVID-19 claims the lives of those who are immunocompromised and/or elderly.

According to a March 11, 2020, paper<sup>17</sup> in The Lancet, 59% of the 191 Chinese COVID-19 patients in the study developed sepsis, and sepsis was present in 100% of those who died. It was the most commonly observed complication, followed by respiratory failure, ARDS and heart failure.

You can learn more about sepsis and its treatment in [“Melatonin for Sepsis,”](#) [“Vitamin C Lowers Mortality in Severe Sepsis”](#) and [“Vitamin C Works for Sepsis. Will It Work for Coronavirus?”](#)

## **Sources and References**

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- <sup>1</sup> [Medscape April 6, 2020](#)
- <sup>2</sup> [Business Insider April 9, 2020](#)

- <sup>3</sup> The Associated Press April 8, 2020
- <sup>4</sup> JAMA April 22, 2020 doi:10.1001/jama.2020.6775
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- <sup>7, 8</sup> STAT News April 8, 2020
- <sup>9</sup> JAMA Insights April 24, 2020 DOI: 10.1001/jama.2020.6825
- <sup>10, 11</sup> Newswise April 23, 2020
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- <sup>17</sup> The Lancet March 11, 2020 doi.org/10.1016/S0140-6736(20)30566-3