

Are Ventilators Killing More People Than They're Saving?? - Global Research

By Mike Whitney



“Researchers in Wuhan...reported that, of 37 critically ill Covid-19 patients who were put on mechanical ventilators, 30 died within a month. In a U.S. study of patients in Seattle, only one of the seven patients older than 70 who were put on a ventilator survived; just 36% of those younger than 70 did.” ([“With ventilators running out, doctors say the machines are overused for Covid-19”](#), STAT News)

Think about that for a minute. What these figures mean is that, if you’re over 70 and you’re put on a ventilator because you have coronavirus, you’re probably going to die. More importantly, it means that it was probably the ventilator that killed you. Isn’t that something the public ought to know?

I think it is.

“One in seven” is very poor odds. They aren’t the odds a rational person would bet his life on unless he had a death wish or a very serious gambling problem. So what’s going on here, and why is there so much misleading blabber about ventilators?

The root problem seems to be that coronavirus is a relatively new phenomenon and the methods for treating it are still in their early phases. Nothing is set in stone, not yet at least. Even so, you might have noticed that, when British **Prime Minister Boris Johnson** contracted the infection and was bundled off to ICU, the medical team did NOT put him on a ventilator, but put him on oxygen instead. And the difference couldn’t be more striking, because today, after 3 days in ICU, Johnson is alive, whereas he probably would be dead if he was intubated. Yes, I am making a judgment about something of which I cannot be entirely certain, but I think I’m probably right. If Johnson had been put on a ventilator, he probably would have died.

But, why, that’s what we want to know?

The answer to that question can be found in the article cited above. Take a look:

“Many (coronavirus) 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.**

The question is whether ICU physicians are moving patients to mechanical ventilators too quickly. “Almost the entire decision tree is driven by oxygen saturation levels,” said the emergency medicine physician, who asked not to be named so as not to appear to be criticizing colleagues.” (“With ventilators running out, doctors say the machines are overused for Covid-19”, STAT News)

Okay, so doctors are making their decisions based on “blood oxygen levels”, right? But blood oxygen levels might signal the need for a different treatment for coronavirus patients than they do for pneumonia and acute respiratory distress syndrome (ARDS) patients. In other words, one size does not fit all. The problem is that too many people are ending up on ventilators when ventilators are undermining their chances for survival. Here’s more:

“....one of the most severe consequences of Covid-19 suggests another reason the ventilators aren’t more beneficial. In acute respiratory distress syndrome, which results from immune cells ravaging the lungs and kills many Covid-19 patients, the air sacs of the lungs become filled with a gummy yellow fluid. “That limits oxygen transfer from the lungs to the blood even when a machine pumps in oxygen,” Gillick said.

As patients go downhill, protocols developed for other respiratory conditions call for increasing the force with which a ventilator delivers oxygen, the amount of oxygen, or the rate of delivery, she explained. **But if oxygen can’t cross into the blood from the lungs in the first place, those measures, especially greater force, may prove harmful. High levels of oxygen impair the lung’s air sacs, while high pressure to force in more oxygen damages the lungs.**

“We need to ask, are we using ventilators in a way that makes sense for other diseases but not for this one?” Gillick said. “Instead of asking how do we ration a scarce resource, we should be asking how do we best treat this disease?” (STAT News)

Can you see the problem? Virus victims develop a mucousy-yellow gunk in their lungs that prevents oxygen from transferring to the blood. Forcing more air into their lungs with a ventilator, doesn’t help that process, it just damages the lungs. In short, it is

the wrong treatment for this particular illness. This explains why Johnson was not put on a ventilator, because the risks far outweighed the potential benefits. Here's more from the same article:

“In a small study last week in Annals of Intensive Care, physicians who treated Covid-19 patients at two hospitals in China found that the majority of patients needed no more than a nasal cannula. Among the 41% who needed more intense breathing support, none was put on a ventilator right away. Instead, they were given noninvasive devices such as BiPAP; their blood oxygen levels “significantly improved” after an hour or two. (Eventually two of seven needed to be intubated.) The researchers concluded that the more comfortable nasal cannula is just as good as BiPAP and that a middle ground is as safe for Covid-19 patients as quicker use of a ventilator.....“Anecdotal experience from Italy [also suggests] that they were able to support a number of folks using these [non-invasive] methods,” Japa said.” (STAT News)

So the treatment for patients with coronavirus is rapidly evolving, but serious mistakes are undoubtedly still being made. One can only wonder how many people might have survived their trip to ICU had their physicians been more aware of the non-invasive alternatives? But don't think for a minute that I'm blaming anyone for using methods or devices that may be discarded in the near future. I'm not, but from my vantage point, it looks like the over-dependence on ventilators might have been a very costly mistake. Check out this last clip from the article:

“Because U.S. data on treating Covid-19 patients are nearly nonexistent, health care workers are flying blind when it comes to caring for such confounding patients. But anecdotally, Weingart said, “we've had a number of people who improved and got off CPAP or high flow [nasal cannulas] who would have been tubed 100 out of 100 times in the past.” What he calls **“this knee-jerk response” of putting people on ventilators if their blood oxygen levels remain low with noninvasive devices “is really bad. ... I think these patients do much, much worse on the ventilator.”**

That could be because the ones who get intubated are the sickest, he said, “but that has not been my experience: It makes things worse as a direct result of the intubation.” **High levels of force and oxygen levels, both in quest of restoring oxygen saturation levels to normal, can injure the lungs. “I would do everything in my power to avoid intubating patients,” Weingart said.”** (STAT News)

“Flying blind” sums it up perfectly. Doctors and health care workers have proceeded on the basis of guesswork and intuition without any empirical evidence that they've settled on the proper treatment for the infection. That should give us all pause.

Assuming that we're still in the early days of the pandemic, many of us might have to decide whether we'll allow ourselves or a loved one to be put on a ventilator. This new research could help us to make a more informed decision. I certainly hope so.

Please watch this excellent 6 minute video of Dr Cameron Kyle Sidell, E.R. and Critical Care Doctor, NY City

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Mike Whitney is a frequent contributor to *Global Research*.