

ICUs across the United States stretched to capacity by COVID-19 Delta variant surge

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The Delta wave of the pandemic has left an immense hidden trail of devastation stemming from a complete failure of local and state public health departments to provide a timely and accurate statistical accounting of the number of cases and deaths. The actual toll of the pandemic becomes guesswork pieced together by daily reports from health systems to their respective states.

However, the limited data available to the US Department of Health and Human Services (HHS) demonstrates that intensive care unit (ICU) capacity utilization across many healthcare systems in the Southeast, Midwest, the South, specifically Texas, and the Southwest, including California, has exceeded 95 percent.

According to the *New York Times*, “One in four hospitals are now reporting more than 95 percent of ICU beds occupied, up from one in five last month.” The latest metrics from the HHS website on hospital utilization indicates that out of 84,513 staffed ICU beds in the country, 67,175, or approximately 80 percent, are in use. Almost 31 percent of these beds are being occupied by patients admitted for COVID-19.

The tragic death of Ray Martin DeMonia, a Cullman, Alabama antiques dealer, in Meridian, Mississippi, from a heart attack earlier this month, may seem anecdotal but depicts in glaring reality the consequences to the population when health care systems become inundated by an entirely preventable disease. DeMonia was turned away from 43 hospitals across three states because their ICUs were full. The nearest available bed was 200 miles away at Rush Foundation Hospital. Delay in care, in this case, led to his untimely death.

A heart attack need not be fatal nor debilitating. Rapid intervention that allows the reopening of a blocked coronary artery can restore oxygenated blood

to the heart muscle and prevent the tissue from dying. If the blockage persists for five or six hours, a significant portion of the heart muscle can fail, and acute heart failure can occur with the heart attack leading to a dangerous combination. After twelve hours, the damage is irreversible. Additionally, dangerous heart rhythms can be generated that make the remaining portion of the heart work inefficiently.

The care of patients in ICUs is labor-intensive. It requires a tremendous investment in resources that include highly trained specialists—a cadre of nurses, physicians, therapists—and an array of complex equipment used to treat patients. Additionally, interventional radiological suites, blood banks, laboratories, and pharmacies must work together intimately to allow the hospital services to function efficiently.

However, when these systems reach capacity, the ability to care, treat, and respond immediately to a medical emergency is compromised. Instead of nurses caring for one patient, they may be assigned three or four patients in their extended shifts. Non-ICU staff are utilized who are unfamiliar with the processes or do not know how to respond to critical results. Patients must be monitored in busy emergency rooms or makeshift units lacking the necessary support systems.

A sustained surge in sick patients also means that essential procedures or operations must be suspended. Patients with life-threatening illnesses have to cope until health systems can return to routine operations. But as the current surge of COVID-19 impacts younger patients, ICU stays are more extended. The state of siege under which the hospitals operate runs into weeks, which can be a matter of life and death for patients who desperately need urgent comprehensive medical attention. They also take an incredible toll on

the mental well-being of the staff, who feel they are perpetually working over an assembly line of severely ill patients.

Speaking with *U.S. News*, the executive vice president of the Houston Methodist hospital system, Roberta Schwartz, frankly stated, “We basically do ICU in the emergency room. You may hold down there for 45 minutes, and you may hold for three days. You’re going to get great care if you can come to one of our facilities. But ideally, you want to get people up to the appropriate unit as quickly as you can.”

“It’s not very comfortable, but it works,” she told *U.S. News* about the makeshift ICU. “And a blow-up mattress is better than a sleeping bag, which is better than a tent outside.”

The answer for the ruling elite to the current crisis is the implementation of hospital care rationing programs, which Idaho’s Department of Health and Welfare (DHW) announced last week as the state faced a massive surge in COVID-19 patients. On September 11, there were over 600 patients hospitalized, far above the winter peak when no more than 466 people had been hospitalized at any one time.

DHW Director Dave Jeppsen wrote, “Crisis standards of care is a last resort. It means we have exhausted our resources to the point that our healthcare systems are unable to provide the treatment and care we expect. This is a decision I was fervently hoping to avoid. The best tools we have to turn this around is for more people to get vaccinated and to wear masks indoors and in outdoor crowded public places. Please choose to get vaccinated as soon as possible – it is your very best protection against being hospitalized from COVID-19.” The crisis standard of care, in basic terms, means resources are diverted to those the hospital staff believes have the best chance for survival.

Yet, beyond meagerly suggesting that residents consider getting vaccinated, Idaho Republican Governor Brad Little, like his counterparts in Florida, Texas and elsewhere, has remained vocally opposed to any mask mandate.

Governor Little is also working with the state’s attorney general, Lawrence Wasden, to use the court systems to stop President Joe Biden’s large employer COVID vaccination and testing mandate.

Meanwhile, patients are being transported across state lines to Spokane, Washington, where there is some

capacity in ICUs. However, as Dr. Christopher Baliga, an infectious disease specialist at Seattle’s Virginia Mason hospital, told the *Washington Post*, “We are keeping our head above water, but barely. Our capacity to absorb overwhelmed patients from other states is severely limited.”

According to an analysis by the *Economist*, though COVID deaths are averaging close to 1,700 per day in the US, excess deaths are almost twice as many at 3,100 per day. Cumulatively, with more than 662,000 reported deaths due to COVID, there have been 860,000 excess deaths. The Institute for Health Metrics and Evaluation, an independent global health research center based at the University of Washington, places the current excess deaths in the US at over one million.

Not all these deaths are directly related to COVID infections. Dr. Steven Woolf, director emeritus of the Virginia University’s Center on Society and Health, noted last year, “Some people who never had the virus may have died because of disruptions caused by the pandemic. These include people with acute emergencies, chronic diseases like diabetes that were not properly care for, or emotional crises that led to overdose or suicides.”

To be even more precise, the current preventable deaths are a byproduct of deliberate neglect on the part of state and federal governments, when in the face of inundated health systems operating at overcapacity they steadfastly refuse to lock down and disrupt the transmission of the virus, thereby perpetuating the social murder that is measured economically and tabulated in the ledgers of the financial aristocracy’s portfolios and ever-larger bank accounts.



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