Recently, a local news station in Houston ran a story about a man who passed away while waiting for a hospital bed. The story went viral.

Daniel Wilkinson, a 46-year-old veteran who served two deployments in Afghanistan, presented to a community hospital a few doors down from his home in Bellville, Texas, a small town on the outskirts of Houston. He was feeling sick and was ultimately diagnosed with gallstone pancreatitis.

In countries with modern health systems, gallstone pancreatitis is a dangerous but highly treatable diagnosis—often requiring an emergency interventional procedure that can be done at most large referral hospitals (including many in the Houston area), followed by a short ICU stay. But with the COVID-19 pandemic raging throughout Texas and much of the larger region, finding an ICU bed these days is no small task. Wilkinson was forced to wait more than seven hours before a bed finally opened at a VA hospital in Houston. But by then, gas pockets had started to form inside Wilkinson’s pancreas, suggesting that the failing organ was spreading an infection throughout his body. After waiting too long to have that procedure done, Daniel Wilkinson died.
For a year or so, we’ve been told repeatedly that the American health system has been on the brink of collapse. In the past month, this phrase has been used to describe the plight of hospitals in Oklahoma, Louisiana, Alabama, and Alaska; last winter, it was used to describe health systems in California and Idaho. Mississippi’s health care system, in a recent New Yorker essay, was observed to be approaching statewide failure, while in a Politico headline at the start of the pandemic, hospitals in New York were quickly reaching a breaking point. Descriptions of health systems at the very limit of functionality rank among other COVID clichés like new normal and in these trying times.

But to say that our health care system is on the brink of collapse is to sugarcoat it. The story of a veteran dying near a city known for having some of the best hospitals in the world—and from a very treatable ailment—illustrates that our health system has already collapsed.

Daniel Wikinson’s story feels at once shocking and almost typical at this point in the pandemic. As a resident physician who has only trained in an era of COVID—I was asked to consider graduating from school early in April 2020 to help with medical staff shortages—my time as a doctor has been defined by working in a system that has already collapsed. The American health system I work in has featured limited personal protective equipment, oxygen shortages, and the construction of field hospitals in convention centers and parking garages. Last winter, many hospitals across the country instituted crisis standards of care, forced to ration health services based on criteria that few people envisioned would be used outside of a mass casualty event, like a terrorist attack. Today, hospitals are full in much of the country, with patients requiring an ICU being airlifted thousands of miles in search of a staffed bed. These are not features of a health system that is approaching failure. These are features of a health care system that has broken down spectacularly, forcing doctors and patients to climb through the rubble looking for help.

There isn’t a textbook definition of “collapsed health care system.” But it can be framed through a related concept in global health, defined by the World Health Organization: health systems resilience. Thought of as bulwark against collapse, resilience describes the ability of a health system to absorb shocks and adapt while delivering core services. That is, during a big disaster, a functioning health care system can take care of the wounded, as well as patients with the assorted health emergencies that pop up in regular life, alongside those who need routine preventive care. In terms of resilience, our system over the past year has not passed muster. Last year, it quickly became
clear that we didn’t have a contingency plan for a prolonged disaster like a pandemic. During the first year of the pandemic, utilization of routine preventive care—like childhood immunizations and colon cancer screening—plummeted while our health system was overwhelmed with COVID. Nearly half of all patients, according to data from a large survey, forwent medical care, following the implications of public health messaging at the beginning of the pandemic to stay home unless there was an emergency (even though hospitals proved an unlikely place to catch COVID). The number of excess deaths during the pandemic in the United States is estimated to be more than 900,000. If America’s health care system might in normal times be too expensive for many to access and, for some, difficult to trust, the pandemic made things terrifically worse. Health care workers, lacking the support needed to function at such a grueling pace for so long, are voting with their feet. Nurses, fed up with working in a dysfunctional system, are quitting their jobs in droves, while an uptick of doctors are retiring early or following other health care workers to the exits.

I don’t blame voices in media and in public health from hedging their descriptions of where our health systems have stood throughout the pandemic. COVID has been unpredictable. No one wants to cry wolf or be wrong. Yet brink and hedge words like it—cusp, verge, threshold—offer us a state of suspended animation between normalcy and a true crisis. Focusing on language so intently may seem pedantic. But there is power in simply stating the truth. It validates the experiences of health care workers on the ground, and those of people who are unable to get adequate health care. In the future, acknowledging that our health system did collapse under the weight of the COVID-19 ultimately sets the stage for comprehensive health reform. It pushes back against any revisionist history that may emerge in the coming years; it’s easy to imagine accounts that conveniently emphasize health care heroes while waving away how flawed our health care system is. Recognizing our failure brazenly could push us to build a system that is more resilient.

Some health care leaders are starting to take a blunter approach in their messaging, in hopes of accurately communicating the help that is needed right now. In Baton Rouge, Louisiana, Catherine O’Neal, a physician and chief medical officer of Our Lady of the Lake Hospital, warned her community recently in a press conference about what it means to have no beds left in her hospital. “We can’t tolerate it,” she said, going on to explain that there are people sitting in ERs waiting for a bed as they risk health complications and even death. “We are out of things in our pockets to open beds. We need you to open our beds for us,” said O’Neal, urging people to get vaccinated. To the
public, acknowledging that the health system has collapsed communicates the gravity of the situation. It adds further urgency to calls for people to get their shots, and to mask in areas with significant community spread. Already, vaccination rates have increased in states significantly impacted by the delta variant.

To say that we’re on the brink of disaster offers hope that the people in charge can take steps to keep us from plunging toward an abyss. It suggests that the situation is at least temporarily sustainable, that maybe you can keep hunkering down and doing what you’ve been doing, and everything will be fine. But it is not sustainable, and it is not fine. The health care system is not approaching some kind of cliff, while still functioning—what is happening right now is killing people like Daniel Wilkinson. People who do not have to die are dying.