The ethical is political: Israel's production of health scarcity in Gaza

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ON THE ABUNDANCE OF SCARCITY AND THE SCARCITY OF 'POLITICS'

One of the most important motifs within (medical) ethics is scarcity: where essential (health) resources are scarce, urgent ethical questions arise. Over the last decade, at least 250 papers addressing the allocation of scarce health resources have been published in the *Journal of Medical Ethics* alone.[i] In the typical set-up, the authors introduce a situation of scarcity and then review and adjudicate the available or recommended courses of action, sometimes through the lens of a pet normative ethical theory.

It is much less common for (medical) ethicists to focus their enquiries on the *origins* of scarcity. Why aren't there sufficient health resources to go around? Who caused the scarcity, and how should they be held responsible? These questions are also firmly within the remit of the discipline.

Discussions of scarcity tend to circumvent these difficult questions by focussing on exceptional cases in Global North settings, where scarcity is relatively rare, and is sometimes defensible or insoluble. For example: it would be wasteful for a hospital to overstock expensive, bulky, energetically intensive, specialist equipment whose supply would only be challenged under the most extreme and unforeseen circumstances (eg, a pandemic), and there may never be sufficient usable donor organs to meet the demand for transplants. Much less attention is given to under-resourced settings, generally in the Global South, where scarcity is common, and is often both indefensible and soluble. The literature appears to favour what is 'unusual' and 'interesting' in some contexts, rather than what is commonplace, and by that fact more worrying, in others. This division of attention entrenches the idea that scarcity is a fixed feature of certain places and lives.

Why do medical ethicists so often fight shy of these meta-questions? They are, of course, harder and messier. More work and greater care are needed to contextualise the scarcity, and that context inevitably requires the authors to engage with 'politics', which is often quietly bypassed in medical ethics. It is much cleaner to excise a problem of scarcity from its political frame and 'solve' it as though it were a closed system. The pressure to publish, and the word limits imposed on those publications, surely also plays a part. It might also be the case that medical ethicists are liable to view ethical issues as problems clinicians must grapple with within the walls of the hospital.

What happens when the walls of the hospital are blown away? When neonatal incubators lose power, and premature babies must be kept warm on sheets of aluminium foil?[1] What should medical ethicists do when extreme scarcity arises because the entire health infrastructure of a place is being deliberately destroyed?

ISRAEL'S PRODUCTION OF HEALTH SCARCITY IN GAZA

The attack carried out by Hamas on 7 October 2023 was not the beginning of the story; Gaza's healthcare system was already dangerously inadequate. The enclave has been under Israeli air, land and sea blockade since 2007, which has obstructed the supply of medical equipment and drugs. Further, Israeli military campaigns, including airstrikes on hospitals, have repeatedly destroyed the existing health infrastructure. As the occupying power in Gaza, Israel is required by international humanitarian law to guarantee that civilians' basic subsistence needs are met, but has at various points over the last 16 years deliberately blocked access to water, electricity and humanitarian aid.[2]

In the last 6 months, more than 33 922 people are known to have been killed in Israel, the Occupied West Bank and Gaza, among them 32 783 Palestinians and 1139 Israelis. The bodies of at least 8000 more Palestinians are buried under the extensive rubble. More than 88 124 people have been injured: at least 79 394 Palestinians and 8730 Israelis.[3] In April 2024, a representative from Gaza's morgue monitoring system declared that the system for counting deaths had effectively collapsed.[4] 1000 children in Gaza have had limbs amputated following shrapnel injuries or after having body parts crushed by collapsing buildings, making them, in the words of trauma surgeon Ghassan Abu-Sittah "the biggest cohort of pediatric amputees in history".[5]

In any context, the most basic determinants of health are food, water and sanitation, shelter, and medical infrastructure, each of which requires reliable access to fuel and electricity. All of these are now critically scarce in Gaza.

Food, water, sanitation and shelter

Even before October 2023, two-thirds of Gaza's inhabitants required external aid to meet their nutritional needs as a result of Israel's blockade. Now, almost everyone left in Gaza requires assistance,[6] but Israeli checkpoints and bombardment threaten its delivery,[7 8] and Israel announced in March that it would block all UN food convoys to northern Gaza.[9] On at least two occasions in February and March 2024, Israeli troops opened fire on those queuing for food, killing almost 200 people and injuring hundreds more.[10–13] In April, six international humanitarian workers were killed in a targeted drone strike after unloading a shipment of food aid.[14]

Even where aid is available, it has been described by the WHO to be just a 'trickle' whose effects are 'barely registering'.[15] Those in receipt of aid struggle to eat a single meal each day, amounting to as little as an eighth of their calorie needs,[16 17] and many have resorted to eating pigeon and livestock feed, cacti and foraged weeds.[8] In March, 12 people drowned while attempting to retrieve airdropped food parcels that had landed in the sea.[18]

In northern Gaza, a third of children under the age of 2 and a quarter of children under the age of 5 are now acutely malnourished.[19] At least 27 children have died of malnutrition or dehydration; their deaths are widely understood to mark the start of a new phase of mortality through starvation.[20] In southern Gaza, where limited aid is more accessible, rates of infant malnutrition have doubled in the last month, and severe wasting has increased fourfold.[19] Formula milk and clean water are scarce, and undernutrition

[i]The following cursory PubMed search was performed on 21 March 2024, covering papers from the preceding decade: (((rationing[Title/Abstract]) OR (scarcity[Title/Abstract])) OR (scarce[Title/Abstract]) OR (triage[Title/Abstract]) OR (resource allocation[Title/Abstract]) OR (fair allocation[Title/Abstract])) AND ("Journal of medical ethics"(Journal)). There were 254 results.

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and dehydration have led to insufficient milk supply among lactating parents.[21]

Half of Gaza's population—1.1 million people—is at risk of famine in the coming months.[20] In the short term, malnutrition increases disease susceptibility[22] and affects the wound healing of those recovering from burns and amputations.[23] In the longer term, it hinders the physical and cognitive development of children, affecting population health and educational outcomes over the life course.

Clean freshwater has been scarce in Gaza for the last 16 years, largely as a result of the destruction of water and sanitation infrastructure by successive Israeli airstrikes and the inability to make repairs due to the restrictions of the blockade. In October 2023, Israel closed the water pipelines into Gaza and cut-off the electricity needed to run the desalination plants that process the brackish water that flows from the coastal aquifer.[24] In February 2024, Israel confirmed that its soldiers have been pumping seawater into underground tunnels across Gaza, leading to the salination of the enclave's groundwater, which is expected to cause long-term damage to health and the environment.[25]

All of Gaza's wastewater treatment plants and most of its sewage pumping facilities have been closed due to the blockade on fuel and electricity.[26] As a result, raw sewage is accumulating in densely populated areas or is being discharged into the sea. Nappies are scarce, necessitating infrequent changing, reuse of disposal items and the use of unsanitary substitutes.[27] Similarly, menstrual products are in short supply, leading some to use strips of tents and clothing as pads, or to prolong the use of tampons, increasing the risk of infections and toxic shock syndrome.[28]

Since October, healthcare professionals have recorded 165 000 new cases of diarrhoea, 45 000 new cases of skin diseases and 8000 new cases of hepatitis A as a result of washing in and consuming contaminated water, and there are concerns about imminent cholera and typhoid outbreaks.[29 30]

It is estimated that 1.9 million people—85% of Gaza's population—are now internally displaced, and more than 360 000 homes have been damaged or flattened.[3] Many are living in makeshift shelters that are scarcely weatherproof, in some cases with 15 people in a single tent. Around 500 people share a single toilet, and there are around 5000 people for every shower.[30 31]

Calculations by researchers from the London School of Hygiene & Tropical Medicine and the Johns Hopkins Center for Humanitarian Health project 58 260 excess deaths in the next 6 months, largely due to the spread of infectious diseases due to malnutrition, inadequate water and sanitation, and overcrowding. Even in the event of an immediate and lasting ceasefire, there are likely to be 6550 excess deaths.[32]

Medical infrastructure

Gaza's health system has long been debilitated by the Israeli occupation. At the start of 2022, 40% of essential medicines and 19% of single-use surgical instruments and personal protective equipment were at 'zero stock'.[33] All medical supplies have been critically scarce since October 2023. Hospitals have been left with no reliable supply of water or electricity, and little capacity to manage the remains of the very many who die, or are killed, on site.[33] Surgeons report scrubbing up with alcohol gel in the absence of water, operating without anaesthesia under the light of mobile phone torches, and using household vinegar in place of antiseptic.[33 34]

By January 2024, Israel's military had attacked health facilities in Gaza 600 times in the space of 4 months.[35] Every one of Gaza's 36 hospitals has now been hit, and just 12 have any remaining functionality; the other 24 have been destroyed.[36] (This is the equivalent of flattening 765 of the UK's 1148 hospitals.) At least 627 healthcare workers are known to have been killed, 212 have been arrested, and 47 ambulances have been destroyed or damaged through targeted attacks.[30 37] By January 2024, Israel had bombed every one of Gaza's 12 universities, in what has been described as 'scholasticide', a hallmark of genocide.[38] No medical students will graduate in Gaza this summer, though the need for doctors has never been so urgent.

Clinicians describe the brutality of the triage decisions that are necessary to make the best use of extremely scarce resources. Dr Seema Jilani, a paediatrician working with the International Rescue Committee and Medical Aid for Palestinians, described a 1-year-old whose arm and leg had been torn off following Israeli shelling and who was at risk of choking as blood flooded his pleural cavity. There was no available bed or stretcher, no paediatric chest drain or blood pressure cuff, no morphine, and his stumps had not yet been surgically treated. He had been placed on the floor while more urgent cases were attended to.[39]

DOING WHAT WE CAN

'Whoever stays until the end will tell the story. We did what we could. Remember us.'

Dr Mahmoud Abu Nujaila, who was working with Médecins Sans Frontières at Al-Awda hospital in Gaza, left the above words on the surgical whiteboard on 20 October 2023, anticipating, under heavy bombardment, that he would soon be cut-off from that story.[40] Nujaila was killed in an airstrike on 21 November 2023, along with his colleagues, Dr Ahmad Al Sahar and Dr Ziad Al-Tatari.[41]

'We did what we could' are the words of doctors operating under conditions of extreme and devastating scarcity. In the coming months, I hope we will see in these pages careful studies of how medical professionals have endured that scarcity in Gaza's healthcare facilities, as well as analyses of how this was allowed to happen, and what justice might look like in the wake of such extreme disregard for life and health. In the more immediate term, as medical ethicists, we must oppose and condemn Israel's deliberate production of health scarcity by every means available to us while we are still able to make some difference to the discourse, if nothing else.

There are, regrettably, many other situations of incursion, occupation and genocide in which healthcare infrastructure is targeted.[42] Each of them requires greater attention in this literature. But their neglect is generally the result of ignorance, which requires a different call to arms. When I ask colleagues about their silence on Gaza, more often than ignorance, they confess that they fear wading into something so 'complicated' and 'political'. This is a predictable response to the reprisals that some of those who have spoken out have faced,[43] but that is no excuse when the stakes for others are so many orders of magnitude greater. Are we ethicists, or not? A 'complicated', 'uncomfortable', 'political' ethical problem is no less an ethical problem. Will we be able to say: 'We did what we could'? The medics of Gaza are doing their jobs at risk of death, we need to step up and do ours.

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