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Prognostic Collapse in Gaza's Besieged Health System

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Letter to the Editor

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Dear Editor,

Disaster medicine has long rested on the logic of triage: a structured process of assessing urgency, distributing scarce resources, and maximizing the number of survivors.[1] Embedded within this framework is the presumption that even amid chaos, some continuity of care remains. That there will be a bed after the bleeding stops, a ventilator once the airway is secured, a course of antibiotics once surgery is complete. Triage, in other words, is not only about the present moment of intervention but about a horizon of prognosis - the belief that clinical action leads somewhere. What we are witnessing in Gaza is the systematic collapse of that horizon. In the repeated destruction of hospitals, the severing of supply lines, the siege-induced absence of basic resources like anesthetics or clean water, triage has become unmoored from its purpose.[2,3] Quite simply, triage in Gaza does not lead to survival. It leads, often, to a slightly delayed death.

The phrase "prognostic collapse" may help give shape to this rupture. It refers to the state in which clinical assessments of survivability no longer hold meaning because the conditions necessary for survival, operating theaters, post-operative care, and intensive monitoring, no longer exist. Prognostic collapse is not just a sociopolitical abstraction; it is a clinical and ethical phenomenon triggered by the mismatch between available resources and overwhelming patient need. What Gaza reveals is the collapse that follows when definitive care is permanently unreachable.

In such environments, triage categories falter. Patients marked for urgent intervention are placed on the floor of collapsing emergency departments, operated on without anesthesia, and discharged into conditions where follow-up is impossible. Prognosis becomes not a question of medical outcome but of systemic impossibility. Triage, in this case, has not failed - it has been rendered irrelevant. Gaza exemplifies what happens when war renders health care infrastructure inoperative. The ethical burden shifts. Traditional models force clinicians to make painful but structured decisions - who receives care now, who can wait, and who is beyond saving. Prognostic collapse introduces a fourth, crueler category: those who might be saved but will not be, because the system is too broken to deliver that possibility. These are not acts of triage; they are acts of survival without support. What, then, should medicine measure when all outcomes collapse?

Rather than despair, we argue for a redirection rooted in the Sendai Framework and Sustainable Development Goals 16 and 17. SDG 16 calls for peace, justice, and strong institutions - an upstream determinant of stable health systems.[4] SDG 17 urges global cooperation to strengthen system resilience. Meanwhile, the Sendai Framework mandates that risk reduction and preparedness, not reactive care, are the most cost-effective, ethically sound responses to disasters.[5] These frameworks offer a mandate: to prevent prognostic collapse before it begins, and to protect systems before they are destroyed. Prognostic collapse, then, is not only a political and ethical signal of failure, but a clinical red flag. When a health system cannot carry a patient from triage to definitive care, global health governance must respond. We must codify prognostic collapse as a recognized state - one that triggers both humanitarian protection and political accountability.

There will be other Gazas. Whether in besieged regions, climate-devastated zones, or future theaters of war, medicine will again be asked to operate in places where the future has been erased. Disaster medicine must be ready; not only with protocols, but with philosophy, and not only with logistics, but with prevention. In the age of prognostic collapse, we must ask not only how to save lives, but how to prevent the system from losing that capacity altogether.

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