Running a psychiatric ward in times of war

War poses challenges to inpatient psychiatric care. At the Sheba Medical Center, in the centre of Israel, some of the beds in the psychiatric wards are located in fortified areas protected against missile attacks, while others remain vulnerable. During missile alerts, staff and patients are given a 10-min warning to enter fortified areas before air-raid sirens sound. During the war between Israel and Iran in June, 2025, most psychiatric inpatients cooperated and could be escorted safely to the fortified areas. However, a subset of patients, although awake and alert, refused to comply. Some said that they did not mind if they died, others were experiencing a psychotic episode; one claimed to be the messiah and immune to harm, and another believed staff intended to poison him. Others, sedated by antipsychotics, did not wake up.

***Panel*: Sheba Medical Center Ethics Committee recommendations for treating psychiatric inpatients during missile attacks**

- Patients who comply or can be woken up will be accompanied by staff to fortified areas
- Patients who do not wake up or refuse to comply, but are not acutely dangerous to themselves or others, can be left, unsupervised, in unprotected areas; cameras observing the public areas of the wards (but not patients' rooms) should be monitored
- No use of physical force to force patients into fortified areas is permitted
- If a patient presents an immediate danger to themself or others (eg, making an active suicide attempt or being physically aggressive), staff are ethically expected to remain with the patient, even at personal risk, and can use physical force, as necessary

An ethical question thus arises: should staff remain in unprotected areas with these patients, thereby risking their own lives, or should they evacuate to the fortified areas, leaving patients who refuse to evacuate unsupervised?

The Sheba Medical Center convened an emergency ethics committee comprising hospital management staff, including IP and AZ, the hospital's legal consultant, and leaders of psychiatry (MW), risk management, surgery, nursing, social work, and religion. The committee made four recommendations (panel). The reasoning was aligned with other hospital settings and reflected established ethical precedents in medicine. For instance, if a patient is undergoing surgery in an unfortified area at the time of an alert, the anaesthesiologist is required to remain with the unconscious, intubated patient.

Although we hope that colleagues in other parts of the world never find themselves having to make such decisions, we hope these guidelines could be helpful for psychiatrists in other areas of war and conflict and provide a basis for ethical discussions in the context of psychiatry under conditions of armed conflict.

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*Mark Weiser, Itai Pessach, Amitai Ziv
Mark.Weiser@sheba.health.gov.il

Psychiatric Division (MW,) and Hospital Management (IP, AZ), Sheba Medical Center, Ramat-Gan 5266202 , Israel

Psychiatric care in Gaza: prescribing amid systematic health care collapse

The mental health crisis in Gaza has reached catastrophic proportions. As one of the few psychiatrists serving more than 2 million people under siege, I witness daily the collapse of psychiatric care standards that would be unconscionable in any other setting. This Correspondence documents the prescribing crisis that exemplifies the broader humanitarian catastrophe.

Gaza had fewer than one psychiatrist per 100 000 people before the war.[1] According to recent WHO data, there are now only three board-certified psychiatrists, five residents and fewer than 20 other doctors who prescribe psychotropics (unpublished). In Ministry of Health facilities, each psychiatrist sees 50–100 patients daily—a caseload that precludes adequate assessment or follow-up. The most common presentations recorded in Ministry of Health dispensary logs are post-traumatic stress disorder, major depression, generalised anxiety disorder, acute psychosis, and chronic schizophrenia—all exacerbated by ongoing trauma.

The prescribing crisis operates on multiple levels. First-generation antipsychotics (such as haloperidol and chlorpromazine) are now prescribed more frequently than newer agents, not by clinical choice but by availability. These medications, with their burden of extrapyramidal symptoms, negative symptoms, and sedation, create a secondary crisis of non-adherence. When patient conditions stabilise, medication disruptions[2]—now occurring monthly—precipitate predictable relapses.

The clozapine shortage exemplifies this systematic failure. A high proportion of patients with treatment-resistant schizophrenia, stable for years on clozapine, have relapsed following supply disruptions. Without alternatives or monitoring capacity, clinicians must resort to cocktails of available first-generation antipsychotics, transforming manageable chronic illness into acute crisis. The opportunity for rationalising treatment is lost. When patients transfer between scarce providers, high-dose polypharmacy becomes difficult to

manage, with each change risking destabilisation. Insufficient trial periods when starting new medications have become the norm. Medications are changed after 1–2 weeks rather than the 4–6 weeks required for an adequate assessment. This stems not from clinical impatience but from practical impossibility: patients are displaced by bombardment, psychiatrists rotate between overwhelmed facilities, medications become unavailable mid-treatment, and evolving trauma creates new symptoms that obscure medication effects.

Prescribing authority has necessarily expanded beyond psychiatrists. Initially, nurses, pharmacists, and general practitioners prescribed psychotropics without supervision. Although now more controlled, psychiatric nurses and residents continue prescribing for chronic cases without specialist oversight. This task-shifting, essential for coverage, can result in over-prescribing for minor conditions and under-treating severe illness.

The absence of coordination compounds these challenges. No central database tracks medication distribution across the Ministry of Health, WHO, and international non-governmental organisations. Donations arrive irregularly, distributed without a systematic assessment of need.

The psychological support infrastructure has similarly degraded. Ministry facilities lack privacy for therapy sessions, with multiple consultations occurring in shared spaces. Although some international organisations (Médecins Sans Frontières, Médecins du Monde, Medical Aid for Palestinians, and International Medical Corps) provide good quality psychological services, they can only serve a fraction of those in need. Doctors trained through the mental health Gap Action Programme provide basic care but cannot address the complex presentations dominating the caseload.

This prescribing crisis reflects the deliberate destruction of health-care infrastructure.[3] When psychiatrists cannot maintain consistent medication supplies, when pharmacies stock only drugs with intolerable side-effects, and when follow-up becomes impossible due to displacement and siege, this constitutes not merely a health crisis, but a systematic denial of the right to mental health care.

The international psychiatric community must recognise that evidence-based practice becomes meaningless when evidence-based medications are unavailable. Guidelines developed in stable settings become cruel fiction when applied to a population under siege. The principle of do no harm is violated not by individual practitioners, but by the conditions imposed upon them.

Immediate actions are required. First, humanitarian corridors must include psychotropic medications, particularly second-generation antipsychotics and mood stabilisers, in their priorities Second, a centralised medication tracking system accessible to all providers could prevent duplication and shortages. Third, international psychiatric associations should establish crisis prescribing guidelines that acknowledge systematic constraints. Fourth, the documentation of medication-related harm must be recognised as evidence of the broader humanitarian crisis.

The mental health needs of Gaza's population will persist long after any ceasefire. Every relapse due to medication unavailability, every extrapyramidal symptom from the forced use of older agents, and every death by suicide during a medication gap represents preventable harm. The international community must work to ensure consistent psychiatric medication supply, or risk complicity in this systematic denial of mental health care.

As I write this between patient consultations—each impossibly brief, most ending with prescriptions I know might not be obtained—I document not individual clinical failures but the collapse of an entire system of care. The psychiatric crisis in Gaza demands not just humanitarian aid but accountability for the conditions that make ethical psychiatric practice impossible.

I declare no competing interests.

Ahmed Alhaj
dr.a.h.alhj@gmail.com

Médecins Sans Frontières, Gaza, Palestine

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Etomidate misuse: a digital era threat to youth and a call for anticipatory control

Etomidate, a short-acting anaesthetic traditionally used in critical care, is increasingly being misused for recreational purposes. Etomidate's rapid dissociative effects and minimal cardiorespiratory suppression appeal to adolescents, especially when repackaged into e-liquids (eg, space oil or kpods) that enable inconspicuous vaping. Case reports from 2023 in east and southeast Asia describe escalating use among youth, leading to dependence, myoclonus, derealisation, and suicidal ideation.[1] In China, national drug surveillance data from 2024 revealed that etomidate was the most frequently misused substance among narcotic and psychotropic drugs.[2] Alarmingly, 86·4% of individuals misusing such drugs were younger than 35 years, highlighting