Hospital Preparedness and Emergency Response during the First 72 Hours of Missile Attacks: Operational Lessons from Wartime Experience

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Modern armed conflicts increasingly expose civilian infrastructure, including hospitals, to direct military threats such as missile attacks. Hospitals provide care for some of the most vulnerable patients, including bedridden individuals and those requiring continuous monitoring that cannot be easily relocated. Protecting these patients during active hostilities presents a major operational challenge. Hospitals must maintain clinical care, prepare for potential infrastructure damage, and remain ready to receive mass casualty victims. Previous disasters and conflict-related evacuations have demonstrated the complexity and risks of relocating hospitalized patients under emergency conditions [1,2].

During the 2025 conflict between Israel and Iran, a missile strike on a major tertiary hospital (Soroka Medical Center) highlighted the vulnerability of hospital infrastructure. This event prompted the development of structured preparedness frameworks to protect hospitalized patients while maintaining continuity of care [3]. Protection measures range from individual protected rooms and shared floor shelters to underground facilities; however, escalating ballistic missile threats have increased protection requirements. Under guidance from the Israeli Ministry of Health (MOH), hospitals developed coordinated plans for potential wartime relocation. These plans were activated at Wolfson Medical Center and other hospitals in Israel on 28 February 2026 following renewed hostilities and large-scale missile attacks.

EMERGENCY MODEL FOR HOSPITAL EVACUATION FRAMEWORK

The response followed a three-stage emergency model consisting of preparation, patient transfer, and operational continuity [Figure 1].

PREPARATION PHASE

During the preparation phase, Wolfson increased readiness as tensions escalated. The first objective was to create a continuity process that would relocate patients to protected spaces within the hospital or to another facility while preserving continuity of care and appropriate clinical care. Wolfson also prepared for a potential mass-casualty situation. All hospitalized patients were rapidly mapped by department heads according to discharge potential, mobility status, clinical acuity, and care requirements.

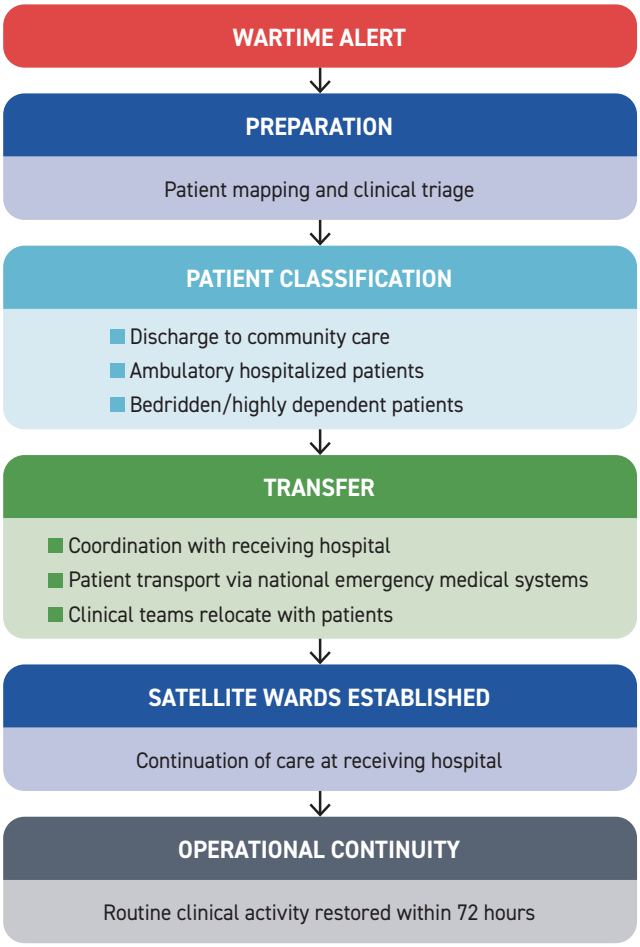
Parallel planning included coordination with a pre-designated receiving hospital under the guidance of the MOH. Clinical teams were designated to accompany transferred patients with the national emergency medical service, Magen David Adom (MDA).

Additional contingency planning addressed possible reinforcement of the nursing workforce with nursing students and coordination with the Israel Defense Forces (IDF) regarding the readiness of YAHZAB, a military hospital support unit. The hospital also assessed its medical and logistical readiness, including workforce availability, emergency laboratory capacity, blood bank supplies, and the availability of protected underground space.

Employee transportation and daycare solutions for the children of critical workers were assessed in collaboration with local municipalities. Further preparations included planning for the temporary suspension of ambulatory services, transition to telemedicine, and a war-scenario drill involving hospital leadership and emergency headquarters.

Figure 1. Wartime hospital evacuation framework

[A] Stepwise framework for patient mapping, clinical triage, classification, patient transfers, establishment of satellite wards, and restoration of routine clinical activity in protected spaces



[B] Representative images documenting the preparation and evacuation of patients from Wolfson Medical Center, their transport by emergency medical services, and the establishment of protected spaces for continuity of care at the hospital

TRANSFER PHASE

The patient transfer phase was initiated with inter-hospital transfers focused on internal medicine departments, which included patients with prolonged expected hospital stays. As part of advanced preparedness planning, relocation of these integral departments had been pre-determined in coordination with the receiving hospital. The hospital was prepared to initiate transfers within 3 hours of the initial missile alerts. All planned transfers were completed within 24 hours, with 111 patients relocated from five departments to another medical facility.

The professional collaboration between the sending hospital and the receiving hospital was conducted through a structured division of responsibilities and joint operational coordination. The sending hospital remained responsible for the direct clinical care of its transferred patients within the protected facility. Its clinical teams accompanied the patients, continued bedside care, and adapted to the receiving hospital's computerized systems. The receiving hospital provided logistical and infrastructural support, including protected clinical space, medical and general equipment, workstations, and staff access permissions to computers. Clinical collaboration was supported by consultations from the receiving hospital's medical teams, while a joint emergency command center, including representatives from the sending hospital, the receiving hospital, and MDA, coordinated the transfer and managed operational issues in real time.

CONTINUITY PHASE

The continuity phase started within 48 hours. Routine clinical activity was re-established at the receiving hospital. In parallel with the inter-hospital transfers, patients who remained at the institution were relocated according to their mobility and care needs as part of a layered protection strategy. Intensive care patients were moved to a protected care area within the hospital. Immobile and highly dependent patients were relocated to protected underground wards, while mobile patients remained on wards on upper floors with immediate access to sheltered areas during missile alerts. The emergency department was relocated to a protected area to maintain emergency care. During this period, patients requiring admission to internal medicine were transferred by MDA from the emergency department to relocated departments at the receiving hospital through inter-hospital coordination.

Communication was maintained through dedicated working groups, including phone broadcast lists and direct coordination between the advance team, the receiving hospital command center, and operational supervisors. However, the experience also highlighted the need to streamline communication through a single coordinating contact and to strengthen predefined interhospital workflows for medical records, patient tracking, and remote consultations.

On the day hostilities began, 539 patients were hospitalized at Wolfson. Within 24 hours, occupancy decreased by 164 patients, representing a 30.4% reduction. Over the following 48 hours, occupancy decreased by an additional 57 patients, representing a further 15.2% reduction from the 24-hour census, and reached 318 patients in 72 hours. In parallel, 70 bedridden patients were moved to protected areas within the hospital during the first 24 hours, representing 13.0% of the initial inpatient population. By 72 hours, 90 additional bedridden patients had been relocated to protected areas, representing 28.3% of the remaining hospitalized patients. The remaining patients were ambulatory and could therefore move to protected spaces on activation of an alert or siren. The decision to transfer internal medicine patients was driven by the need to reduce hospital occupancy by approximately 40%, in accordance with MoH guidelines. This decision also reflected the need to preserve protected bed capacity for additional patients while maintaining preparedness for a potential mass-casualty event.

These operational observations are consistent with disaster evacuation principles described in the American College of Chest Physicians consensus statement [4]. These guidelines emphasize early patient classification, phased operational response, inter-hospital coordination, and preservation of clinical continuity during hospital evacuation.

During the first 72 hours, several operational challenges emerged. A key difficulty involved patients carrying multidrug-resistant organisms, as protected isolation facilities were limited at hospitals. Some patients requiring isolation were therefore temporarily managed in partially protected areas, raising infection-control and ethics concerns. Because this report reflects the sending hospital's operational perspective, the experience of the receiving hospital was not systematically evaluated. This represents an important limitation of the current case study. While the response is described as linear or sequential and occurring in three distinct stages, actions were performed in parallel with the intent to achieve maximum protection for vulnerable patients in the shortest time possible.

CONCLUSIONS

Our experience highlights key principles for hospital preparedness during missile warfare. Early patient mapping and dynamic triage enabled rapid transition to emergency operations. Relocating entire departments with their clinical teams preserved continuity of care, while coordination between hospitals and emergency services helped maintain hospital functionality and protect vulnerable patients.

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