Functioning Under Fire: Field Medical Personnel's Experiences During the October 7 Attack in Israel

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Abstract

Background: On 7 October 2023, a large-scale assault on southern Israel resulted in nearly 1,200 fatalities and the abduction of 251 individuals, with medical personnel among the victims. Field medical personnel provided care under fire, fully aware that colleagues had been wounded or killed. This study examined the challenges these providers encountered and the factors that enabled them to maintain professional functioning.

Methods: This qualitative descriptive study involved semi-structured interviews conducted between December 2023 and January 2024 with 18 Israel Defense Forces Medical Corps field personnel (seven paramedics, five physicians, and six medics) who provided continuous care during the attack while aware that colleagues had been injured or killed. All interviews were audio-recorded, transcribed verbatim, and analyzed using inductive, team-based thematic analysis.

Results: Participants reported overwhelming casualty numbers, challenges in scene and evacuation management under fire, fear for personal safety, and recognition of acquaintances among the injured and deceased. Five interrelated themes, each identified in at least 13 of the 18 interviews, were found to enable continued functioning: personal and moral dedication, prior experience in high-stress environments, awareness of being irreplaceable, the necessity to set aside personal emotion and fulfill duty, and a sense that fallen colleagues would have expected continued service.

Conclusions: Field medical personnel maintained professional functioning under extreme threat through moral commitment, prior experience, and a sense of duty to patients and fallen colleagues. Training that integrates values-based preparation, realistic stress exposure, and structured post-event support may enhance preparedness for combat and other mass-casualty settings.

Keywords: October 7; combat medicine; field medical personnel; resilience; qualitative research; mass-casualty incident; medical corps.

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INTRODUCTION

On 7 October 2023, during the Jewish holiday of Simchat Torah, Hamas launched a large-scale assault on southern Israel, targeting military positions and civilian communities. In this attack, close to 1,200 people, hundreds of them civilians, were killed and hundreds were abducted [1]. Physicians, paramedics, and medics were present both as first responders and as potential victims; some were injured or killed while delivering care [2]. Emergency medical teams faced overwhelming casualty numbers and active combat zones that endangered the teams and constrained access and evacuation [3], while receiving hospitals managed a mass-casualty incident under fire [4].

Combat medicine demands clinical performance under threat, often with disrupted logistics and prolonged or denied evacuation [5]. In combat situations, military medical personnel, mostly medics, must function in a dual role as fighting soldiers and clinicians providing medical care. Among U.S. Army combat medics, this dual role led to recommendations that preparation for recognizing battlefield stress address both the soldier's and the medical provider's perspective [6]. In Israel, acute stress disorder among medics who treated casualties of violent events during the 2000–2003 riots was associated with the number of fatalities in each event [7].

Acute stress can impair divided attention, working memory, information retrieval, and decision-making, with effects that depend on how individuals appraise situational demands and their own resources, as well as coping style and social support [8]. Military personnel operating in high-stress environments must maintain cognitive performance despite threatening and uncertain conditions [9]; under such military conditions, resilience and unit cohesion have been addressed as essential components of coping with stress [10]. Among U.S. Army combat medics nominated by their peers as resilient, effective coping was characterized by social bonding, readiness, dual loyalty expressed through performance, and leading by example. These characteristics were underpinned by loyalty to family, mission, and personal beliefs [11].

During the war that began in October 2023, Israeli hospital physicians working near conflict zones reported a greater sense of danger than colleagues elsewhere but comparable resilience [12]. More broadly, moral distress and moral injury have been documented among medical personnel and first responders, including military healthcare workers [13]. This is further aggravated by grief over the death of someone close; among U.S. infantry soldiers, more than one in five reported difficulties coping with such a situation, which was associated with poorer physical health and occupational impairment [14].

Existing evidence primarily addresses hospital-based clinicians, expeditionary deployments, or outcomes measured post-event. Limited information is available regarding how field-level providers sustain real-time clinical functioning during an ongoing attack in their own country while aware that colleagues have been wounded or killed.

This study investigated the psychological and professional challenges experienced by Israel Defense Forces (IDF) Medical Corps field personnel during the October 7 attack, as well as the factors that enabled continued delivery of care under immediate threat to life while aware that colleagues had been injured or killed.

METHODS

Design

This qualitative study follows the Consolidated Criteria for Reporting Qualitative Research (COREQ) [15]. The study used a qualitative descriptive design, which seeks a comprehensive summary of events while remaining close to the data and to the surface meaning of participants' words [16].

Participants and recruitment

Participants were 18 field-level IDF Medical Corps personnel (seven paramedics, five physicians, and six medics; Table 1) who provided continuous care during the October 7 attack and its immediate aftermath while aware that one or more medical colleagues had been injured or killed. Ten were male; the mean age was 29.2 years (standard deviation [SD], 5.8; range, 19–36). All were serving on active duty. They had operated in kibbutzim, on major roads, at the "Nova" open-air trance festival site, at nearby IDF bases, and in the

cities of Sderot, Netivot, and Ofakim, all under sustained attack and with numerous casualties [4].

Characteristic	Participants (N = 18)
Role, n	
Paramedics	7
Physicians	5
Medics	6
Sex, n	
Male	10
Female	8
Age, years, mean ± SD (range)	29.2 ± 5.8 (19–36)
Clinical experience, years, mean ± SD (range)	3.6 ± 2.6 (1–9)
Interview mode, n (%)	
Face-to-face	11 (61.1)
Telephone	7 (38.9)
Interview duration, minutes, range	37–102

Table 1. Characteristics of the 18 field medical personnel interviewed. Role, sex, age, clinical experience, and interview characteristics of the paramedics, physicians, and medics who provided field care during the 7 October 2023 events. SD: standard deviation.

Individuals were excluded if they had not provided direct, hands-on care in the field (e.g., purely command, coordination, or logistical roles, or care confined to a hospital or rear facility); if their participation began on 9 October or later; if they had been unaware during the event that a medical colleague had been injured or killed; if they were unable to give informed consent; or if a researcher judged that participation might risk their psychological well-being (e.g., acute distress at recruitment). The research team, who had potential participants' contact details, approached them directly by telephone or in person, explained the study, and scheduled interviews with those interested. Of 23 individuals approached, 18 took part; one declined, and four met at least one exclusion criterion before the interview phase.

Research team and reflexivity

Three IDF Medical Corps officers (two male, one female) conducted the interviews: the lead investigator, who has qualitative research experience, and two physicians with limited interviewing experience, whom the lead investigator trained and accompanied during their initial interviews. Participants were informed of the study's aim and that all three interviewers had served in the Medical Corps during the events. The research team assumed that responders had faced extraordinary professional and moral demands for which existing training had not fully prepared them. The study aimed to inform future preparedness and document largely unrecorded experiences.

On 7 October 2023, during the attack, the lead investigator was commanding 19 medical teams and had pre-existing relationships with several participants. The other two interviewers also held command positions over medical personnel. Because these relationships and the hierarchical context could influence participants' disclosure and the interpretation of their accounts, participants who had served directly under an interviewer were, where feasible, interviewed by another team member. When this was not possible, the relationship was explicitly acknowledged and discussed at the outset of the interview.

Before data collection commenced, the research team engaged in bracketing discussions to reduce the potential impact of personal recollections and expectations. Each interviewer maintained a reflexive journal to systematically document emotional responses, assumptions, and any instances in which a prior relationship may have influenced the interview process.

Data collection

Interviews took place between 10 December 2023 and 31 January 2024, with durations ranging from 37 to 102 minutes. Interviews were conducted either face-to-face in a private setting (n = 11) or by telephone (n = 7). A semi-structured interview guide (Appendix) was used to explore participants' roles, awareness of colleagues being harmed, the impact of these events, and the ways in which participants continued to function. All interviews were audio-recorded and transcribed verbatim in Hebrew by the research team. Subsequent analyses were based on these Hebrew transcripts. Quotations included in this report were translated into English by the bilingual lead investigator and independently reviewed by a second bilingual team member. Any discrepancies were resolved through discussion.

Data analysis

Data analysis was conducted using inductive thematic analysis, following the phases outlined by Braun and Clarke [17]. Three researchers collaboratively coded the data using a shared, iteratively revised coding scheme, resulting in a team-based, codebook-oriented approach rather than a reflexive, single-analyst method. This approach aligns with the descriptive aim of maintaining proximity to participants' accounts [16]. Analytic steps are reported sequentially to enhance transparency in interpretive decision-making [18].

First, all three interviewers read each transcript multiple times to achieve familiarization. Second, units of meaning relevant to the study aim, specifically segments describing challenges faced during the attack or factors linked to continued functioning, were coded using ATLAS.ti 23 (ATLAS.ti Scientific Software Development GmbH, Berlin, Germany). Third, the codes were collectively discussed and revised, after which all material was independently re-coded using the updated scheme. Fourth, related codes were grouped into candidate subthemes and subsequently organized into broader themes. Fifth, candidate themes were reviewed through iterative comparison with the original transcripts to ensure accuracy and completeness. Themes were then defined and named. Disagreements were resolved by consensus among the authors, and all analytic decisions were documented in an audit trail.

Peer-debriefing sessions were conducted after every three interviews to review emerging interpretations and challenge underlying assumptions. On two occasions, an external qualitative researcher who was not involved in the events participated as a critical auditor. Summaries of the coded themes were returned to 11 participants, selected based on availability, who were invited to confirm, correct, or expand upon the interpretations. Ten participants responded, and their feedback was incorporated. The adequacy of the analysis was determined by inductive thematic saturation, defined as the point at which further coding produced no new codes or themes [19].

Rigor

Trustworthiness was addressed using Lincoln and Guba's criteria, as operationalized by Nowell et al. [20]. Credibility was supported by peer debriefing, member checking, iterative return to the transcripts, and illustrative quotations. Dependability was ensured through consistent use of the interview guide and consensus-based coding. Confirmability was established by bracketing discussions, reflexive journals, and the audit trail. Transferability was supported by providing a detailed description of the study context and sampling across clinical roles and operational settings.

Ethics

The interviews were conducted between December 2023 and January 2024, initially as an internal Medical Corps professional-learning activity. The IDF Medical Corps Institutional Review Board (IRB), which reviewed the study and the interview guide, determined that the activity met the definition of "staff work" and therefore did not require formal IRB approval (determination no. 1055).

From the outset, the study adhered to Good Clinical Practice (GCP) guidelines and relevant ethical principles and safeguards for research involving human participants. Measures included obtaining informed consent, securing explicit consent for audio recording, protecting participants' anonymity, and maintaining the confidentiality of all information provided.

RESULTS

Participants' accounts addressed both components of the study aim: the challenges encountered during the attack and the factors that enabled continued functioning. Five interrelated themes, comprising 13 subthemes, were identified as facilitating continued action (Table 2; Figure 1). These themes included commitment, experience, irreplaceability, emotional regulation, and obligation to the fallen. Each theme appeared in at least 13 of the 18 interviews, and several accounts referenced multiple themes. For example, Interviewee 17 described both protocol-based routines (Theme 2) and compartmentalized grief (Theme 4).

Theme and subtheme	Paramedics (n = 7)	Physicians (n = 5)	Medics (n = 6)	Total n (%)
1. Personal and moral dedication				
1.1 Medicine as a vocation, not an occupation	3	5	2	10 (56)
1.2 Professional identity as an anchor	7	3	3	13 (72)
1.3 Commitment overriding personal risk	4	4	6	14 (78)
2. Prior experience in high-stress environments				
2.1 Previous combat or mass-casualty exposure	4	4	5	13 (72)
2.2 Accumulated clinical experience building confidence	7	5	3	15 (83)
2.3 Mental templates for triage and prioritization	6	4	6	16 (89)
3. Awareness of being irreplaceable				
3.1 The only qualified provider present	7	5	2	14 (78)
3.2 Scarcity of medical resources amplifying duty	7	4	4	15 (83)
3.3 Recognition that absence would cost lives	6	4	6	16 (89)
4. The necessity to set aside personal emotion and fulfill duty				
4.1 Compartmentalizing grief in the moment	7	5	6	18 (100)
4.2 Suppressing fear for personal safety	5	5	5	15 (83)
5. Fallen colleagues would have expected them to continue				
5.1 Imagined expectations of fallen comrades	6	4	6	16 (89)
5.2 Continuation as a duty owed to the fallen	6	4	5	15 (83)

Table 2. Themes and subthemes, by number of participants in each professional role. Number of participants whose interviews contained each subtheme, by role; percentages refer to all 18 participants. Numbering corresponds to Figure 1 and the Results text. Counts indicate the number of participants whose interview contained at least one coded segment assigned to the subtheme; a participant could contribute to several subthemes. Percentages are rounded to whole numbers.

Challenges faced during the attack

These challenges address the first part of the study aim and form the context in which the enabling themes should be read. Participants faced large numbers of critically injured casualties with injuries of unprecedented severity. They managed the scene and coordinated command under sustained direct fire and repeated missile-warning sirens, while being unable to evacuate at their usual speed or maintain their usual quality of care. On a personal level, participants described recognizing some of the injured or deceased through prior acquaintance or seniority, fearing for their own survival, worrying about family in the affected area, and treating soldiers under their command or alongside whom they served. Challenges varied by profession: most medics discussed treating comrades and civilians, stopping bleeding, providing

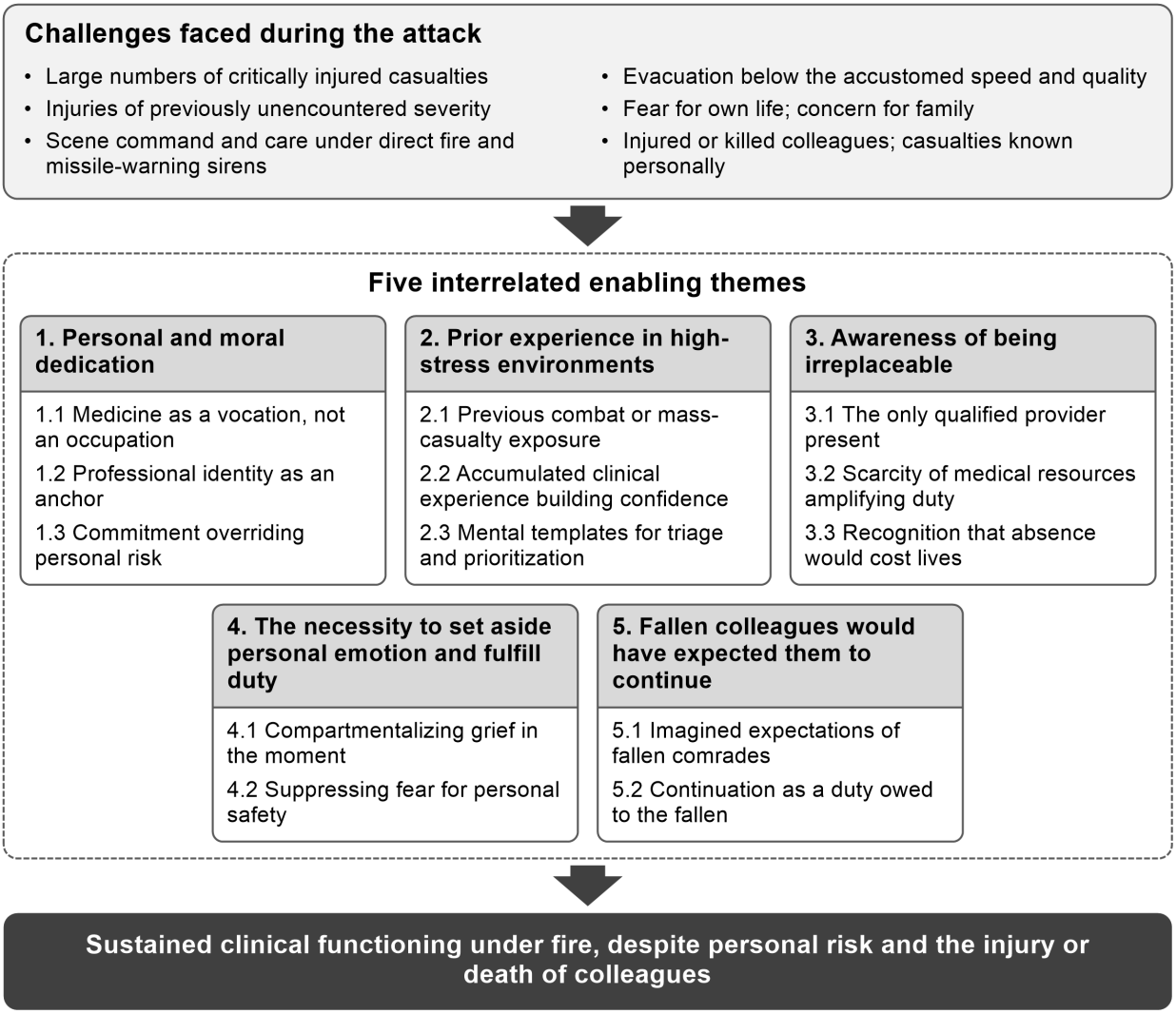


Figure 1. Thematic map of challenges, enabling themes, and sustained functioning. Challenges described by participants formed the conditions under which five interrelated themes and their subthemes enabled sustained clinical functioning. Numbering corresponds to Table 2 and the text.

first aid, and assisting with mental distress. In contrast, most paramedics and physicians emphasized managing multi-casualty scenes, rapid and high-quality evacuation, and command responsibility for their comrades-in-arms, a topic raised by only one medic.

Theme 1. Personal and moral dedication

Participants framed continued action as a moral imperative: the attack was precisely the moment when they were most needed, and they could not withhold care while civilians were being harmed.

1.1 Medicine as a vocation, not an occupation

Arriving at the scene and responding was described as central to the meaning of participants' profession, and they invoked the Medical Corps oath.

"This is the moment when I am needed the most. That's why I chose to be a doctor." (Interviewee 1)

"Women and children are being massacred – and I am the one who must stand between them and death. I took an oath. I swore to save lives." (Interviewee 3)

1.2 Professional identity as an anchor

Across all three professions, participants expected to carry out their role as a matter of course, just as

combat soldiers were responsible for neutralizing the threat, and saw themselves as an anchor of stability for the organization.

"Everyone looks at us – the paramedics – and knows that we are the ones meant to save lives, just as they are meant to eliminate the threat. And if I fail, even for a moment […] the entire force could collapse." (Interviewee 8)

1.3 Commitment overriding personal risk

Although most participants described a tangible, immediate threat to their lives, they emphasized that commitment outweighed personal risk. The medics regarded themselves first and foremost as combatants, for whom the mission took precedence over their own lives.

"I was first trained as a combat soldier, and only afterward did I become a medic. To me, it is absolutely clear that fulfilling the mission is more important than my own life." (Interviewee 10)

"Before anything else, I am a fighter. […] I know that the mission – the duty to stop those who threaten innocent lives, and the duty to save lives – comes before me, before my own life." (Interviewee 18)

Theme 2. Prior experience in high-stress environments

Participants attributed their functioning to prior operational and clinical experience and to ingrained routines for approaching the injured.

2.1 Previous combat or mass-casualty exposure

Prior experience in treating the wounded, raised in all three professions, was described as important to their functioning, although it had been considerably less demanding than 7 October.

"I was a young doctor then, in a previous operation in Gaza, fighting to save three soldiers who were in critical condition. […] And when you face the chaos of war again […] that memory… that certainty that you can save a life… it is worth more than anything." (Interviewee 2)

2.2 Accumulated clinical experience building confidence

Although participants emphasized how the battlefield differed from training and civilian settings, most regarded accumulated clinical experience as a basis for confidence under extreme need.

"The ability to function as a paramedic is not something you're simply given – it is forged through months inside hospital wards […]. And it is that experience, that hard-earned certainty… that allows you to stand in the chaos and know – without doubt – that you can endure, and you can act, no matter the situation." (Interviewee 6)

2.3 Mental templates for triage and prioritization

In most interviews, protocol-based training and a predetermined sequence of casualty care were described as enabling effective functioning under stress and in life-threatening circumstances.

"During officer training, they talked about the trauma protocol repeatedly – until it stopped being something I had to think about and became a part of who I am. […] Even when my mind falters, the training remains… steady, unshaken… guiding my hands when nothing else can." (Interviewee 17)

Theme 3. Awareness of being irreplaceable

Participants reported a heightened awareness that few or no others could provide care, accompanied by a pronounced sense of personal accountability for their comrades.

3.1 The only qualified provider present

Physicians, paramedics, and some medics perceived that their unique value was most evident at casualty scenes.

"Why did I spend ten weeks becoming a medic at the Military Medical Academy? I gained a unique role, strong skills, and the training to act in critical moments. I became someone ready to help and save lives when it matters most." (Interviewee 5)

3.2 Scarcity of medical resources amplifying duty

As casualties were dispersed across the Gaza envelope, the shortage of medical resources became increasingly apparent, prompting participants to view their roles as more critical and indispensable.

"I've never felt such a lack of medical resources […]. That's when it became clear to me just how essential my role is. When you're the only doctor there, the sense of responsibility only grows stronger." (Interviewee 13)

3.3 Recognition that absence would cost lives

Given the precariousness of survival on that day, participants viewed their absence as equivalent to causing harm.

"As an experienced paramedic, I used to tell those I trained: 'Whatever you find at the scene was there before you arrived – it's not your fault.' But on October 7th, I felt different. I felt responsible. […] And if I didn't reach an injured person in time, it felt like their lost chance to survive was on me." (Interviewee 9)

Theme 4. The necessity to set aside personal emotion and fulfill duty

Participants described intentionally separating personal fear and grief from professional obligations, drawing upon personal commitments and the expectations set by their commanders.

4.1 Compartmentalizing grief in the moment

Although all participants were aware that a medical colleague had been injured or killed that day, they described their emotions and cognition as functioning independently, postponing grief until it was appropriate to address it.

"This doctor that fell isn't just a colleague – he's my close friend, my mentor, someone I've always looked up to. But at that moment, none of that mattered. […] All that mattered was saving lives – and you don't think about it, you just act." (Interviewee 17)

4.2 Suppressing fear for personal safety

The unexpected nature of the attack left participants feeling unprepared and intensified the chaos they encountered. Suppressing intense fear appeared to be essential for functioning rationally and increasing their chances of survival.

"You're afraid, maybe even shaking – but panic won't help you. It only puts you in more danger. […] So you push aside the fear and the stress, and focus on one thing – functioning and doing what needs to be done." (Interviewee 16)

Theme 5. Fallen colleagues would have expected them to continue

Participants continued to function and accept risk based on the belief that fallen medical colleagues, some of whom were killed while treating the wounded, would have expected them to persist. This belief served as both a personal example and a perceived obligation.

5.1 Imagined expectations of fallen comrades

Nearly all participants described an implicit expectation that the injured and fallen would have wanted their surviving colleagues to continue providing professional, life-saving care, even at significant personal risk.

"[…] if he can see me now, he would be proud. He would never have forgiven me if I had run away, hesitated, or frozen. […] I could almost hear his voice, pushing me forward – to keep going, to keep saving lives, no matter what the cost." (Interviewee 4)

5.2 Continuation as a duty owed to the fallen

Profound sorrow and frustration over being unable to save their friends were transformed into a commitment to save lives, perceived as a duty owed to injured and fallen fellow medical personnel.

"Our duty to the fallen is to keep going – to keep saving lives, even in the most dangerous situations. Who am I to hold back or hesitate when my comrades gave their lives for this mission?" (Interviewee 1)

DISCUSSION

This study examined how IDF Medical Corps field personnel continued to provide medical care during the October 7 attack while knowing that colleagues had been wounded or killed. Confronted with mass casualties, direct threats to their own lives, and the injury or death of colleagues, participants identified five enablers of sustained functioning: moral dedication, prior experience, awareness of being irreplaceable, setting aside emotion to fulfill duty, and a sense of obligation to fallen colleagues.

Participants attributed their persistence primarily to moral commitment and professional identity, rather than to procedural guidance alone. This pattern is consistent with findings among U.S. Army combat medics, whose resilience was characterized by social bonding, readiness, and dual loyalty expressed through performance, all supported by commitment to the military mission [11]. Similarly, the medics in the present study, who identified as combatants,

embodied the dual soldier-clinician role, for which preparation from both perspectives has been recommended [6]. The findings also align with reports of resilience among Israeli hospital physicians [12]. However, they differ from that study in two respects: the threat was immediate and occurred on home territory, and participants' sense of being irreplaceable was intensified by the overwhelming casualty load, as documented in other reports on clinical experience from the same day [3,4].

Prior experience and well-established protocols were identified as resources that enabled effective action amid chaos. Acute stress can impair attention, working memory, and decision-making, with effects influenced by individuals' appraisal of situational demands, perceived resources, coping style, and social support [8]. Previous exposure to casualties and repeatedly rehearsed trauma protocols may have functioned as such resources. Because the stress of military operations is difficult to replicate in controlled experimental settings, realistic training may be especially valuable. Earlier IDF data from previous violent events also suggest that training and post-event care may help limit long-term psychological morbidity among military medical personnel [7].

Setting aside grief and fear enabled participants to function in the immediate aftermath; however, such compartmentalization is unlikely to be without psychological costs. Among U.S. infantry soldiers, difficulty coping with grief was associated with poorer physical health and occupational impairment six months after deployment [14]. Similarly, among IDF medics, acute stress disorder was associated with the number of people killed in the events they attended [7]. The present data do not allow determination of whether the sense of obligation participants felt toward their fallen colleagues subsequently facilitated adaptation or, conversely, compounded distress over colleagues they had been unable to save.

These findings primarily explain why personnel continued to function, emphasizing motivational and identity-based factors, rather than how they sustained operational effectiveness. However, professional identity and moral commitment, regardless of their strength, cannot replace competencies such as tolerating repeated exposure to severe injury and death, regulating emotions, and recognizing acute stress reactions in oneself and others [8,9]. Training within the IDF Medical Corps could therefore supplement values-based preparation with graduated, realistic simulations of severe injury and death, structured instruction in emotion regulation, and psychoeducation on acute stress reactions. Because emotional detachment that supports performance during a crisis may incur psychological costs if prolonged, training should also prepare personnel to transition deliberately from compartmentalization during operations to emotional processing and recovery afterward. Peer and command structures, along with organizational planning that anticipates caregiver bereavement, should support this process. These implications may also extend to civilian mass-casualty events and to attacks on healthcare personnel [2,3].

Limitations. This study has several limitations. The sample of 18 participants from a single national context was not intended for statistical generalization. Participants served in a conscript military accustomed to recurrent escalations involving the Gaza Strip and may draw on expectations, a sense of duty, and prior conditioning that are less available to professional or volunteer forces. The capacities described should therefore be understood as context-specific. Interviews were conducted weeks to a few months after the events, which may have introduced recall and emotional-state effects. Colleagues within a hierarchical organization approached participants, and some interviewers had command relationships with participants, which may have influenced disclosure, although rapport may also have encouraged candor. The ethics determination was obtained after data collection. Quotations were translated from Hebrew, although the analysis used the original transcripts. Finally, the study was not designed to explain how participants set aside their emotions, nor did it assess psychological state with quantitative instruments or follow participants over time. The same themes appeared among medics, paramedics, and physicians who worked at different sites.

Future research should focus on four principal directions; First, longitudinal studies that combine interviews with validated measures of distress and professional quality of life could track the long-term psychological and professional impacts of these

experiences, including grief and moral distress [13,14]; Second, investigations into coping mechanisms, such as emotional compartmentalization, decision-making under extreme stress, and subsequent processing of loss, could clarify processes that the current study only outlined; Third, comparative studies involving civilian emergency medical services, hospital teams, and other armed forces would help determine whether these themes are relevant beyond a conscript military operating within its own territory [3,11]; Finally, training interventions based on these themes, including realistic stress-exposure simulations and peer-support preparation, should be evaluated for their effects on performance and well-being.

In conclusion, IDF Medical Corps field personnel who continued to provide care during the October 7 attack, despite immediate threats and the injury or death of colleagues, attributed their sustained functioning to moral commitment, prior experience, recognition of their irreplaceability, deliberate emotional regulation, and a sense of obligation to fallen colleagues. These findings can inform the development of targeted training, support, and organizational strategies to better prepare medical personnel for combat and other mass-casualty environments.

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Data availability: The interview transcripts contain potentially identifying information and are therefore not publicly available, to protect participant confidentiality. De-identified data may be available from the corresponding author on reasonable request.

References

1. Goldman S, Lipsky AM, Radimislensky I, et al. October 7th mass casualty attack in Israel: injury profiles of hospitalized casualties. Ann Surg Open 2024; 5(3): e481.
2. Ziv H, Tal T. The harming of medical personnel and facilities during the October 7, 2023 Hamas attacks [position paper]. Tel Aviv: Physicians for Human Rights Israel; 2023.
3. Jaffe E, Wacht O, Davidovitch N, et al. Managing a mega mass casualty event by a civilian emergency medical services agency: lessons from the first day of the 2023 Hamas-Israel war. Int J Public Health 2024; 69: 1606907.
4. Gozlan A, Abuhasira R, Dreiher J, et al. October 7th 2023 mass casualty incident in southern Israel: lessons for emergency preparedness and management. Isr J Health Policy Res 2024; 13(1): 67.
5. Epstein A, Lim R, Johannigman J, et al. Putting medical boots on the ground: lessons from the war in Ukraine and applications for future conflict with near-peer adversaries. J Am Coll Surg 2023; 237(2): 364-373.
6. Chapman PL, Cabrera D, Varela-Mayer C, et al. Training, deployment preparation, and combat experiences of deployed health care personnel: key findings from deployed U.S. Army combat medics assigned to line units. Mil Med 2012; 177(3): 270-277.
7. Lubin G, Sids C, Vishne T, et al. Acute stress disorder and post-traumatic stress disorder among medical personnel in Judea and Samaria areas in the years 2000-2003. Mil Med 2007; 172(4): 376-378.
8. LeBlanc VR. The effects of acute stress on performance: implications for health professions education. Acad Med 2009; 84(10 Suppl): S25-S33.
9. Cantelon JA, Navarro E, Brunyé TT, et al. Emotional, physiological, biochemical, and behavioral responses to acute stress and uncertainty in military personnel. PLoS One 2024; 19(11): e0312443.
10. Buaron Klein S, Shelef L, Tatsa Laur L, Kalla C. Human behavior and coping with stress in a military environment: summary from the "Shoresh" conference, September 2022, Washington, United States. J Isr Mil Med 2022; 20(55): 16-22. [Hebrew].
11. Abraham PA, Russell DW, Huffman S, et al. Army combat medic resilience: the process of forging loyalty. Mil Med 2018; 183(Suppl 1): 364-370.
12. Joachim MV, Atia Joachim D, Korn L, et al. Emotional resilience and sense of danger among doctors in hospitals during periods of heightened tensions and warfare in Israel. Isr J Health Policy Res 2024; 13(1): 68.
13. Rimon A, Shelef L. Moral injury among medical personnel and first responders across different healthcare and emergency response settings: a narrative review. Int J Environ Res Public Health 2025; 22(7): 1055.

14. Toblin RL, Riviere LA, Thomas JL, et al. Grief and physical health outcomes in U.S. soldiers returning from combat. J Affect Disord 2012; 136(3): 469-475.

15. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. Int J Qual Health Care 2007; 19(6): 349-357.

16. Sandelowski M. Whatever happened to qualitative description? Res Nurs Health 2000; 23(4): 334-340.

17. Braun V, Clarke V. Using thematic analysis in psychology. Qual Res Psychol 2006; 3(2): 77-101.

18. Naeem M, Ozuem W, Howell K, Ranfagni S. A step-by-step process of thematic analysis to develop a conceptual model in qualitative research. Int J Qual Methods 2023; 22: 16094069231205789.

19. Saunders B, Sim J, Kingstone T, et al. Saturation in qualitative research: exploring its conceptualization and operationalization. Qual Quant 2018; 52(4): 1893-1907.

20. Nowell LS, Norris JM, White DE, Moules NJ. Thematic analysis: striving to meet the trustworthiness criteria. Int J Qual Methods 2017; 16(1): 1609406917733847.

Appendix. Semi-structured interview guide (translated from Hebrew)

Before beginning (interviewer): Confirm that all inclusion criteria are met and that no exclusion criteria apply. Ensure a private setting and that the recording equipment is working. Begin recording only after consent has been obtained (see below).

Introduction (read aloud or paraphrased to the participant): "Thank you for taking part. Before we begin, I'd like to explain a few things. This work aims to explore the challenges encountered by paramedics, physicians, and medics, and to explain how they sustained their professional functioning within an extreme operating environment. The interview is being audio-recorded, and all information will be kept confidential: the data will be de-identified and reported in a form that does not allow you to be personally identified. There are no right or wrong answers – I am interested in your own experience. Participation is entirely voluntary and uncompensated. You are under no obligation to take part, and you may decline to answer any question. You may also pause or stop the interview at any point, without giving a reason and without any consequence. Do you have any questions before we start? And do you consent to taking part and to the interview being recorded?"

Proceed only once the participant has given explicit verbal consent. Begin recording and ask for consent again while recording.

1. What was your role during the events of 7 October?

2. Who is the person you knew who was injured or killed on 7 October?

3. When, approximately, did you learn that something had happened to them?

4. How did that knowledge affect you?

5. Did you continue to function as you had before – and how?

6. What helped you continue to function?

7. What made it difficult for you to continue functioning, or prevented you from doing so?

8. Is there anything else you would like to add about how doctors, paramedics, and medics functioned on the battlefield, while risking their lives, even though they knew that colleagues had already been injured or killed?