When worst comes to worst – the long road home

Friday 22 July 2011 has made a profound impact on the hearts and minds of all Norwegians. It has made a profound impact on the victims who survived, and also on those of us who participated as health workers.

I can safely say that during my ten years as an air-ambulance doctor, this has been my most extreme experience, and I hope that nothing will surpass it in the future.

The pre-hospital efforts following the bombing of the Government building and the shooting at Utøya island were formidable. Ambulance services from several health enterprises, six ambulance helicopters, the Armed Forces' rescue helicopter, local departments of anaesthesiology and a number of voluntary organisations participated in the rescue effort. At the time of writing, the collection of data from this process is still not completed, and we are also waiting for a comprehensive evaluation that will hopefully help strengthen pre-hospital emergency preparedness even further.

Waiting for access

When two disastrous incidents occur within such a short time, the pre-hospital services are put under pressure. In this case, however, the volume of injuries in Oslo was smaller than was dreaded, and all those who were seriously injured had been taken care of when reports of the shooting at Utøya island started to come in. The emergency response services had already gone into action, and the challenge consisted in reallocating available resources. The air-ambulance department at Oslo University Hospital could therefore mobilise both of its two ambulance helicopters, six extra air-ambulance doctors, two extra nurses and two paramedics. Air-ambulance helicopters from Ål, Dombås, Arendal and Stavanger were also directed to Utøya island, along with rescue helicopters from Rygge and Ørlandet, emergency doctors from Ringerike and a total of 42 ambulances from all the major services in Eastern Norway. Anaesthesia personnel from Bærum and Drammen hospitals also made important contributions to the pre-hospital efforts. What was most frustrating for those of us from the pre-hospital specialist health services who participated in the rescue effort was that we were not given immediate access to the area. During the first hours the situation remained inconclusive. It was unclear whether several perpetrators were present, and shots had reportedly been fired at health personnel. It is therefore understandable that the police were cautious in letting health workers approach the scene. We soon came to know, however, that the number of casualties and seriously injured was high, and it was with heavy hearts that we had to stand back and wait before we could help. This being said, many of us clearly stretched the concept of our own safety quite far. With the benefit of hindsight, we know that we would have been safe after the arrest of the gunman, even though uncertainty continued for several hours with regard to the possible presence of additional perpetrators.

Quick transport

The initial organised health care, including reception, triage and treatment of the injured people arriving from Utøya island, took place on the mainland, and was characterised by a very large inflow of injured patients, some very seriously, over a short period of time. The police and owners of private boats made a formidable effort to bring the most seriously injured persons to shore as soon as possible. Initially there was no time to organise a casualty clearing station, but by using all our strength we were able to assess, stabilise and arrange for very rapid transport of all these patients. It is my impression that what made this at all possible were the early efforts by a number of experienced air-ambulance doctors who had the required skills and experience of triage and primary emergency treatment.

Rescue work at Utøya island

When the first casualty clearing station had to be evacuated shortly after because of a potential security risk, the reception and collection area was relocated, while a small group of us made it to Utøya island to provide help there. The new casualty clearing station near the bridge to Storøya island was set up in an exemplary manner, with a total of seven anaesthesiology teams, six ambulance helicopters, two rescue helicopters and 39 ambulance vehicles. In addition, the municipal health services and the Health Express were present to take care of those who had not been physically injured.

Those of us who ventured out to Utøya island received a small group of injured people, and we were not exposed to the large mass of injuries that we had dreaded seeing. Most of the survivors left on the island were unhurt and in hiding. We could therefore scale down the staffing on the island as the evening progressed, but chose to maintain a presence in case other injured people emerged. When my colleague Jan Erik Nilsen and myself were the last doctors to leave the island after midnight, we had participated in a final search for survivors among the casualties that were left there.

It feels good to make a difference

Even though air-ambulance doctors in their professional capacity are confronted with numerous tragedies and serious injuries, the experience of working on and near Utøya island has been a major burden on us all. For me, my network of colleagues, close friends and family have provided great help in overcoming the experience.

Our contribution to the rescue effort was only one link in the chain that saved lives, but I am grateful for having been able to make a difference. I am convinced that the pre-hospital specialist health services were able make a significant contribution on that day. In our professional community, 22 July 2011 will also be remembered for the outstanding effort that was made by all the helpers, volunteers and professionals alike.

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