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Could this have happened to us?

FRA REDAKTØREN

CHARLOTTE HAUG

(born 1959) is an MD and has an MA degree in health services research from Stanford University. She has been editor of the Journal of the Norwegian Medical Association since 2002.

If 22 July had happened in the health services, would we have seen a Sønderland report or a Gjørv report?

Photo: Einar Nilsen

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> *«««Yes, 'n' how many times can a man turn his head, pretending he just doesn't see?»»»«Bob Dylan,* Blowin' in the Wind*, 1962»*

It took me some time to find out why I felt so uneasy during the days following the publication of the report by the 22 July Commission (1). There were many obvious reasons for feeling ill at ease: the repetition of the grim details, the heart-rending scenes, the appalling destruction. Everything went wrong that should not have gone wrong, even in a chaotic situation: the police management that did not «press the red button» even though everybody soon

realised that this was a terrorist attack – either because they were unaware of the plans (a police director who was new to the job), because they did not think about it (several others) or because they did not have the password to access the computer where the counterterrorist plans were stored (the responsible staff member in the Police Directorate). And finally, of course, the unfortunate story of the yellow note with the crucial information on the perpetrator and the getaway car – which was left unnoticed until it was much too late.

The fact that the police had the information on the yellow note immediately after the explosion in the government building was referred to in an NTB news report as early as August 2011 (2). But why the information was not used immediately to attempt to stop the car became clear only when the report was published: The note had been left on a desk. When the call was sent out, it was unclear – and failed to reach its destination. The NTB news report was a foretaste of what later we would learn about the lack of understanding of risks and of a culture of preparedness in government administration. I quote: «The head of the department of security in the Government Quarter, Jon Ivar Mehus, states that they do not regard abandoned cars as a serious threat (...) This happens on a regular basis here, says Mehus, who adds that the discovery of a suitcase tends to arouse more suspicion» (2).

The Gjørv report's sober descriptions of what happened and what failed to happen on 22 July 2011 and the tragic consequences that ensued may well cause an emotional response. The report is recommended reading – in its entirety. My own unease grew in earnest, however, when the responsible parties – at all levels – started to comment on the report and reveal what they intended to do. My unease was caused not only by their statements, but mostly by the formulations that were used. They appeared disturbing and eerily familiar at the same time.

Already on the day of the publication of the report, this sensation was aroused by the NRK programme «Aktuelt» (3). Programme host Ole Torp made repeated attempts to elicit an answer from Grete Faremo, Minister of Justice, as to what she meant by «taking responsibility». She gave no direct answer, but stated that: «I'm concerned that my responsibility is to improve Norwegian preparedness. I wish to cooperate closely with the Storting. I wish to undertake a thorough review of the police. This is a management challenge, it is an operational challenge. And we also need an appropriate basis for introducing strategic use of ICT and communication systems in a far better way than today.» The response spurred Ole Torp to make a final attempt: «What kinds of errors committed at a high level in the police are required to qualify as gross dereliction of duty? Isn't it a gross dereliction of duty to arrive at Utøya so late that 20 human lives could have been saved?» To this, Faremo responded: «Today, I will abstain for answering such questions, out of respect for the thorough work that has gone into the report.» How can you contest such an answer? In the days that have followed, these types of statements have flowed incessantly, most recently in the report to the Storting by the Prime Minister and the Minister of Justice on 28 August 2012 (4). These formulations are near-identical to the newspeak that we have gradually become used to in the health services, for example as I described in an editorial two years ago (5).

It has now been repeated so often that we almost believe it to be true, that the reason why so much went wrong on 22 July 2011 was the unthinkable nature of the events, and that we could not have imagined them happening. However, this is not so. On the contrary. Chapter 4 of the Gjørv report reviews the threat profile that was known to Norwegian authorities prior to 22 July, and describes the knowledge we had about the lessons that other countries had learned from terrorist attacks. The report shows that exactly this kind of terrorist act could have been expected: «On 22 July, Breivik combined two typical terrorist targets: a government target and a densely populated area. These are classic terrorist targets, including those of lone wolves (Chapter 4.3, page 54). The methods were also among the most common ones: Large fertiliser bombs hidden in vans to destroy buildings, and shooting at «soft targets» where large crowds are assembled, for example in schools, cinemas, subways and trains – or in a youth camp. On 22 July, 77 lives were lost, and hundreds sustained serious injuries. Now we know that the reason why the damage was so extensive was not the unexpected nature of the situation, but the consequence of a *failure* to take expert input seriously, as well as a lack of ability – politically and administratively – to implement the appropriate measures once the reports *were* taken seriously.

Each year, thousands of patients are injured or die as a result of adverse events and medical error. We have no exact figures. This is bad in itself. What is especially bad is that many of these cases could have been avoided. Many of them are disasters waiting to happen. Just as we now can see with 22 July. We could not have prevented the perpetrator from thinking as he did or planning as he did, perhaps not even from putting his plan into action. But the damage could have been reduced, with fewer deaths and injuries, if those responsible had listened and acted upon the information available to them.

It has often crossed my mind: What is really needed? How wrong must things go in the health services before those who have political and administrative leadership responsibilities start taking the situation seriously and do something? How many patients, next of kin and experts must voice their concern that the system is faulty? That slip-ups may occur? That it is no longer medically justifiable? How many forgotten yellow post-it notes, requisitions and test results are required? My preliminary conclusion is that not even an event of a similarly dramatic nature as the terrorist attacks on 22 July 2011 would have been likely to give rise to any changes. Tell me in honesty: What would have been the outcome of a similar event in the health services? A Sønderland report or a Gjørv report?

LITERATURE

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