VIEWS AND REVIEWS

ACUTE PERSPECTIVE

David Oliver: Rosy retrospection, nostalgia, and the NHS

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The NHS turned 70 this year and faces numerous challenges. This has prompted many to debate current and future healthcare services and to look back at the NHS's journey since 1948.

A fond nostalgia has its place. But one step beyond is "rosy retrospection"—a psychological phenomenon of cognitive bias whereby people simplify or exaggerate to judge the past more favourably than the present.^{1,2} Excessively positive retrospective narratives sometimes come from people who weren't there the first time around but speak confidently about imagined golden eras. I've doubtless donned rose tinted lenses myself sometimes but, as I enter my 30th year as an NHS doctor, I'd prefer to avoid them when discussing present and future healthcare.

Before the European Union Working Time Directive³ placed restrictions on junior doctors' working hours some brutal on-call rotas were commonplace (1 in 2, 1 in 3, or 1 in 4), including continuous 80 hour weekend and 36 hour weekday blocks, with no sleep guaranteed.⁴ Tired doctors put patients' and their own health at risk.⁵ On the other hand, the exhaustion came with free (if basic) onsite accommodation, camaraderie, peer support, and the continuity of a firm structure, and we quickly gained vast amounts of hands-on experience. The loss of those hours is still sometimes lamented in surgical specialties,^{6,7} but—with minimal induction, far less senior supervision, a "see one, do one, teach one" approach to many quite risky invasive procedures and operations, and far less scrutiny on safety and preventable harm—the effect of that rosy filter starts to diminish.

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The historical switch, in Modernising Medical Careers,⁸ to run through higher specialty medical training from previously more meandering routes has also attracted much adverse comment, as has the botched introduction of the Medical Training Application Service⁹ in 2007 or more recent findings that junior doctors often feel rushed or pressurised to decide on a specialty stem too early in their career.^{10,11}

On the other hand, back in the day many senior registrars, long qualified to become consultants, waited endlessly for consultant

posts to become vacant. And not for nothing did the Department of Health report that led to Modernising Medical Careers call senior house officers "the lost tribe,"¹² as so many doctors were stuck or drifting at that grade and sometimes trying to enter a specialty they weren't suited to or, realistically, able to enter.¹³ Nor did we have today's transparency and scrutiny around preferential selection based on sex, race, or patronage.

Another example of *la vie en rose* is those yearnings in sections of the mainstream media and letters pages for golden ages of nursing—where A levels, let alone degrees, weren't required, and where fondly remembered, fearsome matrons ruled wards with a rod of iron, insisting on shipshape ward cleanliness, hierarchies, and militaristic rules. Yet patient case mix and healthcare were far less acute and complex; pressure and throughput on beds was lower; and a far more limited range of interventions was available for nurses to carry out, let alone as independent advanced practitioners or prescribers. Care was arguably far more regimented, institutional, and paternalistic—and patients more deferential. Besides, the research evidence tells us that graduate nurses improve patient outcomes.¹⁴

A rosy retrospective makes us forget just how far healthcare has come in terms of evidence, interventions, safety, and outcomes. Clinical staff may formerly have had more professional autonomy, a greater sense of belonging, less managerial and political interference, and a far lower burden of documentation and regulatory or public scrutiny; but some of that burden came about precisely because, when the professionals ran their own show, not everything was rosy.

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