diabetes study results were published in high quality, peer reviewed journals and were probably seen before publication by at least a dozen independent experts in either diabetes or research methodology. The writing—that the study was about to cause a sensation—was probably already on the wall, so it would have taken a brave and rebellious individual to be the first to jump off the bandwagon.

Looking back with the benefit of hindsight at how the UK prospective diabetes study results were presented and received at the time, we believe that this is a good example of the hidden biases inherent in the interpretation of randomised controlled trials. The relatively uncritical reception of the study by conference audiences, editorial committees, and the wider scientific community, could be an example of mass “groupthink”—a well described psychological phenomenon in which a group makes an overconfident and perhaps even irrational decision which it then defends fiercely against dissenting members, whose comments are subconsciously perceived as a threat to the group’s own cohesion.1

We put it to the editors of medical journals that they should, in the interests of minimising interpretation bias, require investigators initially to present the results of clinical trials with a minimum of discussion so that individual clinicians and patients can decide if the results are clinically important. In addition, we suggest that editors should continue to provide space for readers to enter a discourse about the meaning and clinical importance of those results, and indeed they should actively stimulate discussion, perhaps by encouraging publication of dissenting views. Furthermore, when new evidence challenges old beliefs—let it.

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Modernising the NHS
Practical partnerships for health and local authorities
Diane Plamping, Pat Gordon, Julian Pratt

Partnership has become a legal, almost moral, imperative in the health and social care world in recent years. In policy documents and policy documents the analysis is consistent and welcome. We need to find new ways of working: “The strategic agenda is to work across boundaries … underpinned by a duty of partnership … past efforts to tackle these problems have shown that concentrating on single elements of the way services work together … without looking at the system as a whole does not work.”

The result has been an explosion of partnership boards and partnership meetings throughout Britain—and now there is talk of partnership fatigue. This fatigue is mostly due to a proliferation of structures and plans. Yet frustration with talking about partnership should not be mistaken for rejection of the underlying principle. But now is the time to ask some hard questions. When is partnership effective? What sorts of partnerships are fit for what circumstances?

Understand there are different sorts of partnerships

The first need therefore is to understand that there are different sorts of partnerships. Studies of public sector partnerships have shown various sorts of partnerships, each effective in different conditions.2-5 This research

Summary points

A sense of fatigue and frustration with partnerships shouldn’t obscure the fact that they are necessary and can be powerful ways of changing whole services for patients and clients

Some partnerships depend on identifying a shared goal: focusing on the needs of patients helps to do this

Organisations may achieve much with less demanding forms of cooperation—and also help to build the trust necessary for proper partnerships

Different organisations need to find a shared “currency” for successful partnership: beds and money often aren’t appropriate currencies

1723

This is the last in a series of seven articles

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Coordinating partnerships—The underlying assumption of most partnership effort is that all the partners agree the nature of a problem, the nature of its solution, and how this is to be achieved. Every organisation has to do its own part of the work in a manner that allows the whole project to be completed. This usually means appointing someone to manage the joint work, chase everyone up, and hold everyone to account. It is a high maintenance option. There is a lot of evidence about what goes on in these “coordinating” partnerships, from the 1960s onwards:

- Interagency tensions will not go away just because there is money to oil the wheels;
- Partnership between organisations is hard to achieve: cultural, departmental, and organisational differences are not easily overcome;
- Local power struggles over steering groups and management boards can become a painful distraction, which may last for years;
- Creating a truly shared goal is paramount;
- Success will depend on local autonomy and initiative, but tensions will arise between the centre and localities unless there is a genuinely mutual process of setting priorities and targets;
- It is relatively easy to mount a collaborative bid and become a trailblazer: sustaining enthusiasm and commitment over time is altogether different.

Find a shared goal

Finding a truly shared goal requires negotiation and diplomacy. Often negotiation consists of positional bargaining: each player takes a position, argues for it, and then makes concessions, which is time consuming and inefficient and endangers relationships. One practical way of avoiding this cycle is to start from principle rather than position. An example of this is to start with a service model which focuses on what is best for the patient rather than the detail of which institution or what sort of professional.

Service models are really a device for keeping hold of “the whole” rather than starting with the parts. This requires genuine dialogue in which all the partners are prepared to question their own assumptions and to listen to others. It seldom happens in a crowded agenda around a boardroom table. If the goal really is “to make a difference to the way we do things around here” then it is crucial to recognise the worth of bringing all the necessary perspectives together. The perspectives that are commonly missed out are those of frontline practitioners and people who use the service. Changing Childbirth (a policy document on services for pregnant women) and An Ordinary Life (a paper from the King’s Fund that represented a paradigm shift in designing services for people with learning difficulties) are examples of long term initiatives where the importance of the voices of people who use services is paramount. They help unsettle the status quo and keep the focus on patients and their experiences rather than reverting to organisational or professional positions.

Most partnerships, whether between organisations or individuals, involve differences in status, priorities, resources, power, and culture. Unless these differences are made explicit and time is given to reaching common understandings, effective working across boundaries is unlikely. Mutual trust has to be built; it certainly doesn’t come with the agenda papers. So coordinating partnerships must put a lot of effort into negotiating the shared goals that could enable them to make a difference. This is, however, not the only sort of partnership. Given the amount of hard work involved to achieve coordinating partnerships, the partners need to be sure that they can’t achieve what they want with something less.

Build trust gradually

Cooperative partnerships—There are, for example, circumstances in which partners can pursue their own goals most effectively by cooperating with others—using enlightened self interest. “Cooperative” partnership may be an underused form of relationship between organisations, although it uses mechanisms by which lots of individual business gets done: you scratch my back and I’ll scratch yours. This is low maintenance partnership. It does not require the time and effort to reach collective goals.

Interprofessional training, for example, is a goal for both health and social services and has been the focus of many years of joint working. Yet it hasn’t got very far, and one reason may be that focusing on the core curriculum is just too difficult a place to begin. Different partners all want different things, and fighting for them is hard without mutual trust and respectful relationships. It would be easier to start by cooperating on training that everyone wants for their own purposes, such as computer skills or equal opportunity interviewing techniques, and use this cooperating behaviour to develop the trust that is needed for the hard stuff.

The basis of such cooperation is self interest and the trust that actions will be reciprocated. Trust is recognised as central to all partnership behaviours but is often described in personal terms, as an attribute of
Lessons on effective partnership

Many people share the government's aspirations for partnership. That may not make it easy to do in practice, and there may be a sense of frustration and fatigue at present, but the solution is not to throw the baby out with the bathwater. Working together is not a “once and for all and you never have to solve it again” ambition, and there are many lessons worth learning:

- Concentrate on whatever actions are necessary to support working together, not building boards and planning committees and new formal structures;
- Partnerships come in many forms, so select the form—and the behaviour—appropriate to your circumstances;
- If your purpose is to achieve better coordinated services, start by focusing on the whole experience for the patient (or client), not particular professional or organisational solutions;
- Cooperation may arise entirely out of self interest without the need for shared goals. Indeed, this can be a useful place to start joint working. The task here is to develop a sense that people and organisations have a shared future and to set up repeated opportunities for exchange from which trust can grow;
- Trust is based on fair trading between partners. Choose a “currency” that facilitates exchange. This may be different from the in-house currency each partner uses for accounting.

**Find a common currency**

Partners cooperate effectively when they are clear about what constitutes fair exchange between them. This means examining the currencies they use. Organisations use currencies for two purposes, for accounting (how much have you got?) and for exchange. Beds are an example of the former, but it is not hard to see that their value is limited as a medium of exchange with non-NHS organisations (which don’t have beds). Instead the search has to be for common currency, and that means finding out what matters to the other partners. Each must bring something of importance to the others. Successfully opening up new avenues of fair trading relies on knowing what counts for others so that offers can be tailored to their needs.

For example, local authorities and NHS agencies are represented on the many regeneration partnerships that now exist in deprived areas. Their task is difficult, but one area where both can make gains in a common “currency” is employment. NHS organisations face problems in recruiting and retaining staff. Local authorities are charged with reducing local levels of social exclusion and creating jobs. The NHS is often one of the largest employers in areas of high unemployment, so there is scope for new kinds of fair exchange. One example is the “Pathways to Access” initiative that is funded by the European Union to bring local people into NHS employment in Tower Hamlets in east London (www.pathways2access.org.uk).

**A memorable patient**

**Benefits of a cooperative**

In common with many parts of the United Kingdom the GPs in the Exeter area have formed a cooperative for out of hours cover. This means that 95 doctors have joined together to provide out of hours medical care to a large population (over 200 000). This system has many advantages to its members, but I found another one while doing my shift recently.

I was asked to visit a man in a nearby town who was complaining of epigastric pain and vomiting. Having decided subconsciously that he probably had gastric flu that was doing the rounds in Exeter, I thought that a quick dose of prochlorperazine would rectify the situation. He was aged 61 and suffered from polycythaemia and hypercholesterolaemia, but he seemed quite well. Examination was completely normal, and in particular he had no epigastric tenderness. I was happy to explain the bradycardia as a vasovagal response to his vomiting; was reaching for my prescription pad for antiemetics and antacids when a sudden Keeley and I was wondering whether to do anything else.

**Lessons from a cardiac patient**

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A defibrillator. A relative was dispatched to ask the driver to bring in the equipment and in no time at all we had the standard limb leads attached to the patient and there were the tell tale signs of an acute inferior myocardial infarction. We administered aspirin and called for an ambulance to take him to hospital.

This could have been an easy diagnosis to miss and it made me feel good about myself, but without the defibrillators would I have just given him the antacids?

**Alexander Williams general practitioner, Exeter**

We welcome articles of up to 600 words on topics such as A memorable patient, A paper that changed my practice, My most unfortunate mistake, or any other piece conveying instruction, pathos, or humour. If possible the article should be supplied on a disk. Permission is needed from the patient or a relative if an identifiable patient is referred to. We also welcome contributions for “Endpieces,” consisting of quotations of up to 80 words (but most are considerably shorter) from any source, ancient or modern, which have appealed to the reader.