individuals, and therefore not something that organisations can do much about. If, instead, trust is seen as something which grows through repeated episodes of freely entered exchanges then this offers a practical way of promoting cooperation. People can be encouraged to try and try again when they recognise that their futures are linked. In practice, it is the experience of this behaviour that creates an understanding of who is worthy of trust.

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).

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.

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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 cover 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 unremarkable apart from a bradycardia of 60, abdominal 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 thought crossed my mind—could this be a cardiac problem?

This is when the advantage of being in a cooperative comes into play; both cars are fully equipped with resuscitation facilities

and 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.