contrary to the previous ones so that an accretion of crosscutting changes has developed. Powerful, perverse and non-aligned incentives undermine the development of cost-effective, integrated services. Leaders keep changing, and each new one asserts his or her presence by correcting or reversing previous initiatives and instigating new ones. Current initiatives – such as 'payment by results', which has nothing to do with payment by results but rather payment by activity – build in perverse incentives that will distort services in new ways. Until the economics and organisation of services support cost-effective, integrated services of quality for patients, a culture of Confidence, Compassion, Connectedness and Curiosity will not happen.

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None declared

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Ockham's razor

Douglas Wardrop (*JRSM* 2008;**101**:50–1) is right in commenting that the scholastic logic of Ockham's razor is of limited relevance to geriatric medicine. Geriatricians have long taught their students that if an old person admitted to hospital has less than 5.5 or 6.5 diagnoses he or she (respectively) may have been inadequately assessed. But I was surprised to see so little deference to probability in the Editorial. It is not the *number* of different 'entities' – a fine scholastic concept – but their *probabilities* that matters. One of my patients with ulcerative colitis developed a peripheral arthropathy that the literature claimed as a rare complication of chronic bowel disease. Calculation revealed that it was much more likely that she had rheumatoid arthritis as well as her bowel disease rather than the single diagnosis decreed by Ockhamism. Conversely, decades before Lewy Body Disease was defined it was obvious that Parkinsonism (clinically diagnosed) and dementia (also clinically diagnosed) occurred together far more often than was compatible with independent incidence. This prophesied the existence of at least one unrecognised unifying 'entity'. But probabilities varying with sex, age and other demographic factors can be difficult to estimate from conventional medical literature. How much easier both clinical diagnosis and research would be if the NHS had an accessible system of epidemiologically structured medical records matching that of an American Health Maintenance Organization. We could then forget the scholastics.

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None

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Hospital ownership

It was no surprise to read that the ownership style of NHS providers has had little impact on productivity except where owners could cherry-pick their clientele (*JRSM* 2008;**101**:59–62).[1] Health care has many facets. There is no universal panacea. Ownership of the hospital service started with compulsory purchase, followed by rationalization in the form of asset stripping and land sales with doubtful benefit to the local population except where centralization enabled the provision of new buildings which were fit for purpose. The notion that the NHS has to pay its way ignores the fact that it was set up as a national charity (funded by compulsory donations), not a bucket factory. The fiscal fallacy was that an overall improvement in the health of the nation would ultimately lead to a reduction in demand. Free lunches typically generate appetites where previously there had been none.

Ownership should mean more than just possession of the freehold. It should embrace the desires and aspirations of the workforce and generate pride and passion for the service provided. Whilst wastage and financial exploitation should be guarded against, the ethos 'free at the point of access' should remain untainted. Changes aimed at making the service more effective need to focus on the patient, not the purse. Where this leads to more efficient budgetary management, that is a bonus, not a prerequisite. Foundation status is unlikely to change anything other than ownership style unless all participants – including management boards – are subjected to the same 'place of residence' membership criteria. It is obscene that directors should be able to make health care decisions applying to others knowing that they and their relatives would not have to endure the defects which they have imposed on the service.

Historically, changing ownership or the logo has merely allowed managers to indulge in musical chairs.

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None declared

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Medical progress depends on animal models – doesn't it?

With regard to the JRSM article 'Medical progress depends on animal models – doesn't it?' (*JRSM* 2008;**101**:95–8):[1] there is misunderstanding in the preclinical science field about applying bias-reducing principles to animal research.[2,3] Animal project licence applications should be supported by references to systematic reviews of all the existing relevant human and animal studies, documenting the materials and methods used to show how the reviewer attempted to minimize bias. The Home Office Inspectorate should not be satisfied by reference to bibliographic databases and statistical analyses alone because these do not take into account publication bias and variability in quality of bibliographic searching skills.

The reviews need to take account of completeness and quality of research and address the probability that null results had not been reported as equally as were the positive results. The applicant needs to show that they have searched for and assessed what relevant research has already been done and, of equal importance, to show what relevant research has not been done.

Failure to apply these principles was highlighted by Kenter and Cohen in their assessment of the TGN1412 drug trial.[4]