an imperfect knowledge of the well known but not yet printed discovery of a great scientific investigator. What little information there is in his thesis is due to Glisson, while Glisson owes nothing to him.

Why the names of Dr Bate and Dr Regemorter were added to the English edition, *A Treatise of Rickets Being a Disease Common to Children* published in 1651, is not clear.

Francis Glisson is, of course, better known for his description of the fibrous capsule of the liver, in his *Anatomia Hepatis* published in 1654. He also described the sphincter of the bile duct in his *Tractatus de Ventriculo et Intestinis* (1677), but Oddi's (1887) name has become attached to this structure[2].

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Swallowing in motor neurone disease

We read with interest the report of Leighton *et al.* (December 1994 *JRSM*, pp 801–805) on the treatment of swallowing problems in motor neurone disease (MND). The relentlessly progressive dysphagia associated with bulbar and pseudobulbar palsy is a most distressing feature of this devastating disease and presents a major issue in the palliative care of patients with MND. The authors discuss the role of cricopharyngeal myotomy and pharyngostomy in the management of this problem. Although the authors note a patient satisfaction rate of 89%, it is stressed that these procedures are only suitable for patients who are fit for general anaesthesia and acknowledged, at least in the case of pharyngostomy, that morbidity was unacceptably high for a palliative procedure.

In recent years percutaneous endoscopic feeding gastrostomy (PEG) has been increasingly used to alleviate symptoms associated with dysphagia in MND. This procedure is now very widely used and it is unfortunate that this technique was not mentioned until the penultimate sentence of the Leighton *et al.* paper. Our experience in approximately 30 MND patients has already shown the PEG has enormous advantages over both cricopharyngeal myotomy and pharyngostomy. It can be used in patients in whom a general anaesthetic would be dangerous and the average length of in-patient stay is much less than the 8 days quoted for the two ENT procedures. Moreover, the insertion of a PEG reliably and predictably reverses the adverse nutritional status in MND patients with bulbar symptoms. Most importantly in palliative terms, PEG relieves the inexorable feeling of hunger to which MND sufferers were previously condemned during the final weeks and months of their lives. We therefore throughly endorse the comments contained in the last two sentences of this paper. PEG has revolutionized palliative care in MND and we foresee an increasing role for PEG in the management of an ever wider range of patients with neurogenic dysphagia.

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Non-attendance in outpatients

King and colleagues have highlighted the problems of non-attendance for outpatient appointments (February 1995 *JRSM*, pp 88–90). As the authors acknowledge non-attendance has important resource implications for the health service. However, their proposed solution—overbooking—is likely to cause patient and clinician dissatisfaction. Clearly, on some days all patients will attend and this will inevitably lead to queues with consequent dissatisfaction amongst patients. Furthermore, clinicians will be required to either work longer hours to clear the queues, when all the patients attend, or to curtail appointment lengths.

A better solution is to change the appointment method. Two randomized trials of appointment methods within the context of an osteoporosis screening programme have shown that non-attendance to appointments can be reduced from 20% to less than 3% by alteration of the method of invitation[1,2]. These appointment methods were very cost effective compared with the standard appointment system. Appointment methods which either ask the patient to make their own appointment or require confirmation of intention to attend the appointment are associated with very low non-attendance rates. Alternatively, an American study has noted that non-attendance can be reduced through a system of reminders shortly before the appointment falls due[3]. Randomized trials of appointment systems within the context of outpatient departments would be justified.

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Acts of commission, omission, and demission or pulling the plug

There was a reference to the judgement in the Airedale NHS Trust v Bland test case in the article by Shaw (January 1995 *JRSM*, pp 18–19). In this and the small number of similar cases, much unnecessary pain to the relatives and staff looking after him could have been saved by a more logical definition of legal death.

A person's individual personality and ability to behave as a human being depends on the survival of his cerebral cortex. Once this has been demonstrably destroyed, he, as an individual with his own personality has, effectively, died.

It is irrelevant that his brain stem may be functioning to maintain some 'signs of life'. It should be possible at this stage to certify the patient dead and to withhold all treatment. No one could then be accused of murder or even euthanasia.

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