from the pharmacy budget, using donor recruitment staff, or running a simple cash box system and asking recipients to contribute. In France central donor banks have been established, and samples are distributed to AID centres.[15] The French system has the advantage that uniform standards may be applied, hazards monitored, and the number of pregnancies from any one donor restricted. In France one donor could not give samples to two different hospitals—as could happen in some of the larger British cities. There is no evidence of damage to the deoxyribonucleic acid or of teratogenicity from the use of donor or frozen donor semen[11 16]; the main risk to the recipient seems to be transmissible disease. At present donated samples cannot be guaranteed to be free from venereal disease, for with current resources it is not practicable to test each sample. This would be another advantage of a centralised recruitment centre.

Couples may now be told, then, that the rates of conception from AID approach those from natural conception. Now that prognostic factors have been identified some couples may be selected for "do it yourself," low cost AID schemes so that medical efforts may be concentrated on those who fail and those who have poor prognostic factors. The place of AID in the management of male infertility may, however, require reappraisal if the preliminary results of in vitro fertilisation for male infertility are confirmed from life table methods of analysis.

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# Hospital clinical records

In the *BMJ* of 26 January (p 263) we asked the question "Why keep hospital clinical records?" and listed five possible options. Hospital clinical records could be kept in their original format; they could be sampled or selected; they could be microfilmed; they could be destroyed after a certain period of time; or they could be kept, sampled, microfilmed, or destroyed according to local initiative. In the correspondence after the leader two more options emerged; patients might keep their own records, or rigorous file keeping would do much to solve the problem. Perhaps the original question should have been "What should we do with hospital clinical records?"

We thought that both questions could best be answered by those experienced in the subject, and this spring invited participants attended a symposium at the King's Fund Centre to examine the issues (the full papers and proceedings of the meeting are to be published by the centre this month). Inevitably there emerged no immediate answers: it would have been unrealistic to expect any, but the problems were seen clearly, a valuable exchange of information took place, and areas of agreement were exposed.

Clinical records fall into two distinct types: the bound volumes of older records and the case files gradually introduced in the 1920s and 1930s. Many features are common to both. The main problem is bulk. Some district health authorities have appointed archivists, and some county record offices take in the material, but often only up to 1900. Such records take up a great deal of space, and many archivists simply have no room. The fact that the records are closed for 100 years is probably a deterrent. In hospitals the conditions in which many of these volumes are kept are often very poor—in cellars liable to flooding and alarmingly filthy.

Modern case files are not usually held in such bad conditions, but the problem of bulk is magnified many times over. Very few local record offices would be willing to take in modern case files. Many hospitals destroy them after the recommended retention time for possible use in litigation. Others are microfilming—but, though microfilming might satisfy the epidemiologists, unless the microfilm is kept in archival conditions it will not last. Even in archival conditions its lifetime is not certain.

The meeting discussed the question of confidentiality, and mention was made of the successful system in operation for some years at a mental health centre in Manchester which enabled patients to discuss and see their records at any time. Ultimately the issue of confidentiality may be seen in terms of etiquette. The 100 year closure period for clinical records, now generally accepted, was laid down in 1961,[1] though hospital authorities have a discretion to make records available at an earlier date for research.[2] Throughout the day, indeed, the importance of the records for research was recognised, although the needs of the historical researcher, the clinician, and the epidemiologist were seen to differ.

Speakers acknowledged that the overwhelming bulk of the records meant that they could not all be kept. One possibility was the establishment of a medical records centre as a final safety net, but this was seen as a less satisfactory solution than the appointment of archivists by regional authorities. In Scotland only a minority of the health boards have appointed archivists, and only on an ad hoc basis. The Wilson committee recommended the appointment of specified record officers for each regional health authority,[3] but this recommendation was not accepted by the government.[4]

Some kind of sample or selection appears inevitable. How might this be achieved? Should there be a statistical sample? This might satisfy the historian but not the medical researcher. Should a selection be made on a regional basis? The meeting felt that there were strong reasons for seeing the selection or sample of records in three chronological divisions: the older volumes, the modern case file, and the future. Criteria for saving the older volumes might be bulk, type, and quality of the records, combined with the presence

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of indexes and cross references and the potential for use in research. With modern case files the importance of indexes was equally true but here the use of microfilm was to be taken into account. Finally, for the future, it was suggested that a standardised summary sheet for each patient could be retained permanently in hard copy or microfilm.

At the end of the day it was generally agreed that more specific information was needed about how much survives and where. A survey could be initiated by the Public Record Office and the Contemporary Medical Archives Centre of the Wellcome Institute for the History of Medicine, which are already conducting a pilot scheme on hospital records in record offices. Hospital administrators need to have a clearer understanding of the arrangements for hospital records, and the proposed revised guidelines updating HM(61)73 might go some way to help them. A possible reduction of the closure period to 75 years (many government records previously closed for 100 years have now had their closure period reduced to 75 years) would also remove one important disincentive to historical research use. Finally, a working party will be set up to look more closely at the issues of microfilming, selection and sampling, and how best to continue the debate and translate words into action.

In introducing the speakers at the beginning of the day the chairman had quoted Lytton Strachey: "Ignorance is the first prerequisite of the historian." This view had not survived the day.

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# Plasma exchange for Guillain-Barré syndrome

Most patients with Guillain-Barré syndrome recover spontaneously and completely; so claims that therapeutic intervention affects the prognosis must be viewed with caution. Early reports of the beneficial effect of steroids were contradicted by a trial in which 21 patients randomised to receive prednisolone recovered more slowly than a similar group who were not given it.[1] Despite this evidence some believe that steroids are worth trying,[2] and since the course of Guillain-Barré syndrome is so variable further studies are needed of the value of steroids on more patients. There is little except anecdotal information about the value of immunosuppressive agents such as azathioprine and cyclophosphamide,[3] but plasma exchange has been the subject of many single case reports, small series, and now several controlled trials.

In a British controlled trial the course of the disease was slightly better (but not significantly) in the 14 patients randomised to receive plasma exchange than in 15 control patients.[4] There were four deaths in the control group and two in those treated with plasma exchange. This mortality is worryingly high compared with recent reports from other countries but may be explained by the severity of illness in the patients studied. A similar sized American trial combining plasma exchange with prednisolone reported (in an abstract) no significant effect.[5] On the other hand, the results of a multicentre Swedish study were more promising.[6] Thirty eight patients were allocated alternately to receive plasma exchange or not. Weakness stopped progressing sooner, improvement began earlier, and at both one and two months disability was less in the patients receiving plasma exchange. All these differences were statistically significant. Non-significant differences in favour of the plasma exchange group, with respect to duration of hospital stay and time to virtually complete recovery, were also observed. There was only one death in each group. An abstract report of a French trial of 183 patients randomised to receive plasma exchange or not suggested that the early course of the disease was much more favourable in the former.[7] There were six deaths in each group.

The largest study comes from North America, where in a multicentre trial of 245 patients the group randomised to receive plasma exchange fared significantly better than their controls.[8] The mean improvement in disability four weeks after entry (scored on a six point scale) was 1·1 in the plasma exchange group and only 0·4 in the controls. The median times to being able to walk without an aid were 53 days in the plasma exchange group and 85 days in the controls. The median time on the ventilator was 24 days for the 57 patients ventilated in the plasma exchange group, which was 24 days shorter than in the 52 control patients who also needed ventilation. Furthermore, the median times for these subgroups to walk unaided were 97 days in those given plasma exchange compared with 169 days in the others. Only three patients receiving plasma exchange and four controls died.

Each of the trials cited above may be criticised, either for its small size, alternate rather than truly random allocation, exclusion of patients randomised to but not receiving plasma exchange, or use of one tailed rather than two tailed statistical analysis. Nevertheless, the main problem has been that sham exchange was not considered to be justified, and none of the trials employed blind observers. It is almost inconceivable that these trials will be repeated, so decisions on future practice must be made on the information available. On balance this supports the use of plasma exchange and suggests that in experienced units it is safe and accelerates recovery, shortening the period on artificial ventilation and the time in hospital sufficiently to justify its cost. Steroids are not recommended,[1] and their use may negate the beneficial effect of plasma exchange.[5]

Plasma exchange is not, however, available in every district general hospital, nor is it appropriate for every patient. Some patients have such mild disease that admission to hospital may not be necessary. Predicting outcome in the early days of the disease is difficult, but experience suggests that those who require ventilation tend to do badly. About a third of patients do not respond to plasma exchange,[8] which emphasises the need for excellent conventional intensive care.[9] Preliminary data suggest that exchange is more likely to be successful if undertaken early (within two weeks of the onset of the disease[8 10]), and it would seem reasonable to transfer patients who require, or seem likely to require, ventilation to an intensive care unit experienced in plasma exchange techniques. The regimens tested in the trials have

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