Users of Health Sciences Libraries

ESTELLE BRODMAN

FOR GENERATIONS physicians and other health sciences practitioners have considered their work so esoteric and so liable to be used wrongly or in nefarious ways that they built around themselves and their tools and records a wall of privacy. As John Shaw Billings noted in 1883, addressing the Annual Session of the Medical and Chirurgical Faculty of Maryland, "For the last 300 years and more physicians have been known as *the* Faculty. All universities, properly so-called, have other faculties—Faculties of Arts, of Law, or Theology; but by the world at large, when one speaks of 'the Faculty,' he is understood as referring only to the medical profession."[1] If one thinks of oneself thus as the elite and the guardian of high and mighty magic, then one allows outsiders into the sacred circle only after much travail on their part, and only in small numbers.

Nor did this point of view die with the nineteenth century. As late as 1954 the Medical Library Association held a symposium at its annual meeting on the topic, "Service to the Lay Public,"[2] and a glance at the titles of the papers presented shows the continuation of the feeling of separateness and enlightened monarchy evidenced in Billings's remarks. Of the five talks presented, one is called, "Shall We Purchase Lay Material and If So, to What Extent?" Another discusses, "Policies Set Up by the Medical Society Libraries to Regulate the Use of Materials by the Lay Public." In the paper, "What Services Do We Now Give the Lay Public?" the author says, "This function is subject to certain inherent restrictions . . . we have books and journals of a highly technical nature with questionable value to the average lay person."[3] Only one librarian, from the Armed Forces Medical Library (now the National Library of Medicine), even raised the question, "What Services *Should* We Give the Lay Public?" She pointed out that after all librarians are laymen

Estelle Brodman is Librarian and Professor of Medical History, Washington University School of Medicine, St. Louis, Missouri.

themselves and felt that "the only real problem of such service from the point of view of time and ethics is presented by the layman seeking information on personal matters. The function of a medical reference service is primarily to make information available, and its educational function is secondary and limited . . . although the layman does not always realize this."[4] She then brings up the same ethical question which has plagued scientists since the first atomic bomb was exploded: "If the function of a librarian is to give information, it seems that the function of a good librarian is to give information well. The nature of his position does not give him responsibility for its effects."[5]

How far we have gone in broadening access to health sciences libraries in the two decades since these words were spoken can be illustrated by the fact that instead of scheming over ways to keep lawyers and hypochondriacs out of health sciences libraries, we are now encouraging junior college students to use the material offered them in medical school libraries.[6] More and more undergraduate students and those in the allied sciences are being added today to those allowed into the previously sacrosanct areas of health sciences libraries. The very change of name from "medical library" to "health sciences library" or "biomedical library" is an indication of broadened responsibilities.

What has happened since the MLA's symposium to change the view of medical librarians and the users of health sciences libraries? As I hope to show in the next section of this paper, these changes are due to changes in our society and in our health care delivery systems. Since health sciences libraries are mirrors of their societies, changes in the outer world cause the same changes in their reflected world.

WHO PAYS FOR HEALTH SCIENCES LIBRARIES TODAY?

With all our societal changes we have not repealed the ancient law, "Who pays the piper calls the tune." Medical libraries of the past were founded and supported by the professionals they served—the so-called "doctors' library" in the hospital was underwritten by fees from the physicians on the staff; the medical society library has a long and honorable history of being set up and paid for by a group of local physicians who banded together to purchase jointly those books and journals they felt were needed by all of them. Nursing schools provided collections and staff for the use of their faculty and students, as did medical schools, dental schools and pharmacy schools. Commercial firms in the fields of health also provided some

sort of collection of published materials for their research and marketing staffs.

Under these circumstances, it is not surprising that the collections were held tightly in trust for those who had paid for them, and that rules and regulations were made by the "owners" for themselves and to keep out the rest of the world. We who have lived in an era where the blunting of the right of private schools and private clubs to admit or refuse admittance to whom they pleased, and on whatever basis they pleased, has been going on for a generation, can look back on the restrictions to access of medical libraries and medical information with an understanding of what it was really like in the old days.

In the past two decades, however, we have seen almost all the private medical society libraries—with the notable exceptions of the New York Academy of Medicine and the College of Physicians of Philadelphia—disappear into other health sciences collections, cease to exist at all, or become fossilized collections of old and perhaps historical material, to which little attention is given and to which few readers come. Instead, public funds, especially federal monies, have become the mainstays of today's viable health sciences libraries, and federal standards have razed the private fences which successfully preserve the club-like atmosphere of the old society library.

This change of ultimate authority for the health sciences library is part of the total picture of change in medical care delivery systems. The intermediation of third-party payers for medical services in the 1960s and 1970s, such as Medicare, Medicaid, hospital insurance schemes, etc., together with the growth of instrumentation in medicine and the change in the distribution of health care, have brought about profound changes in the way in which medicine is practiced in the United States. The older private relationship between doctor and patient has been upset by the need to explain unusual treatments to peer review committees. The increasingly stern standards for hospitals set up by the Joint Committee for Accreditation of Hospitals and the federal government have necessitated the purchase of expensive equipment for use in the treatment of patients; they have resulted in bringing more patients into hospitals and clinics, rather than having them ministered to in the doctors' private offices or in the patients' homes. This, in turn, has brought into play the work of a whole group of bureaucrats required to administer the hospital or clinic, as well as specialized paramedical personnel, since large enough groups of patients

warrant such additional workers. Indeed, one of the problems of medical practice in the United States is the conflict between the physicians as physicians, and the same doctors as policy-makers through the board of control of the hospital, on which many of them sit.

Faced with the economic need to have the most esoteric equipment and the people to run it, lest the community physician and the patient himself bankrupt the hospital by going to a neighboring and competing institution, the American hospital has had to use what has been called "physician extenders" to perform many tasks previously performed by the physician himself. These physician extenders, such as MEDEX (ex-corpsmen from military medical groups), pediatric nurse assistants, persons trained in taking medical histories, record room administrators, inhalation therapy assistants, health care administrators, radiological technicians, and many others, are educated at lower levels than physicians. However, like Emerson's cook, "who, by dint of cooking the same dinner over and over again, eventually obtained perfection," such physician extenders often become more adept at performing their specialized tasks than were the generalist physicians.

CHANGES IN DISTRIBUTION OF HEALTH CARE

One reason for increases in the amount of medical care after World War II was the medical care system of the armed forces. World War II brought forcibly to the attention of millions of Americans who were drafted into the armed forces the advantage of a freely offered medical care system. When these people returned to civilian life, the national attitude toward widespread health care, paid for (at least in part) by the general populace, changed. Whereas previous to 1945 schemes for a national health system were not politically viable in the United States, afterwards they became a real possibility; and, indeed, within a decade of the end of the war they were assured a place in the national economy. Health care began to be looked upon as the right of every citizen and not a privilege bestowed on them by a gracious oligarchy.

When Medicare, the first such health scheme, was passed by the Congress, an immediate increase in the number of patients seen by physicians was evident. This resulted in greatly enlarged incomes of physicians as a whole—between 1945 and 1971 the average income of a physician in private practice in the urban midwest rose from $15,000 to over $60,000—and to a lowering of the status of the

physician in the eyes of the general public. The latter change was due to a number of reasons. For one thing, the gap between what the physician knows and what the intelligent layman knows about health and disease has narrowed considerably, even in the two decades being examined here, due in part to the emphasis on science in schools after Sputnik I. The physician could not anymore be thought of as the repository of important information beyond the understanding or knowledge of the patient. He had to step down from his position of demi-god to one more closely akin to the automobile mechanic; as a result his actions could be and were questioned by the recipients of the action. The increase in malpractice suits is one example of this.

Moreover, as the physician's income rose, he was seen less as a devoted and inspired helper (very like the clergyman), than as a normal human being with the same desires as his neighbor for the good things of this world. Just as happened during the Black Plague years, when it was strikingly brought to the attention of the ordinary man that the priesthood was composed of men like himself, who feared death as he did, who demanded higher wages for work when they could get it, and who were occasionally not above shady deals to get their ends, so the experience of many people with post-Medicare physicians led to less awe of and respect for them.

But no society of superiors and inferiors lasts long unless the inferiors agree to the decision that theirs is indeed a lower rank, and thus accept the consequences of such a position without revolting against it. As soon as the group refuses to agree to the basic assumption of their inferiority, the entire system begins to crumble. This is clearly visible in the United States in relation to the position of Blacks and women; it can also be noted in the refusal of a large segment of the population to believe that physicians had the correct answers for the ills of society—or even for medical care. The climate of the 1960s and 1970s placed many laymen on hospital and community welfare boards; much to the surprise and dismay of the medical hierarchy, these people demanded real participation in decisions made by the boards. In refusing to be silent, humble, awed nonentities placed in positions merely as window-dressing, these laymen-activists were merely pointing out in forceful terms that the status of physicians had changed very drastically in a few years. In such a situation, it would have been folly for physicians to demand special privileges in medical libraries. (In most cases, of course, libraries were too unimportant a symbol for the physicians to wish to

take a stand on this matter. Not only the physician, but the medical library had lost status over the years.)

One of the reforms for which the lay community leaders began agitating was the redistribution of medical care, so that those in urban ghettos and those in rural areas could be assured of the same quality of medical care as those in rich urban and suburban enclaves. Although they have not been very successful in reaching this goal, they have been part of the movement which led to the attempt to offer medical library service to every health professional in the country; and thus they may be said to have been indirectly one of the forces behind the setting up of the Regional Medical Program and parts of the Regional Medical Library program of the NLM.

What we have described so far are some of the changes in medical care delivery which have had impact on the use of health science libraries. These include the wider spectrum of physician extenders; the increasing use of health services due to the experiences in World War II; the changes in decision-making powers of laymen in health service delivery systems, with its new payer-payee relationship, its control by peer review, and its new breed of administrators; and the view of the physician which dropped him to that of an ordinary man as his income rose precipitously.

EXTERNAL FORCES ON HEALTH SCIENCES LIBRARIES

In the same way and as a result of the same forces, health sciences libraries were also changing. Such external causes as the anti-intellectual feeling of many legislators about academicians; the belief that there has been enough research and that public monies should not go for furthering such a difficult-to-account-for effort were freely discussed, as the pages of *Science* reveal.[7] The adage that the country should not "throw dollars at the problem" of health care; the feeling of those around the President of the United States that administrators and their goals are superior to research, humane medicine and *its* goals; the belief among large groups of the population that the lengthy expensive education of physicians and health professionals was a waste of time and money, have all led to the cutting off of funds which had been flowing from local, state, and national governments to health care and health educational institutions. In some cases these reasons have resulted in acceptance of the legislators' views by faculty in order to be sure of some continued support. Even the changing urban/rural ratio in the

country has had an effect on medical practice, since the clustering of people in the city brings both sophistication and the growth of economically viable specialist groups.

Since health research workers, educators, and students tended to be the best and largest group of users of health care libraries, this change of emphasis has had effects on the everyday work of these libraries. But, in addition, entirely new groups of people have entered the health "business," which now accounts for one-fourth of all the goods and services produced in the United States, so that a sociologist wishing to study the single institution which has the widest array of diverse groups of people working in it can profitably turn to the hospital for his universe.

These new groups of people also blur the traditional separation of health sciences library users into scientists, engineers, and technicians, because many of them act at different times in different ways, and some act simultaneously, on two or more levels. Beyond that, a new kind of use—that made by an administrator, i.e., by a director of a large enterprise—has become increasingly important as the health sciences institutions have become bigger and more complex. Such a person is a generalist *par excellence,* who uses details only to synthesize their consequences; and who brings different problems to the library than did those who were looking for scientific-technical information only.

These changes in (1) the educational background of the many groups now needing health sciences literature, and (2) the subject areas which must be stocked, as well as (3) the forms in which the literature (and education in general) is presented have caused serious problems for whose solution the health sciences profession is still searching. While these new uses are coming to the fore, however, the problems of the health sciences professional who is a nonuser of libraries still await attacking.

Put another way, whereas in the past the medical librarian could expect a fairly homogeneous group of readers who were used to reading and who knew the subject matter in the books and journals far better than did the librarian, now the situation has changed drastically. To serve all the differeing groups involved in health care delivery today, the health sciences library must stock material of all levels of sophistication and in many forms; and to many of the users (or potential users) the librarian is at least as knowledgeable as the reader in the subject. This has the effect of forcing the librarian to make many more value judgments than he has been willing to do in

the past, and to become the interpreter as well as the supplier of information.

Users go to health sciences libraries for a variety of reasons. The majority go for the solution of some particular problem, although they go there generally only after personal contacts have not furnished the answer needed. Study after study has shown that the usual course of action of a problem-oriented practitioner is to ask his colleagues and peers first, especially the one person in the group whose past record of knowing the answers is good. Such a person can be considered a "gatekeeper" who directs others onto the right road from his own experience and knowledge. Only after this source fails to find the answer does the practitioner with the problem seek more formal means for solution. If all else fails, he will go to the library. Even there, however, he wishes only an answer, not a thorough review of everything that has been said on the subject.

Those engaged in research, on the other hand, seek out the literature much more frequently and for at least two reasons. They, too, may be trying to solve a particular problem encountered in their research; but more often they are trying to find previous work in their field so that they do not unknowingly duplicate it, but can build on earlier work in their efforts to add to the store of man's knowledge. For them all the sophisticated keys to the literature which provide a deep and widespread conspectus of the past are useful.

Most people in the health sciences also keep up with their field by subscribing to one or more journals in their field, in which they browse for general knowledge and suggestions, although the influx of people in the allied fields with less education and less of a tradition of such reading has resulted in a diminution of this use of the literature.

Much more serious than this, however, are the numbers of health sciences personnel who never use formal means of access to what is known or being uncovered in their field. It used to be said, for example, that rural medical practitioners and those in community medicine (as opposed to academic medicine) did not use the literature because they had no easy access to it. As a result, over the past twenty years the federal government has been trying a variety of ways to bring to any health sciences practitioner anywhere the store of knowledge in even the most sophisticated of our libraries. The first attempt took place in the 1950s with the passage of the Hill-Burton Act, which provided funds for hospital buildings. Here

money was made available for erecting and furnishing a small library area in each hospital, on the assumption that if such a library were available, the health professionals in the hospital would use it; later access to these libraries by any practitioner in the community was emphasized.

The RMP, a decade later, also attempted throughout its work to bring the knowledge available in the medical centers of the country directly to the physician and other health professionals at a distance from these centers. To that end it provided free closed-circuit television programs, peripatetic lecturers, pilot studies, consultations, education through Dial-A-Subject tapes, free telephone service to the central points, and library services at will. Because the RMP was much more decentralized than most federal programs, it is difficult to get a picture of what was done throughout the country. Certainly some areas were more successful than others in their work, for a variety of reasons, and this was true of the library components as well. Another article in this issue discusses this matter more fully, but it is probable that the conclusion will be drawn after all the evidence is in, that the health sciences practitioners' mode of using libraries was not much changed by the work of the RMP.

The other massive attempt to provide health sciences information through libraries to all practitioners was mounted by the NLM through its Regional Medical Library network. Again, one needs more complete data before absolute conclusions can be reached; but an *a priori* observation might well be that this program strengthened the work of all health sciences libraries throughout the nation, without bringing in many new users of the systems which had developed over the years in medical libraries. As has been shown[8] new and innovative efforts, such as MEDLINE, have been used primarily by research workers and only secondarily by clinicians, for which presumably the system was designed.

The problem which remains now is to develop means of providing health sciences information to those who need it but do not use the formal library means now in existence. Services which have been developed in the past are obviously not fulfilling the needs of a large group of practitioners. Until new services are devised, the influx of heterogeneous health sciences library users can only mean a dilution of the means developed over the years to help the research worker and the academic clinician, without actually aiding the health sciences workers who need, more than ever before in a rapidly

changing field, to keep up with new advances and to use libraries for problem-solving. How to do this and especially how to do it without massive infusions of federal funds are the challenges of the next two decades.

References

1. Billings, John Shaw. "Medical Bibliography," *Transactions of the Medical & Chirurgical Faculty of Maryland.* 1883, pp. 58-80.

2. "Service to the Lay Public," *Bulletin of the Medical Library Association,* 43:241-62, April 1955.

3. Clark, Gertrude M. "Service to the Lay Public. IV. What Services Do We Now Give the Lay Public?" *Bulletin of the Medical Library Association,* 43:255-56, April 1955.

4. Chambers, Jacqueline L. "Service to the Lay Public. V. What Services *Should* We Give the Lay Public?" *Bulletin of the Medical Library Association,* 43:257-58, April 1955.

5. *Ibid.,* p. 262.

6. Brodman, Estelle. "Delivery of Medical Information in the 1970s," *Bulletin of the Medical Library Association,* 59:579-84, Oct. 1971.

7. See for example: "Mental Health: NIMH Reeling over Proposed Budget Cuts," *Science,* 180:284-85, April 20, 1973; and "New Energy Message Downplays R & D," *Science,* 180:475, May 4, 1973.

8. Washington University. School of Medicine. Library. "Experience with MEDLINE over 15 months," *Annual Report, Supplement.* St. Louis, 1973, pp. 81-94.