Toward Hospital Library Standards in Canada*

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ABSTRACT

A report is given on Canadian hospital library standards as recently developed and incorporated in a new *Guide to Hospital Accreditation, 1977*. The new Canadian standards are compared with MLA recommendations to the Joint Commission on Accreditation of Hospitals. Their development is sketched and the contribution from Quebec of a model of hospital classification is examined. This model provides differential minimal library standards based on the function of the hospital rather than on its size alone. Use of these minimal standards as a practical means of developing hospital libraries is discussed and their implications for accreditation visits are underlined.

THERE is one point which we must all understand. It is a very simple point, but like all simplicities, it comes over us with something of a shock. Right from the beginning we must realize that librarians are the only ones who really understand libraries. Or, to put it the other way around, we must begin discussing hospital libraries by grasping the fact that no one we deal with in any hospital will understand much of what we are talking about. They will think they do, but there is an unspoken difference in concept which shadows every discussion of information services between librarians and hospital personnel, at all levels. And that is why we need standards for hospital libraries: spelled out, black-and-white, count-'em standards.

The need for something concrete, down on paper, about hospital libraries is not a new discovery. For the past twenty years those people who have been involved with running hospital libraries, and with trying to improve them, have been working in various ways and with various groups to spell out what they are trying to do. But the process of defining has been hard going, and the disagreements have been heated. As a result, most of the summaries that these various committees have been willing to release have made broad general statements, leaving the specifics to individual interpretation. And so the debate goes on.

In 1970 the American Library Association published a set of standards designed to cover both staff and patient libraries in hospitals [1]. In 1972 the Library Association of Great Britain published a similar statement [2]. Both these publications were updates of previous attempts; and in both countries the administrative framework was already developing for regional cooperation among libraries in the medical field. The statements incorporated this idea.

NEED FOR CANADIAN STANDARDS

However, in most places in Canada, there is still neither legislation nor financial support for coordinated library services. For a long time medical librarians in each province have been muttering about their own special needs for a statement of hospital library standards to support their suggestions to the administrator of the hospital each librarian is trying to serve in virtual isolation. The problem was discussed repeatedly at meetings of Canadian librarians at the Medical Library Association, at meetings of medical librarians at the Canadian Library Association, and at annual meetings of the Associate Committee on Medical School Libraries of the Association of Canadian Medical Colleges (ACMC). Finally, Sheila Swanson, Librarian at the Academy of Medicine (Toronto), accepted the challenge and called together a Working Party early in 1973.†

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†Members of the Working Party besides Mrs. Swanson, who was at that time Chairman of the Health Sciences Section of the Canadian Association of Special Libraries and Information Services (CASLIS), included Mrs. Beatrix Robinow, Health Sciences Librarian at McMaster University, Hamilton, Ontario, and Past Chairperson of the Associate Committee of ACMC; Miss Jane Wachna, then Librarian of the Canadian Hospital Association, Toronto, Ontario; and the author, then Librarian for the Ontario Medical Association, Toronto, Ontario.

The rest is history. A year and many drafts later, a Canadian version of hospital library standards was presented to the Associate Committee of the ACMC. This draft had wrestled particularly with two major problems characteristic of the Canadian situation. One of these was the isolation of individual hospital libraries, the majority of which were not working in any sort of conjunction with other libraries; the other was the extreme difference in the information requirements of different kinds of hospitals.

The crux of these problems seemed to be the method of defining the differences between hospitals, which were not entirely differences of size. The traditional designation of a hospital by the number of its beds was not helpful when two hospitals of the same size had developed strong departments in entirely different fields, or when one was accredited for residents and interns, and the other was not. The solution came from an impeccable Canadian source.

In 1968, while other groups of Canadian medical librarians were still discussing the problem they faced, a committee of l'Association canadienne des bibliothécaires de langue française made a study of hospital libraries in Quebec and produced a set of standards [3]. Their hope was to spark some interest among professional library groups in Canada, but their draft did not circulate as widely as they had wished. Nevertheless, those who did see their standards realized that this Quebec committee had hit upon a new way to measure the information needs of a hospital. It had taken account of the extent to which a hospital was involved in teaching various levels of personnel and had used this as the basic criterion for assigning information requirements. The new measure seemed to make it relatively easy to gauge the extent and depth of the collection needed and the type of personnel required by any given hospital library. Combined with a number-of-beds measure for the smaller, less-complex facilities, the measure from Quebec became the basis for standards worked out by the new Canadian Working Party meeting in Ontario at the suggestion of their academic colleagues.

Acceptance of Canadian Standards

The Associate Committee of the ACMC accepted the draft of *Canadian Standards for Hospital Libraries* from the Working Party and circulated it for comment, during 1973 and 1974, among colleagues in all the provinces across Canada. The reports were favorable, although librarians in the province of Quebec were alarmed by one characteristic of the new *Canadian Standards for Hospital Libraries*. The objective of the Working Party had been to lay down a baseline, and the Quebec librarians wondered whether such minimal guidelines would be mistaken for optimal ones by hospital administrators and government officials who were not entirely aware of the implications. They were afraid that if this happened, such officials might create difficulties and withdraw support for the good libraries already in existence.

Nevertheless, after considerable dialogue, the *Canadian Standards* were accepted in principle and passed on to Canadian medical library groups in the Medical Library Association and the Canadian Library Association. Only after the *Canadian Standards* had been accepted by the entire community of medical librarians was the draft presented to the next most-interested professional group in the medical field.

In Canada it is traditionally the medical staffs who have worried about the caliber of the medical libraries in their hospitals. In fact, they have often put down their own money to improve the situation [4]. In every Canadian province medical societies, departments of continuing education at medical schools, and colleges of physicians and surgeons have made themselves responsible for library services in their own community hospitals. In Ontario, the Ontario Medical Association maintains a Committee on Medical Library Services, which for nearly ten years has supported a medical librarian in the field to act as a consultant for hospital libraries. In 1974 the final draft of *Canadian Standards* was presented to this committee, which studied it in considerable depth. Their recommendation went for endorsement to the Board of Directors of the Ontario Medical Association, and then on to the Board of Directors of the national body, the Canadian Medical Association. Having been accepted there and also by the College of Family Physicians of Canada [5], the draft was published in the *Canadian Medical Association Journal* [6]. At the same time, a copy was forwarded to the Canadian Council on Hospital Accreditation, which was in the middle of revising its *Guide to Hospital Accreditation.*

Canadian Standards Compared

There are some unique features of this version of hospital library standards, and perhaps the best way to illustrate them is to compare briefly this Canadian version with the revision of the *JCAH Standards* developed by an ad hoc committee of the Medical Library Association at about the

same time [7]. First, it may be wise to point out that regionalism in medical library services is still largely a pious hope in Canada. The idea has never received any substantial financial support from either the federal or the provincial governments, as it did in the United States. In 1969 the Ontario government did publish a beautiful blueprint [8], but it has never been implemented. In British Columbia the government was moving toward a regional system for medical information until it was turned out of office about a year ago. The only notably successful coordinated library service for hospitals in Canada is the British Columbia Medical Library Service, maintained by the College of Physicians and Surgeons of that province for its members.

It follows that regional medical library service, as it exists in Canada as a whole, is a grassroots effort, largely supported by those individual medical schools that recognize the need. In many places working nurses are still relatively badly served; they augment their own resources in many imaginative ways. These are some of the reasons that the statement on the *Canadian Standards* has been made with reference to hospital libraries as individual units, rather than as parts of a cooperative effort. It is also for these reasons that the Canadian statement refers to a relatively unsophisticated type of hospital library.

It might be illuminating to remember that both the Canadian and the MLA/JCAH documents were put together against a background of actual hospital practice. This means that the two sets of standards were written, in some respects, as manifestos against the worst practices currently in effect. In both documents, the declaration that the hospital library should be organized as a department of the hospital, with its own budget funded by the hospital, should be understood as one of those manifestos, as should the corollary that a qualified medical librarian should manage the library.

It may not be so apparent that the call for provision of professional supervision for inadequately trained library attendants is much closer to reality in the American context, where consortia are developing. The Canadian reality provides neither the regional mechanism nor the trained manpower that is available across the border. This may be one reason why it has been a Canadian community college which has organized the first program on the continent designed specifically to train medical library technicians [9]. In any event, in the current climate the Canadian insistence on this principle of professional supervision of hospital libraries is a genuine exercise in hope.

The Americans, in spite of the fact that they call for a professional librarian—who should know how to run a library—spell out in much greater detail than the Canadians just what the librarians ought to be doing. It is hard to say whether this is meant to educate the hospital administrator and the advisory committee, or whether it is put into words because there are still so many places where these activities are not carried through, even by a "qualified" librarian. The advisory committee itself is assumed by both groups to have the responsibility to work with the librarian to develop policies and procedures which will benefit the hospital. The Canadians go on to point out that this committee can also go a long way toward smoothing the path for cooperation between the library and the rest of the hospital.

Among the forces which shape the collection in a hospital library, the MLA document lists the services that the hospital library offers, the information needs of the users, and cooperative arrangements with other hospitals. This last is not emphasized in the Canadian version, which merely suggests that better document delivery can be achieved through interaction with other libraries.

Basic services are stated in much the same way in both documents, but the prevalence of less-sophisticated services in the majority of Canadian community hospitals is well illustrated by the guideline that information should be provided "well beyond immediate patient care requirements." Computerized services are not even mentioned.

The two documents end on curiously different notes. Perhaps because of vigorous efforts to develop regional networks and consortia, our American colleagues are acutely aware of the woeful lack of consistent statistics on information services from hospital to hospital, and the American document ends with a call for written records. The Canadians, on the other hand, conclude their document with a series of three appendixes [10], which spell out the minimum requirements for hospital libraries implied by their statement on standards. In these appendixes the authors offer categories for the several types of hospitals, as suggested by the Quebec librarians [11]. To these categories they assign specific minimum staff and specific minimum levels for their collections. They also include some rules of thumb for planning space requirements and a list of basic references that are particularly useful in

Canada. For a working librarian these appendixes are sheer gold dust.

Progress of Canadian Standards

The *Guide to Hospital Accreditation, 1977* was published last fall by the Canadian Council on Hospital Accreditation, and the section on Staff Library Services has been intensively revised [12], largely in accordance with the draft of the *Canadian Standards*. To the great relief of medical librarians in Canada, the council accepted the idea that a library should be a separate department with its own budget funded by the hospital, and that it should be under the management of the librarian. The suggestion that a regional service might provide professional supervision for an inadequately trained hospital librarian was not deleted; and the suggestion of an interlibrary loan network also stayed in. At the moment in Canada, as we have mentioned, no regional arrangements for health sciences library services are functioning, except in British Columbia, where the doctors look after themselves. Canadian interlibrary loan networks exist primarily in connection with some of the larger medical schools. Under Beatrix Robinow, for instance, the Health Sciences Library at McMaster University has provided Canada with an outstanding demonstration of what could be done regionally, by developing such a network in the Hamilton district [13]. In addition, the new accreditation *Guide* articulated for the first time the need for work space for the library staff and study space for the users. This was the first concrete move away from a closet of books with the word "Library" on the door. As a matter of fact, in the new *Guide* the staff library has emerged, for the first time, as a real place.

Appendixes from the Canadian Standards

However, the format of the *Guide* did not allow for the appendixes which had been attached to the draft of the *Canadian Standards,* and they were abandoned. This is unfortunate, because the appendixes were highly practical. They put in concrete terms basic quantities of books, journals, and square feet, which could be translated into dollars and cents. Hospital administrators understand dollars and cents, and they are remarkably agile at working back from financial statements to an understanding of the library concept being projected.

Since only minimums can be legislated, the appendixes of the *Canadian Standards* established a graduated scale of minimum collections, minimum staffing, and minimum space requirements. These were assigned to hospitals according to type of facility. The various kinds of hospitals were divided into categories which attempted to take into account the size of the hospital, the complexity of its organization, and its responsibilities for training not only medical personnel but other staff as well.

The categories number five; and Category One for teaching hospitals sets the scale for all the rest. It includes the following characteristics [14]:

1. The hospital is affiliated with a faculty of medicine of a university.
2. It is accredited for internship and residency in various specialties.
3. It maintains research projects.
4. It has a medical staff of at least 200 physicians, residents, and interns, and appropriate supporting staff.

By this scale, of course, teaching hospitals require the most extensive collections and the largest staffs, an obvious fact. But the minimums cited are actually far below the standards achieved by the majority of well-known Canadian teaching hospitals. Therefore, in a Canadian teaching hospital, any library that barely meets the minimum standards laid down in the appendixes is really below the general standard, and the need for money and planning to effect improvements is self-evident. This may be a negative value, but it is a concrete measurement which hospital authorities can understand.

Uses of the Appendixes

This scale is, indeed, only one of the values to be found in a short form such as the appendixes, which compile a few working rules into half a dozen pages. Such formulas are useful tools for the health sciences library community as a whole, even though many items are debatable and all must be revised repeatedly. They should be kept in print as working papers. The place to work out the revisions is in the field, where hospital libraries are being overhauled, and where planners, administrators, health personnel, and librarians are arguing every step of the way. Norms which start as a handy talking point should be justified, or modified, in action. A vigorous tug of war between theoretical values and the realities of a hospital should result in a streamlined information service, one that has a vital role to play in the hospital because it is designed to deliver the type of

information the hospital really needs in a form it can use.

The potential advantages of specific minimums in hospital library management are many. Most library committees are too busy to work their way through a complete rationale for library service. If they have been convinced by an accreditation team or a continuing education enthusiast that a library would be an asset for the hospital, they want to get on with it. They want to know what goes into the library—never mind why.

Because the general understanding of libraries by people in the medical field is hazy and the dynamics of library service are barely understood, concrete numbers—of square feet, adjustable shelves, video cassette players, and professional journals, for example—can be substituted for explanations. These figures are comprehensible, and when they are itemized in terms of dollars and put in a package with a salary range for personnel, a hospital administrator is much better able to deal positively with the proposal. It is the ambiguity of a library, the vagueness of its requirements, and the apparent anonymity of many of its services that defeat plans for renovation or expansion. They seem insubstantial. A library committee involved with facts and figures is more likely to stay around to develop its dual role of advisor and facilitator as the library evolves into a productive operation.

Of course, when the dollars begin to exhaust an acceptable budget level, the time has come to suggest cooperative library services and cost sharing with one or more hospitals nearby. In Canada this idea is more acceptable when it is approached for the first time in monetary terms, even though regionalism is the gung-ho word in Canadian urban planning, as it is everywhere else.

The point is that facilities for continuing education and patient care information are considerably easier to sell when they are presented as a cost package rather than as a service package. The service package sounds vague to anyone unfamiliar with the dynamics of a library. The ultimate argument is always, Does it save lives? In spite of all a librarian's convictions, only the cost package sounds real to administrators. And a library service package may be bought for the hospital as an amenity, without any real understanding of its value. That will come later as a surprise. It is rarely possible to prove the value of the library before the fact; such an approach results in inadequate funding every time.

Recently, a survey of hospital libraries was undertaken in one of the largest provinces of Canada by means of a mailed questionnaire. The purpose of the questionnaire was to document the number of libraries in hospitals throughout the area and how extensive the libraries are. There had been no previous record, for instance, that more than four hospitals out of five actually did have a "library."

The statistics which accompanied the returns were, however, dismaying. Convinced that an ineffectual library in a hospital is not necessarily an improvement over no library at all, the committee compiling the survey report took the time to compare incoming statistics on these hospital libraries with a set of minimums derived from the appendixes of the *Canadian Standards*. The results were quite graphic. Category Three is a sample to cite [15]. This category is two grades less demanding than the role of libraries in teaching hospitals. The libraries in this class are all to be found in large active-treatment community hospitals, which may be complexes of many different departments but are not necessarily affiliated with a university medical school and are not running research projects. The libraries might be expected to be large enough to require at least one professional librarian full time. In this group the returns were 92%. Of these, 37% of the collections of both books and journal subscriptions fell below the minimum standards; 50% of annual purchases of books for the collections were below the minimum advisable; 58% were operating on barely adequate budgets; only 54% were adequately staffed; and in 29% of the hospitals the nurses had found it necessary to operate their own information services independent of the central library. This kind of information may be discouraging, but it also presents a situation that can be tackled. And although the librarians themselves may be well aware of such deficiencies, it is difficult to alarm anyone else without concrete norms to measure against.

Aftermath of Canadian Standards

As a result of the publication of the *Canadian Standards* and of the response of the Canadian Council on Hospital Accreditation, Canadian health sciences librarians today have much stronger criteria to back their arguments than they did a year ago. The next step is to test the minimum standards published in the appendixes by using them as a rule of thumb in promoting hospital library development and in planning library services. The testing that has already been done has shown that the minimums need considerable adaptation in their application. The requirements of psychiatric, convalescent, and

other specialized hospitals call for somewhat different norms. It is becoming more obvious than ever that a good deal of experimentation in collecting statistics will be necessary to outline these differences.

Teaching hospitals have unique requirements also, as we all know, and perhaps a graduated set of minimum standards should be developed especially for them. Besides their broad responsibilities for training and research, their patient care problems are often extremely complex. In addition, in Canada they frequently acquire a mandate to serve a large medical community in the surrounding area out of their information resources. Library standards set at a bare minimum prove to be quite meaningless in the face of a good collection which already serves all these masters to some extent. Perhaps minimum standards for teaching hospitals should be based not only on the place of the teaching facility in the total hospital complex, but also on the length of time they have carried certain types of responsibilities—a sort of first, second, and third gear.

Finally, as important as it is to articulate hospital library standards, it is even more important to make them stick. Here again, the general lack of understanding of the dynamics of good library service does us in. There is as yet no evidence that the accreditation of any particular hospital will really be affected either way by the caliber of its library. The Ad Hoc Committee of the Medical Library Association has suggested that orientation presentations on library services become part of an accreditation surveyor's training. To this Canadians can say only: Hallelujah!

It seems legitimate to wonder aloud, also, whether there might one day be a hospital-library survey team. Or whether a circuit-riding library consultant might be available as an accreditation backup service, to act as an advisor to any hospital which has received recommendations on its library from the surveyors.

Certainly there are a great many facets of a hospital that the surveyors (or, as they are called in Canada, the accreditation team) must understand. Surely one item could be made easier for them to handle. At the very least, the mysteries of the library might yield to a set of tables which outline minimum performance standards for the surveyors to check off in addition to consulting their current manual. Such a list would seldom be entirely accurate; it might need upgrading often; it would certainly be controversial. It should be possible, however, for us to outline a bottom-line cluster of statistics for each type of hospital that would spotlight recognition, even by a non-librarian, that any library with less assets than this would simply never work.

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