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ABSTRACT

The three papers presented at the Program Meeting of the Interagency Council of Library Tools for Nursing at the 1969 Convention of the National League for Nursing are: (1) Library Service for the Hospital Nurse by Jane M. Fulcher, (2) Library Service for the Public Health Nurse by Eleanor F. Lefson and (3) Health Services Libraries as a Community Resource for Health Personnel by Joan M. B. Smith. (MF)

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QUALITY CARE--COMMUNITY SERVICE--LIBRARY SERVICE

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Of the Interagency Council on Library
Tools for Nursing at the 1969 Convention
Of the National League for Nursing

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THE LEAGUE EXCHANGE

The League Exchange was instituted as one means for the sharing of ideas and opinions. Many other means are, of course, available--notably, biennial conventions, national and regional conferences, and meetings of state and local leagues for nursing. Further opportunities for the exchange of knowledge and information are afforded in Nursing Outlook, the official magazine of the National League for Nursing, and in other professional periodicals.

It is recognized, however, that the time available at meetings and the pages of professional magazines are limited. Meanwhile, the projects in which NLN members are engaged and which they should be sharing with others are increasing in number and scope. Many of them should be reported in detail; yet, such a reporting would frequently exceed the limits of other media of communication. The League Exchange has been instituted to provide a means for making available useful materials on nursing that would otherwise not be widely available.

It should be emphasized that the National League for Nursing is merely the distributor of materials selected for distribution through the League Exchange. The views expressed in League Exchange publications do not represent the official views of the organization. In fact, it is entirely possible that opposing opinions may be expressed in different articles in this series. Moreover, the League assumes responsibility for only minor editorial corrections.

It is hoped that NLN members will find the League Exchange useful in two ways: first, that they will derive benefit from the experience of others as reported in this series, and second, that they will find it a stimulus to the dissemination of their own ideas and information. There are undoubtedly many useful reports that are as yet unwritten because of the lack of suitable publication media. NLN members are urged to write these reports and submit them for consideration for publication as a League Exchange item.

To the extent that all NLN members draw from, and contribute to, the well of nursing experience and knowledge, we will all move forward together toward our common goal--better nursing care for the public through the improvement of organized nursing services and education for nursing.

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LIBRARY SERVICE FOR THE HOSPITAL NURSE

Jane M. Fulcher

What puzzles the hospital nurse? What wishes for information run through her mind? To get at least a partial answer, we put the following question to about one hundred of our nursing service people at the Washington Hospital Center: "If you had at your nurses' station a magic box that would immediately give reliable answers to any questions you asked it--in your role as a nurse--what are some of the questions you might have asked in the last few hours?" Here is a sample of the responses:

What is Zenker's diverticulum?

Did Mrs. Wilson have blood drawn today?

What symptoms do you look for first in staphylococcus infections?

Give me information on cirrhosis of the liver.

What are the tests you give for cancer?

What nursing care do you give a patient with split thickness skin graft?

How do you deal with an overanxious family in order to reassure them in the best possible way?

Medication is ordered IM and can only be given IV!

Where is the orderly?

Do parents have insurance for a newborn automatically? When the newborn needs hospitalization for longer than three days, does the insurance cover it?

What is the influence of potassium on glucose-insulin metabolism?

Is there another name for the drug "Omnipen"?

Why is calcium gluconate at the patient's bedside after the removal of a thyroid nodule?

What are the signs and symptoms of carotid blowout?

Are patients really "always right"?

If when feeding a CVA patient you hear a gurgling-type sound, does it mean the patient is congested or just holding liquid in his throat?

What is the Stevens-Johnson syndrome?

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When Maalox or any magnesium-based antacid is given, why or how does it cause a lowering of the phosphorus and sodium electrolytes?

How do I work a nebulizer?

How would you answer a patient who has a breast tumor and is upset because of this and would like some reassurance from the nurse?

When will I get a raise? (This last from a nurse's aide.)

Some day, I think, the magic box will be a reality on every nursing unit. My guess is that it will accept all questions, give immediate answers to many, and refer others to appropriate sources of information, such as the personnel department, the library, or a consultant. Questions that the black box cannot answer today--without the help of consultants or the library--it will be able to answer tomorrow, because every non-trivial question and answer it handles will enlarge its store of quickly available information.

In our hospital, we do not yet have an automated medical information system. What we do have is a well-supported library plus a few books half-chained on each nursing unit, and we make it a practice to attach literature to a patient's chart at the request of any doctor or nurse.

Our library serves everyone in the hospital--and many people outside--except that for recreational books, we refer patients and staff to the volunteer department library. It provides a pleasant reading room or book-truck service to the floors. The Washington Hospital Center is a general, short-term, voluntary nonprofit hospital with more than 800 beds and over 30,000 admissions a year. The library's potential clientele consists of about 3,500 people, including--in round numbers--1,000 attending physicians, 150 house staff, and 200 student nurses, as well as varying numbers of medical students, technicians, and other employees. Most important, from the point of view of this audience, are about 550 RNs and LPNs on the nursing service staff. In 1968, we loaned almost 33,000 items for use outside the library. Student nurses are our heaviest borrowers. (I've been puzzling for years over why these girls will carry great armloads of books and journals back to the dorm rather than sit down in our comfortable, quiet library to read the few pages in each piece. Apparently, the overriding wish is to stay near the telephone!)

To find out how our loans are distributed among our clientele, we counted all the loans outstanding on a chosen day in April. To prepare for this talk, I was especially interested in how much use hospital nurses were making of the library. On that chosen day, 947 items were on loan outside the library. Of these, 112 were loans to attending staff, 115 to house staff, and 113--about 12 percent--to nursing service staff. The figures were not surprising. We see many hospital nurses in the library. Moreover, in answer to the magic-box question "When did you last go or send to the medical library?" only 14 out of 100 persons checked "not ever."

What can the nurse expect in the way of information when she walks into the library? She is not, I fear, on the threshold of "all" knowledge. We can't answer the question "Did Mr. Hines go to be X-rayed yesterday?" We don't know the answer to "Where is

the water cart?" or "Where is the orderly?" We can't explain "why the doctors can't write discharge orders early so that the patient can leave at the proper check-out time."

What the nurse does find is a threshold--or at least the front steps--to a vast amount of published literature, the best of it right in the room she enters, the rest of it more or less available by interlibrary loan from other libraries all over the United States.

Our nurses usually start with the card catalog. There you will find names of authors, titles of books, and about 1,700 subject headings directing you to books or homemade collections of articles dealing with these subjects. One of my ambitions is to have our card catalog so well developed that it will direct you toward published information on almost any medical or paramedical topic you bring to it. If you want to know what procedure is involved in a revision of scars, you will be able--in this ideal catalog--to look under Scars and find references either to the literature itself or to another heading, such as Surgery--Plastic, under which the pertinent references have been listed. In other words, this "ideal" card catalog will accept your questions almost as you have phrased them in your mind.

At present, when you come to our library, you must be ready to generalize your question. In the card catalog, you will find the headings Aspirin and Digitalis, but not Maolate. To get on the trail of this, you will have to look for a book on drugs and then search for Maolate in the index of the book itself. You will find the headings Tracheostomy and Mastectomy, but for material on cholecystectomy, you must still look under Biliary tract.

When you don't find what you are after, you should be ready not only to generalize but also to ask the librarian to help you. I want very much to know what kind of information you seek. I have often wished I could hide a little man in the card catalog to record every term you try in your searching. With this information, I could make the trail easier for the next person. Moreover, there is a good chance that I can find what you want, if not yet in our own library, then perhaps in some other local library or in the National Library of Medicine.

A library becomes stronger by being exercised and stretched. What we can't do today we may be able to do next week or next month if we know your need. A nurse from the newborn intensive care unit came in to find information on the Lucey light or bili light. We couldn't find it for her when she asked, but the information is available now. If you look in the catalog under Lucey or Bili, you will find reference to a "collection of publications about hyperbilirubinemia of prematurity and its prevention by phototherapy."

We haven't done so well in our pursuit of articles about "constant care" for terminal or confused patients. For a topic such as this, we turn to the periodical indexes, especially to Hospital Literature Index, Nursing Literature Index, and International Nursing Index. Apparently, articles focusing on the "constant" aspects of care for these patients have not yet appeared. Since we now know that the Staff Development Office is interested in such articles, we will be watching for them in new journals and will notify it if any come in.

I spoke earlier of half-chained books on the units. Most of our patient care units have a few--in some cases, a very few--reference books shelved at the nurses' station. We were slow to start this practice because we doubted our chances of keeping the books where we put them. The first ones we placed were heavily chained. Then, during a remodeling project, many of the chains were unfastened. To our surprise, the books still remained at the stations. Since then, we have been putting a short chain on each book but have been making no effort to attach it to the wall. I hope our losses will remain

small, because putting even a few books "where the action is" makes much sense.

Our third substitute for the magic information box is the program we call "Latch," which stands for "Literature Attached to the Chart." Any doctor or nurse can call the library and request a Latch by telling us the patient's name and room number, the doctor's diagnosis, and any other information that will help us to understand what is needed.

We then search out a few good articles on the subject, staple them to a cover sheet, and attach them to the chart. I would like to have them on the chart within the hour, but usually the process takes a little longer.

The number of Latches at any one time varies. At the time of writing this paper, literature was on the charts of patients who had the following problems: Amphetamine withdrawal, myasthenia gravis, possible blastomycosis, lupus erythematosus, amniotic fluid embolism, consumption coagulopathy, hepatorenal syndrome, thrombophlebitis and cancer, toxoplasmosis in pregnancy, and tubercular meningitis. Two of these were requested by nurses; the other eight, by doctors.

The literature is supposed to remain attached to the chart until the patient is discharged and then to be returned to the library. Latches that come back to us are cataloged, put in blue binders, and shelved with the books, to be readily available the next time such information is wanted.

Somewhat similar to our Latch collections are our regular collections. These are made up principally of tear sheets from duplicate journals given to us by many of the doctors. I go through the tables of contents of the duplicate journals, marking articles to be torn out and mounted by one of our volunteers. She staples the article to a punched strip that serves as an expander for the inner margin when we put it in a pressbinder. So far, we have cataloged approximately 900 of these collections and find them very popular.

At this writing, 70 of them--on subjects such as shock, burns, Guillain-Barré syndrome, ileostomy and colostomy care, and rotating tourniquets--are out on loan. On the shelves at the moment are many that would have answered some of the questions turned up by our magic-box questionnaire--group dynamics; grief, mourning, and separation anxiety; cardiac pacemakers; psychologic aspects of cancer; radical neck dissection nursing; the unconscious patient; the "difficult," or "problem," patient; and nursing audits.

Perhaps many of you come from much smaller hospitals with less active, less well supported libraries than ours. I have wondered if you yourselves could make these tear-sheet collections work for you. Doctors seem to give away numerous good journals such as the Journal of the American Medical Association, the New England Journal of Medicine, and the specialty archives. Although I think one set of all these should be kept intact with your other journals, and articles on specific subjects located through the periodical indexes, second copies might well be dismembered and the useful articles grouped into "package" libraries similar to ours.

Much literature is available and more is coming to help the small medical library. I am currently enthusiastic about an article that appeared in the February 27, 1969, issue of the New England Journal of Medicine. It is called "A Core Medical Library for Practitioners in Community Hospitals." The authors, Stearns and Ratcliff, say that the initial cost of this core library is less than $2,000 and that the whole can be placed on about 60 linear feet of shelves. They also say (and I thoroughly agree), "Essential to this development is the appointment of specifically designated library personnel."

A core library costing $2,000 or even $5,000 a year is a much cheaper answer than the magic box I fantasied earlier. However, in my opinion, the smallest as well as the largest library systems require this same contribution from you--the stimulation of your questions. Whatever the size of your present library or the current state of your librarian's competence, let her hear what you need. If we can't satisfy you from our local resources, we can turn to a larger library; the larger library can turn to a regional library or to the National Library of Medicine. If the information has been compiled and published, there should be ways of getting it.

Perhaps your need is too trivial or evanescent to warrant mobilizing the entire medical information system. Nevertheless, I would suggest that you voice it--in a "do-you-happen-to-know" kind of way. Recognizing that need for certain information exists prepares us to register that information when an opportunity arises. For example, two of the magic-box questions had to do with dehydration. I am now alerted to watch for good articles on that subject. The next time someone asks, we will probably be ready.

LIBRARY SERVICE FOR THE PUBLIC HEALTH NURSE

Eleanor E. Lefson

The more I thought about what I would tell you, the more I felt like the poker player down to his last coins when he was asked, "How're ya doin'?" "I dunno," he replied. "What? You don't know how you're making out?" "Oh, sure," said the player, "I know how I'm making out, but I don't know how I'm doing it."[1]

I am indebted to Robert F. Mager not only for this analogy but also for this simple statement: "Sometimes we know how well we are doing, but don't know exactly how we are doing it. If we knew what we were doing that was contributing to success, and if we knew what we were doing that was contributing to failure, we could do more of the one and less of the other."[2]

A seemingly quiet event during one of our regular supervisors' meetings triggered a chain reaction of thought and action. It was a simple question.

Our supervisors asked whether or not a library system could be maintained. The response, that "none is foreseeable in the near future as neither the personnel nor space is available," was admission of failure in solving a problem that was pressing.

We could admit defeat. What I could not admit was that there was no alternative. Perhaps what we were suffering from was a crisis of vision. If that were so, then a do-it-yourself version of Mager's affect analysis[3] might at least relieve the pressure. Procedurally, this includes observation, conferences, review of instructional materials, the immediate environment, and administrative practices.

What did I find? We used our library resources in two ways: (1) as definitive instructional aids and (2) as a bookshop-browsing approach to learning. The first followed principles of the teaching-learning process. The second way was wishful thinking about self-motivation.

In our work setting, the demands of the service creates a need for instructional resources of immediacy. The learner's (staff nurse's) objective is met if what she has easily accessible is brief materials, up-to-date and pertinent to the problem she is attempting to resolve. The time she allocates is used for maximum productivity rather than dissipated in a hunt through textbooks.

Illustrations that may interest you are:

1. Program Resource Notebooks. These large, looseleaf notebooks are in every health district. They have been compiled by our consultants, one for each specialty. The contents are differentiated for the use of the nurse in her own quest for more knowledge and for her use with the patients and families she serves. The contents are numbered and an ordering system has been devised.

2. Policy and Procedure Manual. The system for keeping this looseleaf manual up to the minute, devised by the Associate Director for Service, is one of our best instructional aids. When a change has been made, a memo is sent to the

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supervisor advising her of what change has occurred and which numbered pages to remove. Two copies of the revised data accompany the memo. One copy is the supervisor's "work copy," to be used as she discusses the change with her staff; the other copy is for insertion into the notebook.

3. Quarterly publication Second Glance. Each nurse receives a copy of this four-page leaflet especially geared to the current developments in any program. The items are brief and topical and provide for additional exploration by listing references.

4. Xeroxed articles. These articles are used before, after, or instead of formal inservice education sessions.

5. Studies of significance--for example, Camille Jeffers' study, Living Poor.[4] Published as an inexpensive paperbook, this is an account of "how poor parents in a housing project made and lived with hard choices and established child-rearing priorities in their own ways."

The young staff nurse confronted with poverty and its effects can hardly sort out her reactions. Reading such a study is not an additive experience but a remaking of experience. Her own needs are illuminated. Her perceptions are sensitized.

These are some of the successes. What of the failures? We have books in our central office and books in every health district. They are cataloged and we have a charge-out system. New acquisition bulletins are sent to staff. Some books are read frequently, some rarely. Gradually, some disappear, never to be located again. Keeping track of them is impossible for the supervisor in the health districts--and frankly, impossible in our central office, despite good clerical assistance. Actually, aside from a core group of references that serve immediacy needs, I believe we indulge in wishful thinking about the use of books for development of ourselves and our staff.

I say "wishful thinking" because I have become convinced that Herzberg's studies based on his motivation-hygiene theory[5] answer the perennial question, "How do you motivate an employee?" It is not by buying more books and expecting knowledge to spread by contagion, but by examining the job itself, because what a person does is the source of his satisfaction. Achievement, responsibility, recognition, advancement, growth--these are the factors that create job satisfaction. If they are present, learning needs will be self-defined as well as defined by the instructor.

I have not become so convinced of my do-it-yourself analysis that I believe it will serve all purposes. My final thought was that library science is a professional discipline with a body of knowledge and practice of its own. Although we could not add this discipline to the other disciplines represented on our staff, perhaps we could still have access to it.

What followed was a long,enlightening conference at the main library with the coordinator of the Office of Work with Adults and Young Adults and the head of Community Services. They and the head of the Department of Business, Science, and Industry plan to visit Community Nursing Services in direct consultation. They spoke of possible services--for example: (1) packets of books relating specifically to the problem at hand and loaned as all public library books are loaned, (2) discussion leaders on social issues, (3) Xeroxed materials at a minimal charge, (4) bibliographic lists appropriate to the teaching objective, and (5) films.

What took me so long to seek consultation? That is a subject for another speech on the job of the educational director today. This incident may illuminate it. Instead of leaving the library after my conference, I went into one of the reading rooms. Out of force of habit, my eye scanned the shelf of new books. The first title that caught my eye was Human History: A Race Between Education and Catastrophe. Then my eye roved over the titles of new paperbacks. This time my attention was caught by Yoga Made Easy. So you see, I still have another alternative.

References

1. Robert F. Mager. Developing Attitudes Toward Learning. Palo Alto, Calif., Fearon Publishers, 1968, p. 83.

2. Ibid.

3. Ibid.

4. Camille Jeffers. Living Poor. Ann Arbor, Mich. Ann Arbor Publishers, 1967 (first page of introduction).

5. Frederick Herzberg. "One More Time: How Do You Motivate Employees?" Harvard Business Review, Jan.-Feb. 1968, pp. 53-62.

HEALTH SERVICES LIBRARIES AS A COMMUNITY RESOURCE FOR HEALTH PERSONNEL

Joan M. B. Smith

Medicine, it has been observed, is a victim of its own success. Everyone is aware of the vast increase of scientific knowledge, the development of medical skill, and the advancement in public welfare programs. An informed public regards good medical care as a right; there is a clamor for more knowledge and greater skill and service. Profound doubt exists, however, that medical institutions as presently organized can deliver an acceptable quality or quantity of health care.[1]

The roles of those in the health care professions have changed as a result of the rapid increase of knowledge and the changing social milieu of medicine. The self-employed professional nurse of 40 years ago who performed all the nursing functions for one patient, frequently in the patient's home, has become the professional nurse of today who sells her skills to an institution for a fixed salary, performs specialized functions for a number of patients, and works with other nurses and health care personnel as a member of a team.[2]

The health services librarian also finds her world changing. She has always been employed by an institution and her horizons used to be fairly well bounded by its walls. There was always some interlibrary loan, of course, but recently the proliferation of scientific publications, the increase in educational programs for health care personnel, and the government-supported research and clinical programs carried out in private institutions have made demands on each library that have caused the librarian to seek out colleagues in the biomedical library community to share resources and competences. These changes are evident in many parts of the country, but since I am part of the Detroit biomedical library community, I shall describe our experience.

Our association, the Detroit Medical Library Group, consists of about 50 members, mostly hospital librarians, who meet approximately four times a year to discuss mutual problems and plan projects. There is a long history of association and cooperation among biomedical librarians in the area, but the Group in its present form dates from 1962. The Wayne Medical Library, the only major biomedical resource library in the area, has provided leadership that the other members have willingly accepted. They have modified their own policies and procedures when necessary and have provided data for investigations. Fortunately, the Group has a mechanism for disseminating the results of its studies in the report series of the Wayne Medical Library and Biomedical Information Service Center. If there is no way to publish such data, the value of collecting it is greatly diminished.[3]

The Group's first cooperative project was a union list of periodicals, published in book form to serve as a locating device for librarians processing interlibrary loan requests.[4] The Wayne Medical Library planned to use the facilities of the Wayne Computing Center to produce a published list of its own holdings. Production of a union list was

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suggested to the Group in 1962, and 12 members agreed to add their holdings after adapting their records to Wayne's bibliographic style. The Group also devised a cooperative method of financing the project.[5] Supplements and new editions were issued to keep the list current. In 1966, Wayne's general libraries added their serial holdings to the list.[6] Community participation has increased, and the 1968 edition listed holdings of 11 departments of Wayne University's libraries, 21 hospital libraries, a dental school, a pharmaceutical house, and selected holdings of the University of Michigan's libraries.[7]

The most obvious benefit of the list, help for librarians processing interlibrary loan requests, was not the only gain. Revising their periodical records to conform with the specifications of the union list increased the bibliographic sophistication of the librarians who participated. Most important perhaps was the knowledge that their group action had produced a valuable tool. As a result, there was increased readiness to undertake new projects.

A Union Catalog of Monographs was also produced cooperatively. Since 1964, a steadily growing number of the biomedical libraries of the community have sent to the Wayne Medical Library a copy of main entry catalog cards for newly acquired texts and monographs, thus producing a union catalog on cards. It first appeared in book form in 1966.[8] Although financial considerations may end publication of the catalog in 1969, it will be maintained on cards at the Wayne Medical Library and its information will be available to biomedical librarians of the community.

The primary purpose of these two publications is to facilitate interlibrary loan. Performance of interlibrary loan generates easily measurable data that can be analyzed to learn about the functioning of a library network. Loan policies of institutions,[9] cost of lending and borrowing at the Wayne Medical Library,[10, 11] cost of borrowing in three hospitals,[12] time taken to process requests,[13] document flow among institutions,[14] and categories of users of the service,[15, 16] have been investigated and reported. Because the purpose of interlibrary loan is to deliver documents to users, we have studied the composition of the user population. The interrelatedness of the medical community is apparent from such study. Physicians frequently hold appointments in more than one hospital and residents and interns often spend affiliations in several. As they go from one hospital to another, they encounter library service of varying degrees of excellence.

A questionnaire completed in October, 1966, showed 38 teaching hospitals in Metropolitan Detroit. These maintained 170 separate postgraduate medical programs for 1,543 students.[17] Only 33 of the teaching institutions have interlibrary loan service, so there are postgraduate medical students who at some time in their training will be without it. Also, we do not know precisely how much service is available to various user groups at the institutions that profess to give it because library policies vary widely. The hospital has become the prime site of postgraduate medical education without universally acknowledging that it has a responsibility to provide access to the scholarly record of medicine for those it accepts as students.

The practicing physician in Detroit does not fare better. In a study of library service available to members of the Wayne County Medical Society, it was found that 20 percent of the physicians of the Society did not have library service through their hospitals if library service is defined as the provision of interlibrary loan service.[18] Staff lists were then obtained from 57 hospitals in the tricounty area of Wayne, MacComb, and Oakland. Study of the lists identified 1,651 physicians who were not members of the

Wayne County Medical Society and who therefore were not counted in the previous survey.[19] Five hundred and ninety-one physicians, or almost 35 percent, were not affiliated with a hospital that provided interlibrary loan service. If we add the Wayne County Medical Society members without library service, over 1,000 physicians in the tricounty area do not have organized library service through their hospital libraries. It is true that the physician has other means of obtaining information--from his colleagues, from journals and other literature he may receive, and from the ubiquitous drug detail man. Still, the modern practice of medicine is based on a constantly increasing body of scientific knowledge beyond the ability of an individual to organize and store. The physician needs access to a library in a location convenient to him, his hospital. The hospital must accept this responsibility to a greater degree than it now does in Metropolitan Detroit.

To study library service available to practicing physicians and postgraduate medical students is only a beginning. Other members of the health care team also have information needs and fare even less well. Access to hospital libraries is regarded as a privilege, and this privilege is not universally extended. The nursing profession has experienced several kinds of library service, some far from good.[20] Sometimes, apparently out of deference to the hierarchical structure of hospital society, a separate library, usually with inadequate financial support, has been provided for nurses and nursing students. Nurses have fared better when the hospital provided an "integrated" library--that is, a library where the literature of nursing is housed with biomedical literature and the nurse shares access to it with the physician. Thus, biomedical literature may be available to the nurse at Hospital A, while to her colleague at Hospital B in the same city it is, if not a closed book, at least an out-of-bounds library. Unfortunately, since the nurse's institution is her access point to the library network, if it does not accept responsibility for her literature needs, she lacks access to the resources of the community. Beyond this, who is responsible for the literature needs of the registered nurse who, absent from her profession for a few years as a housewife and mother, now wants to refresh her knowledge before returning to work? No institution is responsible for lending her a few recently published texts, since she does not have borrowing privileges anywhere. Systematically collected data about library service to the nursing profession is rare. At present, the Wayne Medical Library is conducting a study of library services and resources available to those involved in nursing education programs and to hospital staff nurses in the Detroit area.[21]

Although we are far from the realization of an ideal library network in Metropolitan Detroit, the network concept is familiar to the Detroit biomedical library community. Hence, cooperative arrangements among libraries in a geographical region to deal with demands on literature resources beyond the capability of one institution seem quite natural. Nor does regionalism seem an unlikely way to solve some problems of the delivery of health care.

The year 1965 saw passage of two pieces of legislation that incorporated the regional approach. Public Law 89-239, the heart disease, cancer, and stroke legislation adopted regionalism as a method of making the latest advances of medical science available to the practicing physician wherever he is located. The Medical Library Assistance Act of 1965 includes the formation of regional medical libraries as one method of improving the flow of biomedical information from the point of generation to the consumer.

Heart disease, cancer, and stroke legislation hopes to reverse the centripetal tendency of medicine, which in the past concentrated so much of the national medical resources

in a few great teaching and practicing centers.[22] This is to be accomplished by the establishment of more than 50 Regional Medical Programs based on cooperative arrangements between medical teaching institutions, community hospitals, and practicing physicians. Specifics of Regional Medical Programs will vary from region to region as befits the previously existing health care resources of the communities involved. Each regional program will concern itself with the continuing education of all health care personnel. The community hospital is seen both as the center where the majority of medical services are performed and as a learning center where physicians, nurses, and allied health personnel have access to the resources of a medical library and to all the audio-visual adjuncts of modern education. Some Regional Medical Programs will include provisions for support of libraries and training of library personnel and some will rely on existing resources and on the regional programs of the National Library of Medicine.

The Medical Library Assistance Act of 1965 authorized federal assistance for the construction of libraries, training of personnel, research and development, library resources, regional libraries, and the provision of support for health science scholars and biomedical publication.[23] The Act is administered by the National Library of Medicine. Ten regional medical libraries will be formed by 1970 by granting funds to existing strong libraries with traditions of regional service.[24] The first concern of each regional library will be to act as a resource library to supplement existing interlibrary loan programs of the area. The second obligation is to provide access for the libraries of the region to Medlars, the computerized medical literature search system at the National Library of Medicine. The regional libraries will also supplement conventional reference services, provide training programs for librarians, survey information needs and resources in the region, support continuing educational programs for the health professions, and give leadership in programs of centralized technical processing.

The biomedical libraries of Metropolitan Detroit are served by the Kentucky-Ohio-Michigan Regional Medical Library. Ten academic institutions in the three states have signed an agreement to create and maintain a regional biomedical library service to be supported in part by a federal grant. Since we have 10 medium-sized biomedical resource libraries in the area rather than a giant one, each will serve as the resource library of first recourse to biomedical libraries and qualified individuals in a prescribed geographic area. Union lists of periodical holdings of all 10 resource libraries will be maintained at each one and requests that cannot be filled at the first library contacted will be referred to the appropriate one. If items requested are not held by any of the resource libraries of the region, they may then be referred to the National Library of Medicine. Our regional interlibrary loan program became operational on April 15, 1969, so we have barely begun. We already have access to Medlars through the Regional Medlars Center at Ann Arbor. The entire regional medical library program will become operational step by step.

Through exploitation of a system of strong interinstitutional relationships and the employment of an advanced technology, we hope to provide a much improved document and information delivery service to the personnel of the health care and biomedical research community.

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