

Medicus Deus: a review of factors affecting hospital library services to patients between 1790–1950

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Question: What are some of the historical societal, medical, and public health trends leading to today's provision of hospital library services to patients?

Data Sources: Literature from the archives of the *Bulletin of the Medical Library Association* and other library sources, medical journals, primary historical documents, and texts from the history of medicine form the core of this review.

Study Selection: The period of review extends from about 1790 through 1950 and focuses solely on trends in the United States. Of primary concern are explicitly documented examples that appear to illustrate the patient-physician relationship and those between librarians and their patient-patrons during the earliest years of the profession's development.

Data Extraction: An historical timeline was created

to allow the identification of major trends that may have affected library services. Multiple literature searches were conducted using library, medical, and health anthropology resources. When possible, primary sources were preferred over reviews.

Main Results: Juxtapositioning historical events allows the reader to obtain an overview of the roots of consumer health services in medical libraries and to consider their potential legacy in today's health care libraries.

Conclusion: This review article highlights early developments in hospital library service to patients. Further research is needed to verify a preliminary conclusion that in some medical library settings, services to the general public are shaped by the broader health care environment as it has evolved.

Watch also the faults of the patients, many of whom often lie about the taking of things prescribed for by not taking disagreeable drinks, purgative or other, they sometimes die. Give necessary orders cheerfully and with serenity, turn his attention away from what is being done to him; sometimes you have to reprimand him sharply and severely, and sometimes you must comfort him with attention and solicitude . . . Perform (these duties) calmly and adroitly, concealing most things from the patient. [1]

Miss Kennedy: I had a case where a man asked me if we had any information about Peoria. I told him that this was a medical library. He said: "I know, but I thought you might have something about dentistry, too." He wanted something on Pyorrhoea.

Miss Walker: I always make them bring a letter from the doctor. [2]

INTRODUCTION

If the author used the phrase "doctor as god" in conversation, readers would likely recognize the concept it exemplifies: the old and slowly dying physician-patient relationship, wherein one did not ask or argue but was cared for by a beneficent father-doctor, whose decisions went unquestioned. In their profession, librarians are nearly equally familiar with the "missionary" roots of librarianship, wherein public librarians led patrons along a path of higher thought toward improvement. If knowing this history is instructive, then considering the provision of consumer health information services in medical libraries in the context of developments in medicine and public health might also be valuable in looking toward the future.

Highlights

- This review explores major historical trends leading to today's provision of consumer health services in United States hospital libraries.
- Links are established between the practices of bibliotherapy and the early professionalization of library services, establishing librarians as subject specialists.
- Lack of recognition of the value of patient education, power imbalances between provider and patient, and the struggle for professionalism among medical practitioners limited the early role of hospital libraries.

Implications for practice

- The paper proposes questions central to a necessary discourse about the nature and goals of consumer health information.
- Lessons learned from this review suggest health information services are shaped by the broader health care environment. An examination of historical factors after 1950 is necessary to attach direct meaning to current consumer health information practices.

This review begins just before 1800, when the first medical schools began to operate in the United States, and ends before 1957, when a landmark court case ushered in the age of informed consent. The intent is to trace modern evolutions in health care in their societal context, then to place the growth of hospital library services in that context. The importance of bibliotherapy in the creation of a unique niche for medical libraries in the health care environment is emphasized. To construct a timeline, a thorough scan of all early issues of the *Bulletin of the Medical Library Association* (1911–1960) was performed, then the range of scrutiny was expanded to include resources from each era from other library, medicine, and public health publications. Because medical library development in other countries took place in contexts unique to those environments, this review is limited to the United States and its literature.

1790–1850: “MIASMIC CLOUDS” AND EARLY PUBLIC HEALTH

During the last decade of the eighteenth century, poor or nonexistent waste treatment facilities, lack of knowledge, and crowded living conditions encouraged the rapid spread of disease. Yellow fever, typhus, influenza, and cholera caused widespread mortality among an increasingly dense urban population [3, 4]. Control of epidemic disease was limited to the use of quarantines, which had begun to be enforced (albeit only during times of imminent threat). States’ rights were considered inviolable, so whatever was done was local [5]. Battlefield hygiene and medical practice was even worse, with infection acting as a major contributor to death counts during the War of Independence, the War of 1812, and the Mexican-American War [3]. However, the devastation of disease in epidemic proportions, especially among soldiers, focused attention on the need for change, and, by the early 1800s, the most affected cities had appointed boards of health, imposed quarantine measures, and otherwise had begun to take action [3].

Because cause was unknown, noncontagionists and contagionists argued for primacy (the former, who argued for the existence of “miasmatic clouds” created by rotting organic materials that spread disease, versus the latter, who felt quarantine was crucial because disease was spread by contact in some way), and the prevailing voices of power, including those concerned with the economic well-being of the cities, usually dictated the approach to public health [5]. Typical of the era, disease was considered to be the result of moral failure, with the well person presumed to be an upstanding and God-fearing citizen [5].

During the earliest years of the nineteenth century, bibliotherapy was regarded as the function of the physician, rather than the medical librarian. In 1802, Benjamin Rush recommended the establishment of a small library in each hospital whose function would be to provide for the “amusement and instruction of patients” [6]. The purpose of the educational materials

was the advancement of the patients’ educations—particularly in the areas of philosophy, morals, and religion—and no mention is made of providing medical information. Rush recommended that bibliotherapy be used for treatment and called for trained professionals to work with asylum patients. Because novels, at that time, were thought to contribute to insanity, his suggestions were primarily for the use of nonfiction books [6, 7].

Such was the atmosphere in 1844, when the first hospital library intended for patients was begun at Massachusetts General Hospital. In an historical overview, Panella notes that the term “hospital library” was actually used to designate what we might now term patient or consumer health libraries—though at that time, the functions, collections, and purposes were entirely different [8]. This first library began by providing religious and moral reading materials to patients as they left the hospital [7]. Reports from the hospital’s Library Committee record sustained collection growth and popularity. Interestingly, the library also used interlibrary loan from local public libraries to provide materials including technical, business, Braille, and foreign languages books [8].

1850–1900: THE IMMORAL ILL

Epidemics continued to rage through the country between 1850 to 1900, killing thousands: yellow fever, influenza, cholera, smallpox, typhoid, scarlet fever, typhus, and diphtheria were all widespread. In 1867, more than 3,000 people died from yellow fever in New Orleans; the following year, the same disease caused more than 13,000 deaths in the lower Mississippi Valley. It was the latter that led to the establishment, by Act of Congress, of a National Board of Health to enact quarantine and other measures. Though the board encountered tremendous political opposition due to states’ rights and personality conflicts, it did effect some changes, most notably, a marked lessening of epidemic-related mortality [5, 6].

Even after Robert Koch had discovered the cause of tuberculosis in 1882, finding effective treatment proved a far more difficult task. The disease affected the poor disproportionately, and health practitioners remained convinced that its causes were immorality, “bad heredity,” and poor sanitation. Patients were often moved to a cleaner, more disciplined setting, which gave health care staff the opportunity to teach patients about good hygiene and dietary habits [9]. Although the New York Sanitary Commission was established in 1861, the efforts were underfunded and sporadic [10]. One 1865 report cited garbage and filth piled to a depth of two or three feet along New York streets [11].

When Herman Biggs, of the New York City Department of Health, became a leading figure in the efforts to prevent the spread of cholera, for the first time the need to involve patients in their care through education was recognized. With a strong background in bacteriology [11], Biggs was ideally suited to bring about

the needed changes. He instituted mandatory notification, free examinations, nursing follow-up of reported cases, isolation of identified active cases, and, finally, the promotion of awareness throughout New York [9, 12]. Directly related to these efforts, the New York City Henry Street Nursing Service began in 1893 to provide nurses who taught hygiene, infant care, and the care of tuberculosis patients by their families [6].

Throughout the last years of the 1800s, and with the shift from what had been a largely rural population to more of an urban one, labor disputes and civil unrest signaled growing dissatisfaction with a widening gap between the new social classes. Riots and strikes by an increasingly angry populace brought change, including the eight-hour workday, child labor laws, and worker's compensation. Awareness of a growing disparity between technological, economic growth, and lagging public health services sparked new social reform movements. Middle- and upper-class women began to join social change movements, including those concerned with salary reform, suffrage, temperance, and public health education, and worked with the newly established school nurses and well baby clinics to educate mothers about breast feeding and infant care [5].

Beginning in the mid-1800s, medical inventions began to appear on a more frequent basis, though for the most part, they were initiated in Europe because American medical schools were less than productive. With 40,000 doctors in the United States by 1850 [13], it would seem that the country's citizens were well cared for, but medical education itself was far from ideal. Encouraged by the early shortages of doctors, some practitioners found it lucrative to supplement their income by starting their own "medical schools" (which could consist of a one-room office and one practicing physician) where students could attend subscription lectures and then graduate to practice having had little hands-on experience. Even the larger and more reputable venues for medical education were inadequate: Harvard Medical School's 1870 medical exam consisted of nine professors questioning the degree candidate for five minutes each [3].

In a widely read medical etiquette manual, *The Physician Himself*, published in 1881, C. W. Cathell recommended practices that included concealing facts from patients, using misleading terms for medications (for example, "kalium" instead of potassium), and calling diseases something other than what they were. The rationale for such practice was the widespread belief that the relationship of trust between physician and patient—and hence, the therapeutic efficacy—depended on the patient's ability to put his or her health entirely in the doctor's capable hands [14]. The presence of hope was viewed as central to the effectiveness of a cure: active avoidance of the disclosure of the patient's condition was most desirable. As Bartlett noted [14], it was not entirely unknown (though rare) that patients would question or even challenge their caregivers—much more so, he states, than was common in Europe, where the authority of the practitioner went

without question. This might have been due to the lack of respect for physicians in American culture [15, 16] and to the lack of medical certainty, as well as the widely publicized negative accounts of bad practices. In general, distrust of medicine by the lay public was very common and not misplaced: "It was not until about 1910 that a patient consulting a doctor had a better than a 50–50 chance of benefitting from the encounter" [16].

The prevailing model of the physician-patient relationship may have led to the rationale, in bibliotherapy, that distraction from illness was most desirable and that the provision of salutary materials tailored to the patient's mental and physical status functioned therapeutically in healing the patient. By 1880, the Massachusetts General Hospital, where the first hospital library was begun, had started to permit the circulation of religious and moral reading materials while patients were still in the hospital, rather than sending them home with the patients upon discharge, as had been the practice. The 4,000-volume collection also included works of "fiction, travel, biography, poetry, and history, works in sixteen foreign languages and twenty popular magazines" [17].

The hospital library's connection to bibliotherapy began in the mid-1800s, when John Minson Galt published *On Reading, Recreation, and Amusements for the Insane* [16], thought to be the earliest writing on the topic. In it, Galt recommended titles useful to patients with particular problems and provided guidelines for bibliotherapeutic work. It is with bibliotherapy that librarians first began to provide direct assistance to patients on a more than casual basis. During his tenure as the superintendent of the Eastern Lunatic Asylum of Virginia, Galt saw no problem with permitting patients access to books not only for the purpose of "moral therapy," but for entertainment. He became well known for his advocacy of patient libraries in asylums and was often a featured speaker on the topic of bibliotherapy. Supervision of the library was performed by an assistant physician, so that records could be kept of the patients' reading, with all records made available to the asylum's director. Brief mention is made of a librarian, but no specific recommendation is made for a trained staff member.

1900–1950: TWENTIETH CENTURY DEVELOPMENTS TO 1950

By 1902, the program of awareness begun to control tuberculosis had grown to become the country's first mass education campaign whose focus was on a particular disease. The association created during this effort, known as the Society for the Prevention of Tuberculosis (now the American Lung Association), was first of many such efforts [9]. Following this example, others began to promote maternal-child health and prevention of heart disease, cancer, and many other diseases and conditions, spawning today's proliferation of associations focused on prevention and public education [14].

Still, there was much room for improvement. Political support for public health was further boosted by the realization, at the onset of World War I, that many conscripts were physically or mentally unfit for service. Coupled with the devastating influenza epidemic of 1916 to 1918, the need for public health education was increasingly viewed as a key to change. During this era, patient and public health information was published and distributed not only in English, but also in German, Hebrew, and Italian. Even with the changes in public health, however, conscription examinations for World War II in 1939 revealed that many young men were still unfit for service [5].

An important contributor to the expansion of public health involvement was the Committee of One Hundred on National Health, whose purpose was foreseen as nothing less than the control of preventable illness. Led by J. Pease Norton and Irving Fisher, the committee gathered its "One Hundred" from among the leading figures in public health, medicine, social policy making, business, politics, labor, and agriculture to assess current problems and recommend changes. Recommendations made to the National Conservation Commission included school health programs, research in preventive health, provisions for the collection of vital statistics, and mother-baby care—an ambitious agenda that became the foundation for public health in the early 1900s [9]. Additionally, the committee recommended that the government should "provide for the dissemination of information" to the general public just as it provided information to farmers about conservation and animal husbandry, making the comment that one of the purposes of the committee should be to "lay to rest claims that animals were better cared for than humans" [18].

If the primacy of Western medicine had become entrenched by improved medical education and a movement toward licensure and standards for health care, federal involvement between 1900 and 1950 further supported that predominant voice. Public health itself—particularly the efforts lent to preventive medicine—began to lose political support, with the result that far more money was expended on curative than on preventive medicine, a trend that would continue [11]. The 1921 adoption of the Maternity and Infancy Act, known as the Sheppard-Towner Act, by the United States Congress matched state funds for creating public health initiatives to prevent child mortality by providing prenatal care and teaching mothers about child hygiene and care [14], though opposition to this program by increasingly powerful medical voices brought about its defeat by 1928. School health programs supported by public health were also regarded with distrust by many health care professionals, who saw such practices as interfering with their own [5].

By 1946, the leading causes of death were heart disease, cancer, and accidents, bringing increased focus on chronic disease [5]. In 1946, the passage of the Hill-Burton Act provided funds for new hospital construction, so that health care services were more accessible for all citizens [5]. This improvement also brought

about change in the social functioning of rural areas and small towns, which were transformed from communities whose churches, extended families, and neighbors shared home care for the sick, socialization of the young, and support for those in crisis to communities that increasingly relied on this new presence in their midst [11].

Both public health and medicine, as in the late 1800s, continued to emphasize the individual's responsibility for healthy living, with the failure to be healthy seen as a result of their refusal to comply with standards. Instead of working to improve sweatshop conditions, medical professionals counseled the public to desist from spitting on public sidewalks, and, rather than working to clean up and enforce housing standards in tenements, they taught mothers infant hygiene [5]. Hospitals were viewed by practitioners as places where the invalid could not only have their health restored, but where they could learn to be healthy [19].

The 1910 publication of Abraham Flexner's *Medical Education in the United States and Canada* [20] is recognized as having changed the course of medical education altogether [11]. Charged to investigate "conditions which, instead of being fruitful and inspiring, are in many instances commonplace, in other places bad, and in still others, scandalous," Flexner reported on 155 medical schools [20]. His recommendations included nothing less than a complete overhaul of medical education, and his emphatic descriptions of colleges that were churning out new doctors after brief and repetitive didactic training led to the closing of 76 schools. In response, standards in education became far more stringent, inevitably moving toward licensure, professionalism, and an increasingly homogeneous Western medical ethos [11].

Unlike the previous era, the early 1900s saw tremendous advancement in the role of libraries and librarians in the hospital setting. By 1904, the Patients' Library at the Massachusetts General Hospital became the first organized library [21] to hire a full-time librarian. Edith Kathleen Jones published extensively, and her views on the organization and management of library services in hospitals were widely influential, including her four principles:

- First, an organized central library
- a librarian with personality, knowledge of books and library technic (sic)
- third, an annual appropriation sufficient for the purchase of new books as they are published
- fourth, the exclusion of morbid, gruesome and unwholesome literature [22].

Jones's recommendations exemplified an approach to early patient libraries that matched the physicians' view of patients as children, evident in medical publications of the era [17, 19, 23]. A 1927 article recommended that librarians' education should include not only psychology, literature, and sociology, but also hygiene, both "physical and mental, of physiology, and sanitation" [17]. Librarians were encouraged, in this prescriptive article, to "probe quite carefully and cautiously in to very closely [*sic*] personal problems," in-

cluding the patient's "mental background," education, the interactions of physical state with mental well-being and whether the patient would be "content with the sensationalism of much of the present day output" or whether the patient might need, "mentally speaking, milk for babes or food for thought" [17].

Librarians' roles in the institution needed to be carefully considered to gain the approval and support of those in power, and their limits were made clear. One example of this was the pronouncement of Morris Fishbein, editor of the *Journal of the American Medical Association*, in his 1934 address to the Hospital Libraries Round Table of the American Library Association:

Medicine has been the subject of intense overspecialization during the past quarter of a century. That same period has witnessed the coming of social work, dietitians, hospital librarians, radio technicians, and innumerable other accessories to medical care. Physicians have viewed this invasion of their responsibilities somewhat askance. Let it be emphasized that all of these services must be accessory to medical care itself. . . . The hospital librarian will, of course, realize that as yet her relationship to medical care is an exceedingly modest one, yet its potentialities are only beginning to be realized. [23]

Only brief mention is made of the provision of medical information to nonmedical visitors in the medical library literature of the day. In one such article, the author described the type of requests she received, including a narrative of health information-seeking behavior. Even though this was not described as common, Beausejour's wording seemed to suggest that while such needs were not often encountered, neither were they turned away (although no effort was made to follow up—Mary Ann was left on her own to find what she needed):

Mary Ann was in the hospital with a new baby. She took a love story. During a conversation with me she intimated that she was afraid of her inability to take care of the baby when she got home. I suggested a book or two on the care of the baby, and one day much later I discovered Mary Ann prowling in the vicinity of the Parent-Teacher bookshelf. [21]

Perhaps due to the long-term nature of their institutionalization, private and public hospitals for the insane were some of the earliest to establish patient libraries. In 1906, the secretary of the Iowa Library Commission, Alice S. Tyler, visited one such asylum, and her appalled reaction to the state of patients at that time—"hopeless and aimless"—led her to persuade the Iowa legislature to appoint an institutional library supervisor whose task it would be to organize libraries in state institutions, including hospitals. Using a "group system," librarians were assigned to several institutions and were responsible for selection, cataloging, and services, including the hiring and training of a person at each location, frequently an inmate or patient, to perform the role of librarian. The first supervisor funded by the Iowa legislative act was Miriam E. Carey, who set up the system and then began

the same work in Minnesota. Carey's description of the patient librarian's activities mentioned visiting patients on the ward and reading aloud, "story telling, and generally exploiting the library in ways that have greatly increased its usefulness" [24]. Nebraska, Indiana, and Vermont soon followed Iowa's lead, funded by those states and operated under the auspices of either the state library associations or the state boards of control [8].

In 1911, Jones conducted a study of library services available in 121 institutions for the insane, using her results to urge greater involvement by the national library associations in the reading facilities already available in the hospitals. Addressing the ninth annual meeting of the League of Library Commissions, Jones passionately reminded that body of the dire need for materials and services, saying:

I wish I could say this loudly and emphatically enough to be heard over the whole country, the insane are not imbeciles and they are not children. If the old ladies like to read the stories they loved when they were young, so do old ladies everywhere. [25]

Though Jones's plea was not ignored, it was not until 1915, when a second, corroborating study [26] conducted by Julia Robinson (then secretary of the Iowa Library Commission), that the American Library Association moved to establish the first institutional library committee [8]. Members of the Committee on Library Work in Hospitals and Charitable and Correctional Institutions actively promoted library services through both library and medical journals, including a column called "Institutional Libraries" in the journal *Modern Hospital*, and then created the *Manual for Institution Libraries*, whose purpose was to aid the organization and management efforts of a growing number of librarians nationally [8].

Beginning in World War I (1917), the American Library Association's War Service worked to distribute materials and provide services to wounded American soldiers worldwide, proving that such services helped the healing process by encouraging patient well-being. Based on that premise and with government support, the American Library Association placed hundreds of librarians overseas throughout both wars. Publicity was overwhelmingly positive, and the American Library Association viewed it as an opportunity to acquaint citizens with the types of materials available through libraries and their functions of providing entertainment and even education. Efforts were made by librarians to establish bibliotherapy as a medically beneficial therapy, and the medical profession supported those efforts. In an article published in *Modern Hospital* in 1925, Josephine Jackson expresses her view that:

the right book is an active therapeutic agent . . . since it actually affects the body chemistry of the invalid. As the sick man's fancy is thrilled with high hopes for the hero . . . that very mood proves a stimulus to his glands of internal secretion—thyroid, adrenal and others—which respond by pour-

ing out an increased supply of their diaphragmatic secretion, making the heart less sluggish, the diaphragm more vigorous, and the digestion livelier. [27]

Jackson's words lent strength to the hypothesis that librarians were supported in their bibliotherapeutic practices by physicians, as well as that the rationale for such activities (and the attitude toward patients) was likely grounded in medically based claims about the salutary health effects of carefully selected reading materials. Such claims were unsupported by anything but anecdotal evidence and occasionally were roundly criticized. For example, a 1939 *Library Journal* article complained that:

So far most of the work in bibliotherapy seems to be based on untested assumptions rather than upon systematic scientific observation and controlled experimentation. . . . If we are to have a science of bibliotherapy we must pass beyond the anecdotal stage in formulating principles and proceed to scientific experimentation. [28]

In a 1934 article, "Closed to the Public," Farrow provided library anecdotes that seem amusing now, but that mirrored prevailing views of the health care profession toward the general public. Her narrative tells of a woman who came in with lists of requests, spent hours researching, and then used the library's telephone to call people (apparently her customers) with prescriptive advice. The author's evident frustration with this state of affairs and her satisfaction with the decision to close the door to public access exemplifies the attitudes of some medical librarians toward serving the general public throughout this period [29]. Another example was found in a 1949 article by C. Lamar Wallis, librarian at the Rosenberg Public Library in Galveston, Texas. "What does the public want in a medical book," he asked (and so he titled his presentation before the forty-eighth annual meeting of the Medical Library Association):

Too often it is just what the old gentleman wanted—information on how to treat oneself without consulting a physician. We should like to believe otherwise, but too many conversations with readers lead right back to this conclusion. [30]

Wallis continued by alternatively characterizing some lay medical information seekers as curious, somewhat psychopathic, suspicious, looking to satisfy morbid curiosity, or those abnormal few who seek anatomy texts and even fewer looking for information about sex (here he explained that such questionable materials were placed in a special collection, where they were "administered by a librarian"). To be fair, Wallis did eventually discuss the needs of the "normal" information seeker who intended to:

simply know more about what is wrong with him or how he can avoid becoming ill. He wants a medical book to give him an honest, clear, forthright exposition of his physical makeup. He wants to be told as far as is possible in layman's language, what he can do to keep himself and his family

healthy and what he must do in case of illness to aid in his recovery. [30]

Clearly, members of the public were actively seeking health information, even though their access to certain topics was deliberately impeded. However, use of the hospital library for medical information was still not the norm through the 1940s and even into the mid-1950s, when it was reported by one librarian that "[o]ccasionally, we have a request from a doctor for a patient to read a certain article and we do honor such a request by having the article put aside and ready for the patient when he comes in" [31], although others allowed patients to circulate materials, if only overnight, and noted the use of the library by in-house, nonmedical staff:

Sometimes the office workers will come over to look at our books on nutrition and will sit down and copy a reducing diet of interest. Or perhaps a member of the family has been placed on a diet by a physician and they want to know more about it. Mothers who are employed by the hospital will consult our books on child guidance and child care. Girls who are engaged will ask for books or articles on "How to prepare for marriage." We show them how to find journal articles on this subject, and allow them to borrow the books which are available. [32]

In recognition of the importance of public health information and a rising volume of such information requests, the National Health Library began in 1933 to distribute a list of books on the subject of health to public libraries, with the intended purpose of helping lay readers "choose material that is factually correct and authoritative" [33]. By 1955, when the *Bulletin of the Medical Library Association* published a series of papers presented at the fifty-third annual meeting on service to the "lay public," librarians were actively debating what would develop, over the next thirty years, into consumer health services. "I might say here that it does not seem to me that we can brush aside the public entirely," writes Beehler:

[w]ith practically every magazine which comes off the presses today containing an article or two on health matters or recent advances in medicine, the layman is becoming more and more aware of what is going on in these fields and is developing a growing interest in it. He no longer is satisfied with being given a pretty pink pill for whatever ails him; he wants to know the whys and wherefores. He wants an intelligent answer and there should be some place for him to go to get an intelligent answer. Naturally, he goes to a medical library. [34]

CONCLUSION

An examination of the development of library services to patients from the late eighteenth through the mid-twentieth century is as complex as the examination of any other sector of society whose changes reflect overall change in the environment. Considering these parallel events leads to the tentative conclusion that the

early role for medical librarians in service to individuals for personal health information was largely restricted to bibliotherapy due to a number of factors. These included the lack of recognition by the medical profession of the value of patient education until public health reforms found public health education to be a crucial element in the alleviation of epidemics. Other factors included the recognition by librarians that physicians would readily protect their turf against incursion, as they had by the gradual exclusion of all but Western medical practices, coupled with the beneficent role of those same physicians, without whom medical libraries would not have existed. Given these contributing elements, it was not surprising that the practices of medical librarians tended to reflect (as Anderson did, in her passionate assertion that patients or the public were really not entitled to medical information [2]) the paternalism that characterized medical practice into the 1950s and beyond.

To render this analysis more directly meaningful to the practice of medical librarianship today, particularly with regard to the provision of consumer health information, the review would need to extend beyond the mid-twentieth century.

Additional complexities enter the study at that point, embodied in the issues of consumerism, medical ethics, insurance and litigation, contributions of the various media to the national dialogue, recurrent (or resurgent) folk medicine, and evidence-based medicine. Questions are myriad, and only a partial list is provided here, because it is certain that others would occur, if this review were extended. What legacy might be evidenced in the approach to consumer health services? Did the practices and attitudes of earlier medical librarians mirror those of physicians? How, over time, has this been reflected in the library literature? Bringing it to the present day, one might ask about the dominant discourses in the field of librarianship with regard to consumer health information services—with regard to information about issues (such as complementary and alternative medicines, for example) that might not be supported by the medical professionals they also serve. Directly related to these questions, what are the discourses about the division between “consumer health” and “patient education?” Are medical librarians (particularly in hospital settings) empowered, as they might be in public or academic settings, to freely provide information to individuals, or does the awareness of political pressures to conform to expected practices act as a barrier to the free flow of information?

It is interesting to consider questions generated from reading the historical literature of medical librarianship’s development and to attempt to parallel observations made by doing so with trends and developments in the broader society. Issues in the medical arena include well-explored power imbalances between patients and physicians, with many researchers pointing to the possession of proprietary knowledge (even to the extent of deliberately mislabeling diseases and drugs) as a means by which practitioners exerted the

control once believed necessary to a successful therapeutic relationship. During a time when evidence-based practice in medicine asks physicians to consider patient values in treatment, thus continuing the trend toward righting historically rooted power inequities in that relationship, librarians are not exempt from examining their own practices.

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