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REVIEW ARTICLE

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The historical development and current landscape of health library standards: A critical review

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Abstract

Background: Since the emergence of the first health library standards, a large body of literature has been published in this field, most often focusing on a particular standard, or set of standards. In the case of literature reviews, they have been usually partial and integrated into a broader study.

Objective: Identify and analyse national health library standards developed in different countries worldwide over the past 70 years, tracing their historical development and current status.

Method: A comprehensive search of published literature was conducted in Scopus, Web of Science, Medline, LISA, and Google Scholar up to May 2023. The reference lists and citations of retrieved papers were reviewed. After screening and eligibility, a total of 112 papers were included in the final selection.

Results: More than 40 national hospital library standards published by a group of Anglo-Saxon and European countries were identified. In a chronological approach, the standards have been arranged by decades, from the 1950s to the present day, and the context of their appearance, their main contributions, and the relationships between them have been analysed. The major trends that have marked their evolution and development over time have also been established.

Conclusion: Standards have a key role to play in the important challenge facing health libraries today to demonstrate the high impact and value of their services in the functioning of their organisations and in improving patient care.

KEYWORDS

libraries, health science; libraries, hospital; libraries, medical; review, critical; standards

BACKGROUND

Standards are an important part of library and information work and in an increasingly connected electronic environment probably they will become even more so. Library and information professionals will need to understand which standards apply to their work. Even more importantly they will have a significant role to play in the development of new standards concerned with information management and retrieval.

It is with this paragraph that Hopkinson and Haynes (2006, p. 33) conclude their article entitled 'Librarians need standards'. If in 1972 Hirsch posed the question 'Why do we need standards?' (Hirsch, 1972), these authors go a step further, turning it into an almost provocative statement and raising three key points to justify it: the recognition of the importance of standards, their knowledge-based use, and the necessary involvement of library professionals in their development.

Health librarians have long recognised the importance of standards in their professional practice. Although the use of standards has sometimes been a controversial issue within the library community (Jones, 1990, p. 82; Weech, 1982, pp. 3–4), their benefits are generally accepted. Compliance with standards ensures that health libraries can provide the resources and services necessary to meet the educational and research needs of their diverse user groups and, most importantly, to contribute to high standards of patient care (Library Association of Ireland, 2005). As the standards have tended to be developed and endorsed by library associations and other professional bodies throughout their history, the involvement of librarians in their development seems to be guaranteed to the extent that the standards are the result of, and reflect their experience, knowledge, and expectations.

Hospital library standards began to emerge in the early 1930s in the United States of America (Wolfgram, 1985, p. 3). From that time to the present, a large body of literature has been published in this area, reflecting the interest of the professional community. In addition to the standards themselves, all kinds of related studies have been published, with different objectives and scope: from works focusing on the analysis of a specific standard, to articles presenting experiences of the use of standards in accreditation processes, to studies with a more historical perspective, or papers discussing the importance of standardisation work itself.

However, most of the published work has looked at a particular standard or set of standards developed in one country at a particular time. Studies covering extended periods of time or large geographical areas are rare. In the specific case of literature reviews, they have tended to be partial and integrated into a wider study.

It is against this backdrop that we have undertaken the present work, with a broader focus. This critical review aims to identify and analyse the health library standards developed in different countries around the world over the last 70 years, to trace their historical evolution and to present the current situation.

Key Messages

- Outcome based standards are an essential tool for health libraries to assess the impact of their services, to communicate best practice and demonstrate the value they bring to their organisations.
- To ensure quality assurance and continuous improvement of hospital library services, standards should be regularly reviewed and updated, adapting to the challenges of the environment and the changing information and knowledge needs of their clients and institutions.
- In practice, it is difficult to enforce compliance with hospital library standards unless external organisations require it for accreditation, either of the libraries themselves or of their institutions
- Health librarians should use evidence-based standards to raise awareness among hospital authorities and accreditation bodies of the need to ensure that libraries have the necessary resources and services to effectively meet the information management needs of hospitals.
- Standards for health libraries must be underpinned by solid evidence derived from the literature research and from the library professional practice.

METHODS

Since the aim of this paper is to comprehensively examine the national standards developed in the field of health libraries, going beyond a mere description of the relevant literature to include an analysis of their content and their main contributions and innovations, we decided to use a critical review as the method to achieve this aim. The PRISMA methodology (Page et al., 2021) was used as a tool of systematically developing the search and selection process of the publications to be included in the review.

Information sources and search strategy

The search was conducted from September to the end of November 2022 in four electronic databases—two interdisciplinary (Scopus and Web of Science), one specialised in Medicine and Health Sciences (Medline) and one specialised in Library in Information Studies (LISA)—and in the academic search engine Google Scholar. The search was repeated in mid-May 2023 to identify new developments in hospital library standards. This allowed us to incorporate into the work the most recent MLA standards (Tarabula et al., 2022), which were included in the October 2022 issue of the Journal of the MLA, but were

not found in the previous search, as they were not published until March 2023.

In order to select the key terms to be used in the searches, some national hospital library standards were reviewed to identify the most relevant words that delimited the topic. The specific search strategies developed were:

- One combining all terms in a single search: (hospital librar* OR health* librar* OR medical librar*) AND (standard* OR guideline* OR accreditation OR 'quality assurance'). This was used in the WoS, MEDLINE and LISA databases.
- Another that combines three separate searches: ([hospital librar*] AND [standard* OR guideline* OR accreditation OR 'quality assurance']) OR ([health* librar*] AND [standard* OR guideline* OR accreditation OR 'quality assurance']) OR ([medical librar*] AND [standard* OR guideline* OR accreditation OR quality assurance]). This was used in Scopus because it returned a higher number of relevant documents than the previous strategy.

In the case of Google Scholar, individual search queries were developed for each combination of keywords (e.g., hospital library standards, hospital library guidelines, hospital library accreditation, etc.) due to the limited search functionality of the search engine.

Following scoping searches, the terms were limited to titles only to ensure relevance and retrieve a manageable set of results. All databases were searched without restrictions on language, country, and year of publication.

The table include in the Appendix shows the search strategies used for each database and Google Scholar, as well as the number of references obtained.

Several websites and the reference lists and citations of the retrieved documents were reviewed to identify additional papers that met the specified criteria. Most of the grey literature was obtained from Google and Google Scholar and, to a lesser extent, from Scopus, mostly located among the secondary documents. The Opengrey.eu database was also searched, but no relevant references were found.

Eligibility criteria

In order to select the documents to be included in the study, the following inclusion and exclusion criteria have been adopted:

a. Inclusion criteria:
   - Standards for libraries serving hospitals and other health care institutions in their various stages (published, final draft), versions and editions, and their supporting materials such as manuals, handbooks, implementation guides or toolkits.
   - Reviews or studies of a particular hospital standard.
   - Other hospital regulatory documents which contain standards or guidelines for libraries, such as hospital accreditation manuals.
   - Studies dealing with the history or development of standards in the field of hospital libraries.
   - Studies that present and analyse experiences of the use and application of hospital library standards (i.e., evaluation, or accreditation processes).
   - Studies on the initiatives developed by different countries in the field of standardisation of health libraries.
   - Opinion pieces (editorials, introductions, etc.) or papers discussing on the importance, necessity, or impact of hospital library standards.
   - Bibliographies or literature reviews on hospital library standards.

b. Exclusion criteria:
   - Standards for hospital libraries with regional or local scope unless they have had national influence.
   - Studies using standards for other types of libraries (e.g., university libraries) applied to health sciences libraries.
   - Specific standards for academic health sciences libraries (medical school libraries, medical college libraries, etc.) and patient libraries as they are considered to have a different scope, purpose, and functions than hospital libraries.
   - Standards adopted by a country that are literal translations of national standards from other countries.
   - Standards for a specific service, aspect, or activity of the hospital library (e.g., reference service, information literacy, literature searching, facilities, staffing or collection development).
   - Studies written in languages with alphabets other than Latin.

Study selection

Previous work developed in the field of health libraries standardisation (De la Mano & Harrison, 2012; Harrison et al., 2014, June) had allowed us to identify, retrieve and analyse several national standards and other related publications which were used as a starting point for the present literature review.

The initial literature search in the selected databases and in Google Scholar yielded 437 records, of which 188

were removed before screening for duplication or incomplete references.

The titles and abstracts of the 249 remaining records were screened against the criteria to identify those relevant to the topic. Of the 140 publications resulting from this screening, up to 26 could not be retrieved for various reasons (e.g., full text or electronic version not available, not located, etc.).

The retrieved publications were then assessed for eligibility by removing those that met at least one of the stated exclusion criteria. The main reason for exclusion was that the publications were written in languages with alphabets other than Latin, mostly in Persian, but also in Chinese, Korean or Japanese. This factor biases the results of the analysis, as it does not allow us to know in detail the initiatives and projects developed in the field of study in these Eastern countries, unless they have been published in English.

A further 39 publications found through websites, citation searches and reference lists were also included once they had been assessed for eligibility.

As a result of the above process, a total of 112 publications were included in this literature review. A flow chart describing this process is shown in Figure 1.

Data extraction

Data were extracted from the included standards documents and other closely related publications (revisions, supplementary materials, etc.) to provide the following information for each standard: the date of its publication and the institution that promoted it; the factors that led to its development; its scope; its main contributions in relation to previous editions, if any; the influence or relationship with other national standards; and its intended use.

These data, combined with the information obtained from the analysis of other types of studies, such as those relating to the analysis of the hospital and medical environment surrounding the appearance of the different standards or the experience of their use, allowed us to

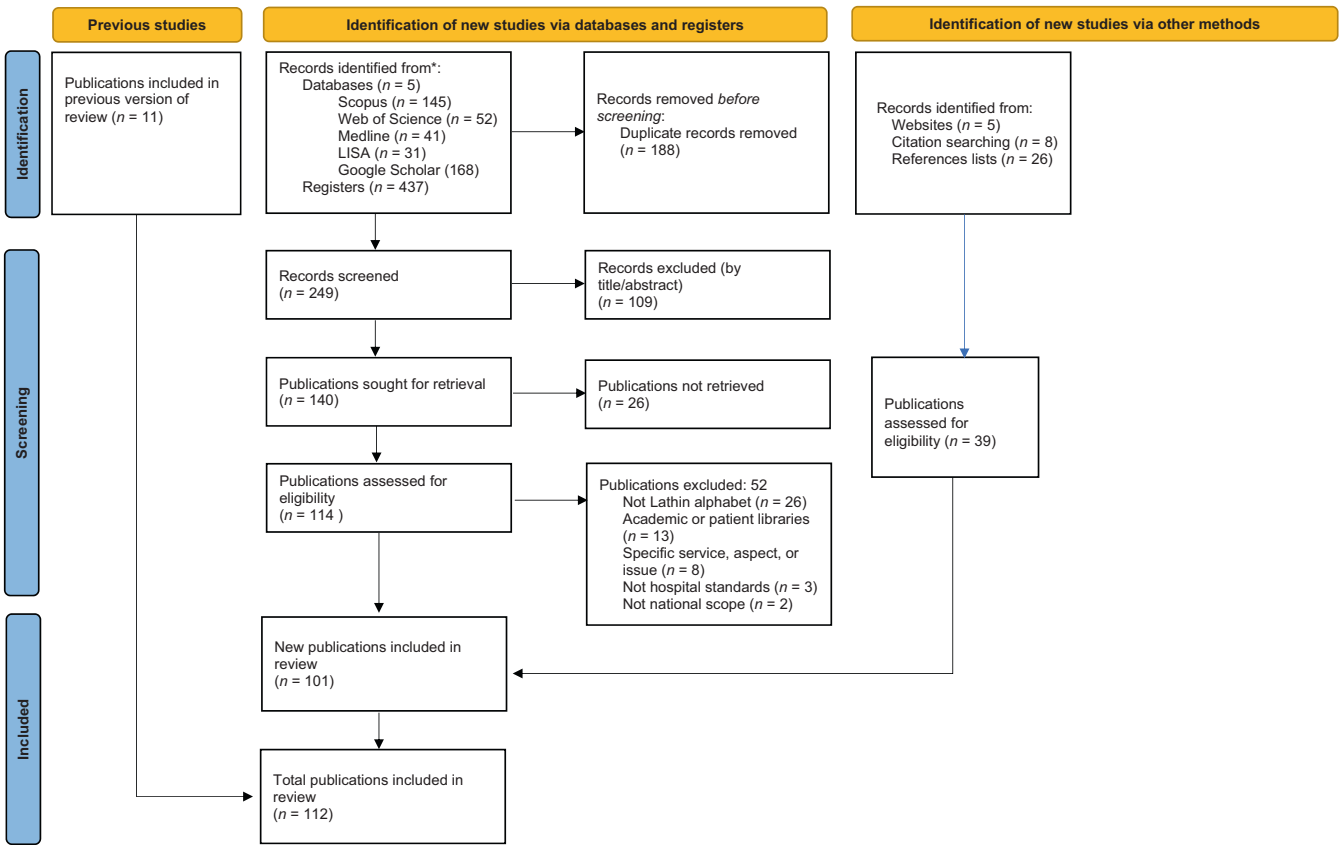

FIGURE 1 Study selection process (PRISMA flowchart). *Source*: Adapted from: Page, M. J., McKenzie, J. E., Bossuyt, P. M. et al. (2021). The PRISMA 2020 statement: An updated guideline for reporting systematic reviews. *Systematic Reviews* 10, 89. https://doi.org/10.1186/s13643-021-01626-4

obtain the necessary information to build the framework on which this work is based.

RESULTS

More than 40 national standards, in their various editions and versions, from seven Anglo-Saxon and European countries, are included in the final selection.

A chronological approach has been adopted to present the results obtained in an organised and systematic way. Specifically, a decade-by-decade analysis has been carried out, from the appearance of the first hospital library standards in the 1950s to the most recent standards published in the last 4 years. At each stage, the published national standards and their main contributions have been identified, the environment in which they appeared has been analysed, and the relationships and influences between the different national standards have been established. In the case of the current standards, a more in-depth analysis of their content and evolution has been carried out to identify the main trends and challenges in the field.

The beginnings: The advent of the first hospital library standards in the 50s and 60s

Since the early decades of the twentieth century, the health sciences library community had been concerned with standards, as reflected in Purington's bibliography of articles on hospital, medical and nursing library standards published between 1925 and 1945 (Purington, 1946). But it was not until 1953, after many years of uncertainty, that the Hospital Libraries Division of the American Library Association (ALA) issued the first edition of *Hospital Libraries: Objectives and Standards* (Joint Committee on Standards for Hospital Libraries, 1953).These standards were accepted and endorsed not only by the three library associations whose members comprised the Joint Committee that developed them (ALA, Medical Library Association (MLA) and Special Libraries Association), but also by the American Hospital Association, the American College of Surgeons and the National League for Nursing. It is considered the first set of national standards in this field, and dealt separately with patient, medical and nursing libraries. For each type of library, the standards covered staff qualifications, duties, and status; library collection and use; budgetary provisions; and location and equipment, including quantitative recommendations (Lima, 1954).

In parallel, we find the first mention of the medical library in hospital accreditation standards, when the Joint Commission on the Accreditation of Hospitals (JCAH) published its first set of *Standards for Hospital Accreditation* (Joint Commission on the Acreditation of Hospitals [JCAH], 1953). It included the medical library as a desirable but not essential requirement for hospital accreditation (Foster, 1979, p. 226). This was changed in the revision of the standards published in 1956, where the medical library became an essential service.

After subsequent revisions (1957, 1960, 1964 and 1965) without major changes in the requirements for medical libraries, in 1966 the JCAH undertook a complete revision of its standards, and the new *Accreditation Manual for Hospitals, 1970* was released (JCAH, 1971). However, the new standards could only be considered guidelines or suggestions.

Of all the organisations that have sponsored standards and guidelines for hospital library services in the United States of America, the JCAH (later the Joint Commission on Accreditation of Healthcare Organisations, JCAHO) has played the most influential and central national role since its inception. This role has been 'indirect but persuasive' (Buchanan, 1993, p. 68).

The JCAH's influence extended beyond national borders to hospital accreditation in Canada. The Canadian Medical Association (CMA) was a founding member of the JCAH and remained as such until late 1958, when the Canadian Commission on Hospital Accreditation (CCHA) assumed full responsibility for the Canadian accreditation programme. The standards used in the JCAH programme were also initially adopted by the CCHA, and the two commissions agreed to maintain a close relationship, so that the standards subsequently developed in Canada were quite similar to those in the United States of America (Eagleton, 1988, p. 146).

In the United Kingdom, the Library Association published the first printed set of standards in 1965, *Hospital Libraries: Recommended Standards for Libraries in Hospitals* (Library Association, 1965). According to Flandorf, there was little previous experience of standard-setting to draw on, so it is not surprising that they were also influenced by the American standards of 1953. The Library Association standards also recognised the need for two types of libraries—the recreation library for patients and the health science library for hospital staff—with separate rooms, but both supervised by a qualified librarian as head of department (Flandorf, 1966, p. 288). These standards were, in Matthews' words, 'an essential tool in that era of pioneering services and expansion' (1990, p. 56). The revised edition of these standards was published in late 1972 (Library Association, 1972) with minor changes in figures and quantitative recommendations only to suggest an improved level of service provision (Humphreys, 1972, p. 327).

At the international level, after several years of preparation, the *IFLA Standards for Hospital Libraries* were

published in 1969 (International Federation of Library Associations and Institutions [IFLA], 1969), based on information and statistics from 21 countries, with the main emphasis on service to patients (Yast, 1972, p. 279). A few years later, hospital library issues were included in the IFLA *Standards for Public Libraries*, published in 1973, and since then there has been no further initiative to develop a separate set of standards for this type of library.

The important achievements of the 1970s: The strengthening of hospital library standards

There is broad agreement among the authors that the 1970s was a very active period in the development of hospital library standards. The reasons for that dynamism can be found in the increased importance and development of hospital libraries during those years, together with other factors described by Foster: 'the increased demand for services, the growth of the health care industry, libraries' growing role in the national information network, and the introduction of new technology' (1979, p. 227).

Also at this time, as part of a wider movement in the US health care environment to adopt and apply the concept of quality assurance, the first initiatives to establish a quality assurance process in hospital libraries were undertaken (Self & Gebhart, 1980).

In this context, a revised edition of the 1953 ALA standards was published in 1970 as *Standards for Library Services in Health Care Institutions* (Association of Hospital and Institution Libraries, 1970). In contrast to the previous edition, a unified library serving the entire hospital population was promoted; all recommendations were phrased as 'should' (encouraging) rather than 'shall' (mandatory); 'hospitals' became 'health care institutions'; and the idea, introduced in 1953, that a qualified professional librarian was the key to good library service was reinforced (Yast, 1972, p. 286). One of the major changes introduced was the replacement of the traditional quantitative standards with qualitative ones, because of the breadth and variety of institutions in which these would be used.

However, the initiative that received the most attention from American health sciences librarians was the revision of the 1970 JCAH standards for professional library services, which came into effect in 1978 with the publication of the new edition of the *Accreditation Manual for Hospitals* (JCAH, 1978). Based on the philosophy that all hospitals should be accredited according to the same guidelines, it also included qualitative rather than quantitative standards (Stinson, 1982, p. 126). New issues for hospital libraries were the delineation of staff qualifications, the requirement for continuing education, the emphasis on needs assessment and goal development, and the requirement for detailed written policies and procedures (Topper et al., 1980, p. 214). According to Foster, the observance and application of these management principles would be the elements that would lead to the development of hospital libraries (1979, p. 228). It was also the first time that library services were defined to meet the diverse needs of medical and hospital staff (Wolfgram, 1985, p. 36). These standards therefore represented a strong commitment to health library services by an influential accrediting body.

Meanwhile, in 1975 the Canadian Standards for Hospital Libraries, developed by the Ontario Medical Association and endorsed by the CMA, were published, based on the earlier American standards of 1970 and English standards of 1972 (Ontario Medical Association, 1975). This was the first set of standards generally accepted by the various associations concerned with health libraries in Canada, although it is worth mentioning the Quebec draft standards on which they were based (Flower, 1978, p. 297). Although no definitive figures were introduced into the body of the recommendations, appendices were added detailing minimum quantitative standards for providing adequate library services to various categories of hospitals. These were considered to be very useful tools for the whole health sciences library community (Flower, 1978, p. 299).

Hardly 2 years later, the CCHA published the *Guide to Hospital Accreditation* (1977), with the section on staff library services extensively revised in accordance with Canadian standards. For the first time, the library was considered an independent department within the hospital, both organisationally and physically (Flower, 1978, p. 299).

Topper and colleagues identified two main tendencies in the nature and objectives of the standards being developed at the time: a quantitative and specific one, where the purpose of the standards was to force the upgrading of deficient services to a minimum level, exemplified by the Canadian standards; and a qualitative and flexible one, where the standards were seen as statements of quality service represented by the JCAH standards (Topper et al., 1980, p. 284).

In contrast, as stated by Matthews, the 1970s were a different decade in the United Kingdom for health libraries standards. The process of developing new standards after the 1972 revision faced many obstacles: the problem implicit in the word 'standards' was sidestepped by calling them 'guidelines', and the requirement for an evidence-base to establish quantitative recommendations was not considered. The result was a consultative document, *Guidelines for library provision in the health services*, published in 1978 (Library Association, 1978),

which was more diffuse than the earlier standards. At this time, standards were in question, with one of the main objections being that they consisted of measurements of inputs rather than outputs (Matthews, 1990, pp. 57–58).

The situation in New Zealand hospital libraries in the 1970s was like that in the UK National Health Service, with patient services focusing on recreational resources and the need for access to medical information being discussed (Oliver & Bidwell, 2001, p. 84). In 1978, the Council of the New Zealand Library Association published the first edition of *Standards for Library Services in Health Authorities* (New Zealand Library Association, 1978), including libraries both for patients and for staff.

The improvement of the health libraries evaluation process with the development of qualitative standards and the participation of the library in the accreditation process on equal terms with other hospital service departments are identified by Stinson as important achievements of this decade (Stinson, 1982, p. 134). But there were also shadows: at the beginning of the 80s the debate over the suitability of quantitative or qualitative standards was still open; the value of standards continued under discussion, to the extent that some library associations had rejected traditional standards entirely; and the concern about the method of standards development and the importance of an evidence base was as evident as 10 years before (Weech, 1982, pp 3–4).

Managing the economic restrictions and the rising costs of the 80s: The development of *minimum standards*

During the 1980s, the US health care context underwent major changes that had a significant impact on the hospital library environment. On the one hand, the rising cost of health care coupled with limited hospital revenues reduced the funds available to support library services; on the other hand, the spiralling cost of publications and the increased use of sophisticated technology increased the potential costs of any hospital library (Glitz et al., 1992, p. 179). As a result, many hospitals closed their libraries or reduced their library staff while under enormous pressure to provide more services (Holst, 1991, p. 2).

Since the publication of the JCHA Professional Library Service Standards in 1978, it took several years for new national standards to appear. During this time there were some initiatives to develop regional standards for hospital libraries, such as that of the New York State which resulted in the publication of the *Manual for assessing the quality of health sciences libraries in hospitals* (New York State Library, 1983). The quantitative standards it provided were primarily intended for the New York State Health Information Services but could be used to evaluate hospital libraries throughout the country (Messerle, 1984). It also became a valuable reference for Canadian hospital librarians when, in 1983, the CCHA made quality assurance of professional services, including libraries, a major requirement for hospital accreditation (Eagleton, 1988, p. 149).

In 1984, the MLA published the long-awaited quantitative *Minimum Standards for Health Science Libraries in Hospitals* (Medical Library Association [MLA], 1984). These standards were intended to provide both hospital librarians and administrators with a baseline for the level of service and collection size that would be considered minimum, including quantitative data outlining their application.

A few years later, in 1986, in response to the decline in hospital quality, the newly renamed Joint Commission on Accreditation of Healthcare Organisations (JCAHO) initiated a movement towards continuous quality improvement called 'Agenda for Change', the major transition in the accreditation system, which resulted in the publication of a new edition of the accreditation manual (Joint Commission on Accreditation of Healthcare Organisations [JCAHO], 1988). Just 1 year later, hospital library standards were identified as a key factor in the accreditation process.

Around the same time, in 1987, the Canadian Health Libraries Association (CHLA) initiated a review of the 1986 standards because of their loss of quality and soundness of content (Eagleton, 1988, p. 148), which concluded 3 years later with the publication of *Standards for Canadian Health Care Facility Libraries: qualitative and quantitative guidelines for assessment* (Canadian Health Libraries Association [CHLA], 1989). As in the previous cases, the influence of US standards was evident: the descriptive standards were comparable to those in the latest edition of the JCHA's Manual of Accreditation for Hospitals (1988); the quantitative guidelines outlined the minimum characteristics of a library as in the 1984 MLA Minimum Standards; and the final section, devoted to how to assess the quality of hospital libraries, was largely based on the New York Manual form (Jones, 1990).

It was also in these final years of the decade, in 1988, that the Library Association of Australia published the first edition of the National *Minimum Standards for Health Services Libraries* (Library Association of Australia, 1988). It represented the culmination of 6 years' work and was significant as the first set of Australian hospital library standards to be accepted by all health librarians in the country.

Based largely on these Australian standards, the *National Minimum Standards for Health Library Services*

in New Zealand (Health Information Association of New Zealand, 1990) were published barely a year later, albeit with modifications relevant to this country. These standards, which updated the earlier 1978 standards, were intended to ensure that all professionals in health care organisations received adequate library information services, and to encourage library administrators to exceed the minimum quantitative standards set for service improvement. These standards were to be used in conjunction with the guide, *A model for Health Sector library services* (New Zealand. Department of Health, 1990).

Facing the changes of the 90s: The advances in information technologies and the new nature of hospital librarianship

In the early 1990s, American hospitals and their libraries were still suffering from staff and budget cuts, closures, and mergers. It was in that context that New York State decided not to require hospitals to have a library, claiming that there was no evidence that libraries directly contributed to improved patient care. As a result, in 1992 the Rochester research project was undertaken to explore the impact of library services on clinical decision-making, demonstrating that they were valued and considered to make a positive difference to patient care (Marshall, 1992). It was one of the first studies to go beyond measuring inputs and outputs to measure the perceived value and impact of information, which had a significant effect on the field (Dunn et al., 2009).

At the same time, rapid advances in technology were changing the way libraries operated and the expectations of users (Glitz et al., 1998, p. 78).

These changing expectations of hospital library services were formalised with the publication of the new edition of the *Accreditation Handbook for Hospitals* (JCAHO, 1994). In this edition, as a result of the shift from standards for individual departments and services to standards for hospital-wide functions, the standards for library services were incorporated into a new functional chapter, 'Information Management' (Schardt, 1998, p. 504). This chapter was used to group all types of information to be managed as an integrated information system. In this context, the mandate for the existence of a hospital library was no longer specified; the librarian as an individual professional did not appear and there was no definition of a qualified health sciences librarian (Dalrymple & Scherrer, 1998, pp. 10–11). Instead, library professionals were required to manage knowledge-based information (KBI) to support the effective functioning of the hospital (Schardt, 1998, p. 504). Although the implications of these changes for health sciences librarians were much debated, the standards clearly enhanced the value of the hospital librarian's role and strengthened their position within the hospital management team (Doyle, 1999, p. 384).

In Buchanan's view, the 1994 standards were the culmination of a series of accreditation changes that affected hospital libraries over the previous 20 years, and their influence was such that they would profoundly change hospital administrators' perceptions of the library for the next 20 years (Buchanan, 1993, p. 69).

Following the publication of the JCAHO manual and to reflect the changes it contained, the MLA published its own revised standards for hospital libraries (MLA, 1994). Unlike the previous minimum standards of 1984 and following the trend set by the JCAHO, the updated version lacked quantitative standards (Gluck & Hassig, 2001, p. 275). The revision reflected new issues in information management due to the impact of computers and other technologies and changing expectations of hospital libraries.

A year later, in 1995, new editions of three national standards were published, motivated, as with the American standards, by significant advances in information technology. In the case of New Zealand, this factor, combined with the major restructuring of the health system, which required performance-based measures for both quantitative and qualitative assessment, encouraged the publication of an early revised version of the National Minimum Standards (Health Information Association of New Zealand, 1995).

In parallel, the second edition of the Australian National Standards was published (Australian Library and Information Association [ALIA], 1995), reflecting the increasing impact of automation on hospital libraries in the preceding years.

At the same time, a new edition of the 1989 Canadian standards was also published (CHLA/ABSC Task Force on Standards for Library and Information Services in Canadian Healthcare Facilities, 1995). These were based on client needs assessment and continuous evaluation and improvement processes, with the aim of enabling users to obtain the resources and services they needed quickly and efficiently (McAllister, 2001, p. 3).

On the other side of the Atlantic, the *Standards for Irish Health Care Libraries* were first documented in 1993 (Library Association of Ireland, 1993). This document, produced in the absence of previous formal national guidelines, was influential in the establishment of many professionally managed health library and information services in Ireland. They had a significant impact and remained in force until the late 1990s, when it became clear that they needed to be revised.

In the case of the United Kingdom, the emergence of evidence-based medicine in the 1990s, the involvement

of English health libraries in the culture of quality assurance, and the development of accreditation throughout the 1990s (Fowler, 1998) required them to become increasingly aware of the importance of meeting the needs of their customers and to develop standards to support this process (De la Mano & Harrison, 2012). These standards were incorporated into numerous regional or local accreditation systems across the sector, but the differences and inconsistencies between these systems soon highlighted the need to develop a national accreditation system. Thus, in 1998, the first national accreditation scheme, *Accreditation of Library, and information Services in the Health Sector: a checklist to support assessment* (LINC Health Panel Accreditation Working Group, 1998), was published, complemented by a toolkit to facilitate its application in NHS libraries (Trinder, 1998).

As for the other European countries, Ribes, after consulting representatives of several of them in the European Association Health Information Libraries (EAHIL), found that most of them had no written standards (Ribes, 1999, p. 2). In the case of Italy, Portugal, Finland, Sweden, and the Netherlands, they generally used the North American standards published by the MLA, which were also used in Spain.

In the intervening period between the two decades, the third edition of the Standards for Australian Health Libraries (ALIA, 2000) was developed to 'reconcile the demands between qualitative and quantitative standards for both the practitioner and the lay administrator' (ALIA, 2008, p. vii). It was essentially a modification of the 1995 Canadian standards, justified by the important similarities between the Australian and Canadian health care systems and the limited time available for updating the previous standards.

According to Doyle (1999, p. 385), the major development in health libraries during this decade was the shift from managing a physical facility (the hospital library) to managing a function (access to knowledge-based information).

The challenges of the new millennium: The impact of internet and the advent of evidence-based librarianship

The beginning of the new millennium did not look promising, at least in the United States. The early years of the 21st century brought new stories of shrinking and closing hospital libraries due to rapid changes in health care delivery and increased scrutiny of non-revenue generating departments (Thibodeau & Funk, 2009, p. 274). Although hospital libraries entered the new millennium with a history of significant advances in the last decades of the twentieth century (nationwide establishment, formation of local consortia, greatly improved services through Internet access, and new roles for medical librarians), they were concerned not only with maintaining the quality of their services with flat or declining budgets, but also with their own survival (Wolf et al., 2002, p. 39).

In addition, as noted above, the previous decade saw the emergence of evidence-based medicine (EBM), built on the key principle that practice should always be based on current, valid, and reliable research. It soon became clear that the idea of evidence-based practice could be applied to other areas of study. Eldredge was a pioneer in the development of evidence-based librarianship (EBL), not only for first using the term, but also for initiating the movement in earnest (Eldredge, 2000, pp. 290–291).

In this context, the MLA published a new edition of the *Standards for Hospital Libraries* in 2002 (Gluck et al., 2002) to ensure that hospitals had the resources and services to effectively meet their KBI needs and to face the challenges posed by the increasing use of the Internet and new information technologies. To address the omission of the existence of the hospital library and librarian in the 1994 JCAHO standards, the new MLA standards stated that the library should be a separate department with its own budget and that KBI should be managed by a qualified librarian whose role was also defined., A revision of the standards was published in 2004 to include an expansion of standard 6 (Hassig et al., 2005, p. 282).

Two years later, the JCAHO published a new edition of its hospital accreditation manual (JCAH, 2004). By then, the increasing complexity of information management, the consideration of patient safety as a primary issue in hospital evaluation, and the importance of evidence-based health care in ensuring patient safety had reinforced the importance of the medical library and the need for leadership by the medical librarian. However, the new JCAHO standards again did not require that the hospital have a library or a librarian. Instead, they focused on the functions that the library provided to the hospital, and even suggested that library services could be provided through arrangements with other institutions, despite the negative consequences of such a position not only for the survival of the library itself, but also for the quality of care in the hospital (Paradise, 2004, p. 167).

The 2002 MLA standards were used as a model for the new edition of the *Standards for Library and Information Services in Canadian Healthcare Facilities 2006* (CHLA, 2007), which also noted, to a lesser extent, the influence of the third edition of the Australian Guidelines. The new Canadian standards were developed in response to the significant changes that health care

institutions were experiencing because of technological change, regionalisation, and computerisation, and to the challenges of health care delivery, where access to evidence-based literature, provided by library services, was seen as a key element in patient care decisions.

Regarding Europe, the first half of the decade also saw the emergence of new standards for hospital libraries in several countries. In England, a new edition of the accreditation checklist was published in 2002 (Fowler & Trinder, 2002) as part of the continuous quality improvement process and because of the increasing specialisation of health library services. Much shorter, and less prescriptive, it made significant changes to the 1998 edition. It adopted a more comprehensive approach, assessing areas of activity as a whole; emphasised the integration of the library into the life of the organisation; and modified the previous award scheme, replacing levels of accreditation with stages of development. However, in 2005, a new revision of the standard was published to update the guidance material (Fowler & Trinder, 2005). This latest revision was used for the accreditation of English health libraries until 2008.

The second edition of the Irish standards was also published that year to address the important changes that had occurred over the previous decade: the increasing availability and accessibility of electronic resources; the emergence of evidence-based practice as an essential tool for clinical decisions; and the increasing demand for valuable and up-to-date information (Library Association of Ireland, 2005, p. 4). Its scope and organisation were based extensively on the 1995 Canadian and 2000 Australian standards. This is the latest edition of the Irish standards to date.

In November 2004, the first set of standards for German hospital libraries was published to define the minimum resources needed to meet the requirements of an efficient hospital library and its service provision (Ahrens et al., 2004). They outlined goals and guidelines for buildings, budgeting, staffing and equipment. There is no subsequent edition of these standards.

A new edition of the MLA *Standards for Hospital Libraries* was published in 2008 (Bandy et al., 2008), adding a standard to define the minimum level of technology required by hospital libraries and incorporating the 'MLA Educational Policy Statement' and the 'Competencies for Lifelong Learning and Professional Success'.

In parallel, the ALIA published the fourth edition of its Guidelines based on the earlier MLA, Canadian, UK and Irish standards (ALIA, 2008). Despite this influence, they decided to retain the qualitative and prescriptive guidelines rather than the outcome-based Canadian and US standards, arguing that the former promoted a benchmark level of performance across the health sector, whereas the latter were more outcome-oriented for individual libraries (ALIA, 2008, p. ix).

These Australian standards were in turn incorporated into the new edition of the *Standards for New Zealand Health Libraries* (Library and Information Association of New Zealand Aotearoa [LIANZA], 2008), which included the previous New Zealand minimum standards for staffing and space in hospital libraries.

Finally, in the same year, the National Health Library of England published the *National Service Framework for Quality Improvement* (National Library for Health, 2008), which built on and replaced the 2005 Helicon standards. Designed as a quality assurance mechanism, it aimed to modernise library services and staff roles to meet the challenges of the 21st century. However, due to significant difficulties in implementing and managing this tool (Ellis, 2009), in 2010 a new quality accreditation framework was published: the NHS Library *Quality Assurance Framework (LQAF) England* (NHS Strategic Health Authority Library Leads [SHALL], 2010). This represented a 180-degree revision of previous standards by considering the delivery of knowledge as a core function of health library services and a means of transforming patient care and public health (De la Mano & Harrison, 2012).

The LQAF was regularly updated in the following years: in 2012 with two additional knowledge management criteria (SHALL, 2012, p. 6); in 2014 with the merging of these into one consolidated criterion (Health Education England Library and Knowledge Services Leads, 2014); and in 2016 with minor changes (Health Education England Library and Knowledge Services Leads, 2016). This last version remained in force until 2018.

The recent updates: The impact of the digital technologies, the support of evidence-based practice and the development of librarian new roles

Since the mid-2000s, the impact of digital technologies has changed the way health information services are delivered, particularly following the experience of the COVID pandemic (Ritchie, 2021). As health libraries have been early implementers of innovative solutions for the benefit of their virtual clients, this impact has been mainly in the areas of user education (digital literacy), researcher support and access to resources.

In addition, the expansion of evidence-based medicine into other areas has reinforced the need for standards to be underpinned by relevant, and robust evidence. In the case of health librarianship, although Evidence-Based Library and Information Practice (EBLIP) has been conceptually established, its

application to professional practice has yet to be implemented (Miller et al., 2017, p. 125).

As a result, health information professionals, driven by the need to keep pace with technological advances and to support evidence-based research and library practice, have had to take on new roles requiring more specialised skills and higher qualifications.

To complete this picture, in recent years there has also been no shortage of voices from different countries expressing concern about the increasing number of hospital library mergers and closures, budget cuts and reductions in library staff (Frati, 2021; Harrow et al., 2019). In this context, health library staff are once again called upon to advocate to their organisations and stakeholders the value and impact of their services as central to the delivery of quality patient care.

These dynamics are among the key trends in health libraries identified in Murphy's study (2021, 2022a, 2022b), which concludes a series of analyses on this topic developed between 2017 and 2020 by experts from 12 countries on five continents.

In this context, several countries have revised and updated their national health library standards to address these important challenges. New editions of the English, Canadian Australian and American standards have been published in the last 4 years. The main aspects of these standards are discussed below.

As seen above, the LQAF set the standards for knowledge services and health libraries in England from 2010 to 2018. However, in that year, due to changes in the environment and the high level of compliance with these standards achieved by libraries, it was decided to completely review the existing quality process (Edwards & Gilroy, 2021). As a result, and in response to *Knowledge for Healthcare's* commitment to update the LQAF (Health Education England, 2014, p. 48), the *Quality Outcomes and Improvement Framework for Library and Knowledge Services* was first published in 2019 (Health Education England, 2019a). A second edition of the framework was released in 2022 (Health Education England, 2022).

The framework has been designed as an outcomes-based approach to library quality assurance, and to underpin service improvement and innovation. It has moved away from the process quality assessment, standards and compliance that drove the LQAF to concentrate on service improvement, development, and delivery of outcomes, providing evidence of its effect or impact (Health Education England, 2019a, p. 3). In addition, the new framework makes significant efforts to ensure that outcomes are supported by current evidence, which is another key change from the previous framework.

The model has six outcomes that focus on improving library and knowledge services, with the first three aimed at ensuring that these services are seen as essential to their organisations (Edwards & Gilroy, 2021, p. 111) and the other three highlighting the need for appropriately qualified library and knowledge professionals who use robust evidence and demonstrate the positive impact of services.

Its intended use is for NHS trusts to undertake a self-assessment against the outcomes primarily to 'demonstrate the relevance, value and impact of their library and knowledge service to their user base' (Health Education England, 2019b, p. 6). This does not provide an overall score as in the LQAF, but allows a service to be compared with others, either nationally or regionally.

At about the same time, the Canadian, Australian and American Health Library Associations began revising their national hospital library standards, simultaneously and in close consultation, as evidenced by the similarities in their content (Frati et al., 2021, p. 5).

Fulfilling the goal in CHLA's *Strategic Plan 2018–2021* (CHLA, 2018) to review and update the 2006 Canadian standards, a new edition was published in 2021 under a revised title to include social services, *CHLA Standards for Library and Information Services in Canadian Health & Social Services Institutions 2020* (Frati et al., 2021). Like the English framework, it was largely driven by the need for more current and evidence-based standards, the rigour of which was ensured through expert literature searches (Frati et al., 2021, p. 21).

Although a complete revision was not considered necessary, new standards were added to reflect the major changes of the last decade: the need for adequate professional development (Standard Six), the importance of appropriate technology (Standard Eight), and the need to advocate the value of library services (Standard Nine). In addition, other standards were amended to update their content, notably Standard Three, which sets out a minimum level of service, and Standard Five, which includes a new staffing algorithm (Frati et al., 2021, pp. 4–5, tab. 1), which was subsequently incorporated into the Australian and US standards. As with previous editions, the spirit of the Standards is to provide guidance without being prescriptive. They are intended to provide a baseline for the provision of essential library services and resources, and to assist in advocacy for adequate resources.

In late 2021, Ann Ritchie cited the impact of three global developments—the 2008 financial crisis, the role of digital technologies and telemedicine, and the Covid-19 pandemic—to justify the need for a major revision of the 2008 Australian guidelines (Ritchie, 2021). In response to this need, the fifth edition of the Guidelines was published in 2022 (Ritchie, 2022), with significant changes to both the purpose, content, and use of the standard. As with the previous standards, the key improvements in

the new edition were led by ensuring that the guidelines were underpinned by robust evidence derived from literature research (Ritchie, 2022, p. 3).

The purpose has been reworded to 'place health libraries firmly in the context of the core business of their parent organisations' (Ritchie, 2021, p. 9). The content has been revised by updating or adding new criteria to recognise the important and unique role developed by the library in the functioning of its organisation. These changes address strengthening of the library's strategic direction (criteria 1.2 and 1.3); the reclaiming of health libraries as the sole source of authoritative, evidence-based information for their organisations (criterion 2.6); the comprehensive review of human resources management (criterion 3.1); and the recognition of the unique competencies of libraries in providing customer-focused information services (criterion 4.3).The Australian guidelines are intended to be prescriptive and aspirational rather than minimum standards, and to be applicable to all types of health libraries. They can be used as a checklist for assessing the library's performance, as a guide for a quality improvement strategy, and as a planning tool (Ritchie, 2021, p. 10).

To conclude the initiatives developed so far, the latest version of the MLA Standards was recently published in March 2023 (Tarabula et al., 2022). Its main updates concern the increasing involvement of library professionals in information technologies (Standard 4), the extension of the concept of library space to include virtual libraries (Standard 10), the inclusion of staffing formulas and levels of library service, (Standard 3), the expanding role of health librarians in education, research and appraisal of evidence-based literature (Standard 5), and the emphasis on their qualifications and competencies to play a key role in the hospital (Standard 2) (Tarabula et al., 2022, pp. 399–400).

It is intended to guide hospital managers, librarians, and accrediting bodies to ensure that the library has the necessary resources and services, to meet the knowledge-based information needs of the hospital (Tarabula et al., 2022, p. 399).

It should also be noted that in recent years several Eastern countries have used the above standards as a reference to evaluate their hospital libraries and develop their own national standards. This is the case of Iranian hospital libraries, which were reviewed and evaluated against the 2007 MLA standards in 2019 (Saberi et al., 2020), and as a result the *National Standard for Hospital Libraries* was adopted in autumn 2020 (Kabiri et al., 2021). Other examples would be the study developed by Masalinto et al. (2015) in the Philippines, which aimed to identify which types of health libraries were following the 2007 MLA standards, as a step prior to the adoption of their standards for special libraries; or the minimum standards for medical libraries in India proposed by Narang and Kumar Vishwakarma (2021), which took as a reference the main national standards for hospital libraries published in the 2000s.

DISCUSSION

The above analysis of national standards for health libraries over time, from the emergence of the first initiatives to the current standards, has allowed us to identify several trends, which are presented below.

Although we are aware of the bias of the review towards Anglo-Saxon and European countries, due to the difficulty in accessing standards developed in Eastern countries, the first point to note is that most initiatives in health library standardisation over time have been developed by a reduced group of Anglo-Saxon countries, United States of America, Canada, Australia, New Zealand, Ireland and the United Kingdom. To these can be added, albeit to a lesser extent, Germany with only one edition of its standards.

In addition, there has been and continues to be a very close relationship between these countries in the development, revision and updating of their national standards, to the extent that they can be considered to build on each other, as evidenced by the similarities and the cross-references between them. US standards have traditionally had a strong influence on the others, as well as on the standards developed by other European and Eastern countries, which have translated, adopted, or adapted them.

The historical development of standards shows that most countries, especially since the emergence of quality assurance in the late 1970s and 1980s, have periodically updated their national standards, adapting them to the major changes that have occurred in both medical practice, hospital priorities and the health care environment. The strengthening of hospital libraries in the 1970s, the economic crisis of the 1980s, the advent of the Internet, the impact of evidence-based medicine, the technological advances and the recent pandemic are key factors that have changed the landscape of health libraries and influenced the development of national standards.

The analysis of standards production shows a progressive increase in both the number of standards and the number of countries involved in the process. In the last decade there has been a hiatus in this process, and for more than 12 years only the United Kingdom has continued to revise and update its health library standards on a regular basis. It is only in the last 3 years that Canada, Australia and the United States have published new editions of their national standards, again closely linked.

The nature and purpose of standards has also changed over the years. The focus has gradually shifted from resources and service levels (quantitative aspects) to service quality and, more recently, to service outcomes (impact and value). Throughout the review, two questions about these aspects can be identified that have recurred over the years and remain open today. The first is whether standards should be qualitative or quantitative; the second is whether compliance with standards should be mandatory or merely recommended.

In this respect, standards are controversial and various arguments and positions have been adopted over the years, which can be grouped into two general trends: one that opts for quantitative standards because they are more effective, easier to assess and allow minimum levels of service to be required; and another that prefers the use of service quality guidelines that can be flexibly applied to the institution's circumstances on a voluntary basis (Topper et al., 1980, p. 283). As Jones illustrates, '(standards) are seen as either so specific that they quickly become obsolete or not widely applicable, or so general that compliance cannot be assessed' (Jones, 1990, p. 82).

Closely related to the above issues is the question of the use of the term 'standards' or 'guidelines'. Although they are often regarded as interchangeable, it has also been argued that they can be distinguished on the basis that compliance with guidelines is often voluntary or encouraged, whereas compliance with standards should be mandatory. At least in theory, as practice shows that this is not necessarily the case (e.g., the current Australian guidelines are prescriptive, while Canadian and US standards are not). In any case, compliance is difficult to enforce unless some external organisations require it for accreditation or as part of an ongoing assessment programme (Jones, 1990, p. 82).

However, these positions are not necessarily mutually exclusive, but complementary. Several of the standards, particularly since the late 1990s, have attempted to resolve the conflict by including both qualitative guidelines and quantitative standards, depending on which are most appropriate for each of the aspects addressed. This is the case in most current standards, except for the English framework, which has taken a step forward by including outcome-based standards to establish the impact and value of the service, rather than its quantity or quality.

Another trend to note is that in most of the cases reviewed, the development of standards has been driven by national health library associations (e.g., the MLA, the Canadian Health Library Association, the Australian Library and Information Association or the UK National Health Service). However, as the development of standards is closely linked to the accreditation process, in several countries they have also been promoted by national hospital accreditation bodies, which have incorporated them into a broader set of standards covering the full range of hospital functions and services. In these cases, despite occasional conflicts, there has been a close relationship between the library associations and the accreditation bodies, so that the standards developed by the former reflect the main trends of those developed by the latter, and vice versa. The most illustrative examples can be found in the US context, where the JCAH (later JCAHO) has worked very closely with the MLA in this area since its inception, and in the Canadian case, where a similar relationship exists between the CCHA, the current Accreditation Canada, and the CHLA.

In this context, it is also worth noting the evolution of the role of the library in the hospital accreditation process: from being a desirable but not mandatory element in the JCAH standards of 1953, to being considered a key factor in the process a few years later. Indeed, they make a substantial and essential contribution to hospital accreditation, to the extent that hospitals with no or limited library services may be at a disadvantage and risk underperforming in national accreditation processes, as the results of the Australian Health Libraries for the National Standards (HeLINS) research project have shown (Ritchie et al., 2020).

The accreditation of hospital libraries is also becoming increasingly important, and with it the relevance of related standards. Cases such as the United Kingdom, where the first national accreditation programme was developed in 1998, show that accreditation is an important agent of change for health libraries, bringing them a range of benefits in terms of service provision and use, staffing and funding levels, hospital management involvement and user awareness of services (Trinder, 2006). This explains the interest of the current Canadian and Australian standards in implementing a future accreditation system.

Despite this recognition of the importance of hospital libraries, their history has often been one of cutbacks in human and financial resources, if not mergers and closures. Even today, this is a problem that is far from being overcome. In 2019, Harrow et al. (2019) reported a decline of more than 30% in the number of medical libraries in the United States of America between 2007 and 2017. Barely 2 years later, Frati denounced the alarming trend of hospital library closures, budget cuts and staff reductions, and urged decision-makers to take concrete action to ensure that hospital libraries continue to provide their services (Frati, 2021).

Over the years, health librarians have been forced to defend the value and impact of their services to their organisations, with an increasing need to justify their work and even the very existence of their libraries.

Driven by this need for recognition and research evidence, the last decade has seen a significant number of initiatives to measure the impact and value of health libraries, aimed at showing that they are an integral and valuable part of health care organisations. Examples include the 2013 replication of the Rochester project developed in the United States of America and Canadian hospital libraries (Bartlett & Marshall, 2013; Marshall et al., 2013); the 2017 MLA hospital library benchmarking study (Spencer et al., 2019) or the 2019 survey of EAHIL members on the value of libraries to clinical and health governance (Ibragimova & Korjonen, 2019).

We can therefore agree with Marshall that the need to demonstrate the impact of health library and information services remains one of the major challenges for the library and information profession in the 21st century (Marshall, 2007) and one of the major issues requiring research that can provide rigorous evidence of its outcomes.

Limitations of the study

The main limitations of the study stem from the difficulties in comprehensively identifying, retrieving, and accessing the national standards for health libraries developed in each country, as outlined below.

Although the selected databases cover a wide range of sources, by focusing on journal articles and to a much lesser extent conference proceedings or books, there may be national standards that may have been missed if they were not published or referenced in a journal indexed in one of the databases. This is an important limitation as many of the standards, particularly those produced before the 1990s, were published as a printed book or disseminated other than in an indexed journal. We tried to find standards that had been distributed by other means by searching Google Scholar. This enabled us to find several that had been published on the websites of health library associations (e.g., LIANZA), in institutional repositories (e.g., Lenus) or in digital libraries (e.g., HathiTrust). However, we are aware that it is possible that national standards may not have been included in the study because they were not publicly and freely available on the Internet.

Another limitation is the difficulty of accessing standards content where full text was not available. This factor is also relevant to standards produced in the early decades, mostly in printed form as noted above, and for which we were often only able to obtain the reference or summary, unless they had been digitised. When it was not possible to access the original content of the standard, other secondary sources such as reviews, editorials, articles, or reports were used.

Finally, although there was no linguistic restriction in the search strategy developed, most of the national standards identified were from English-speaking countries. Although they are the most prolific in this field, which would justify this predominance, we are aware of the bias of the review towards these Anglo-Saxon and European countries. This is due to the difficulty of accessing standards developed in Eastern countries, unless they have been published or disseminated in English, as in the case of India, the Philippines or Iran, already mentioned. In this sense, almost 30 of the publications initially retrieved and selected were excluded because they were written in non-Latin scripts, most of them in Persian, but also in Korean, Japanese and Chinese.

CONCLUSION

The aim of this work was to identify, analyse and critically review the national health library standards that have been developed over time in different countries around the world. As a result of the bibliographic search conducted, more than 40 national standards were identified, published by a reduced group of Anglo-Saxon and European countries, over a period of 70 years, from the 1950s to the present day.

The need for health libraries to demonstrate the value they bring to their institutions seems particularly pressing at a time when professionals are denouncing cuts in resources and warning of the risk of hospital libraries disappearing.

In this context, standards appear to be a particularly useful tool for raising awareness among hospital authorities to ensure that libraries are provided with the resources and services necessary to meet the information needs of their users. They are also an effective means for libraries to communicate best practice and demonstrate the value they bring to their organisations.

The inclusion of evidence and outcomes-based standards in the latest editions of the national standards for health libraries would be an important step in this direction. By integrating qualitative and quantitative evidence to show the impact of library services, they help to promote evidence-based practice and demonstrate the value of services in terms of outcomes rather than outputs.

We can conclude that further research and ongoing collaboration between health libraries are essential to promote their role in the governance of their organisations, to demonstrate value of their services to quality patient care, and even to ensure their very existence. Standards, as a means for providing guidance and building consensus, are essential in this journey.

CONFLICT OF INTEREST STATEMENT

The author declares no conflicts of interest.

ETHICS STATEMENT

This study was exempted from ethical review as there no participants involved in this study.

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APPENDIX

SEARCH STRATEGIES USED IN DATABASES

Database	Search strategy	Limitations	Hits
Scopus	Three queries in the Advanced Search were combined: (TITLE([hospital librar*] AND [standard* OR guideline* OR accreditation OR 'quality assurance'])) OR (TITLE([health* libr*] AND [standard* OR guideline* OR accreditation OR 'quality assurance'])) OR (TITLE([medical libr*] AND [standard* OR guideline* OR accreditation OR 'quality assurance']))	None	60 documents 85 secondaries documents
Web of Science	TI = ((hospital librar* OR health* librar* or medical librar*) AND (standard* OR guideline* OR accreditation OR 'quality assurance'))	None	52 documents
MEDLINE (Search through EBSCOHost	TI (hospital librar* OR health* librar* OR medical librar*) AND (standard* OR guideline* OR accreditation OR 'quality assurance')	None	41 documents
LISA (Search through EBSCOHost	TI (hospital librar* OR health* librar* OR medical librar*) AND (standard* OR guideline* OR accreditation OR 'quality assurance')	None	31 documents
Google Academic	Advanced search option: Search for articles with all the words in the article title ('intitle')	None	168
Total			437