As Shakespeare put it (in *All's Well That Ends Wyly*): "But thou art too fine in thy evidence; therefore stand aside." As today's family practitioner might update it: "How do you expect me to learn all this evidence stuff you are talking about? I am already struggling with budget managers, contracts with secondary care, and prescribing costs. I hardly have enough time to see all my patients, let alone do the educational stuff I am supposed to do. And now you want me to look up a reference in some electronic library thing whenever someone comes in with an earache?"

This response to an attempt to introduce evidence-based health care to a family practitioner is not unusual. General practitioners (GPs) may see an average of 125 patients per week. During each of these consultations, several questions may arise concerning diagnosis, prognosis, and treatment. Therefore, a practitioner could possibly make 25,000 clinical decisions a year. Given this vast number of problems, it is not surprising that the following 4 points are often raised as barriers to implementing an evidence-based approach within primary care.

1. **Evidence for more than a tiny fraction of the decisions made in primary care cannot possibly be available.** 10 years ago this may have been a legitimate argument, but today it is no longer the case. The number of randomised controlled trials is now huge, and the number indexed (in MEDLINE) under primary care, although still small, has increased 5-fold since 1986 (1). Thus, a quick MEDLINE search identifies 9 randomised trials on the treatment of in-grown toenails, 38 on atopic dermatitis, and 11 on the treatment of glue ear. Only 1 search result (glue ear), however, was published in a primary care journal. A lot of high-quality, relevant evidence is already there, but it remains invisible to most GPs, even those who keep up to date with the mainstream journals (2, 3).

2. **Even if the evidence were available, family practitioners could not find the time to track it down.** Of course they could not. But the move toward a more evidence-based primary health care does not require that practitioners track down evidence on every question or appraise all the evidence themselves. Much of the evidence that answers clinical questions in primary care already has been tracked down, critically appraised, and packaged in easily accessible forms. This journal constitutes 1 of them, and the previous 5 years of evidence that has appeared in its sibling publication, *ACP Journal Club*, is now available on disc (*ACP Journal Club on Disk*). Haynes RB, editor. Philadelphia: American College of Physicians, Serial software for PC or Macintosh.

Many of these single-page abstracts and commentaries relate to primary care issues. Because only about 2% of the clinical articles in the more than 50 journals screened for these publications pass both scientific and clinical criteria, the reading time that is now required to keep up to date with important clinical advances is a small, feasible fraction of its former, unmanageable magnitude. Another rapidly expanding resource is the Cochrane Database of Systematic Reviews (CDSR). This resource, already available on floppy disk and CD and soon to be available on the Internet, contains extensively and methodically searched reviews of randomised trials on the effects of health care and already has become a practical resource for primary care physicians.

But many issues in primary care have not gone through this careful assembly and appraisal, and reliance on non-evidence-based reviews is risky. To address these, clinicians must spend the time required to find the evidence. The amount of time required for searching will vary with each question, but the practitioner who can find 1 hour a week in which to search and read will make huge strides. Often the solution is finding in searching the electronic publications described above, with the additional bonus of avoiding the need to carry out the tasks of critical appraisal. But when this approach is unsuccessful, the next stage involves an electronic search of the literature, either on one's own or with the assistance of a librarian.

Medical libraries are increasingly aware of the needs of family practitioners, and many will take requests for papers by telephone and will fax the requested information to the practitioner the same day. Moreover, many GPs already search and retrieve published evidence on their office computers, and many medical associations provide access to the bibliographic databases (we will present more on this in subsequent EBM Notes). In most searches, the associated abstracts can be downloaded, and they often provide sufficient information to permit the seeker to critically appraise the evidence and determine its clinical relevance and application (4–7).

3. **Family practitioners lack the necessary skills and experience to critically appraise the evidence and determine its applicability within their locality.** Tracking down and appraising evidence sounds daunting to practitioners who are not well versed in computer use, literature searching, or critical appraisal. However, the courses and workshops in critical appraisal that were started at McMaster University in Canada are now also being run in the United Kingdom and in other parts of the world, and increasing numbers of undergraduate and postgraduate courses are teaching these skills. In recognition of the im-
importance of these skills, for several years the examination for the UK Royal College of General Practitioners has included a section requiring the critical appraisal of a clinical article.

4. The relevant evidence cannot be recalled during the consultation when the answers are required.

Even if successful in solving all the foregoing, practitioners face the challenge of storing the results of their searches and critical appraisals in ways that can be readily accessed when they need them. Merely setting them aside is a recipe for failure and frustration. With computers on the desks of a growing number of practitioners, pre-appraised evidence such as the CDSR and ACP Journal Club on Disk, and reference-managing software, the potential exists for keeping the evidence needed to assist with the most frequent questions and decisions literally at one's fingertips.

“The future is here now; it just isn't evenly distributed yet!” Even with these 4 solutions, too many questions remain for an individual practitioner to answer. But collegial help is on the way. With a growing number of family practitioners learning how to search and critically appraise, the opportunities for progress through collaboration are rapidly increasing. For example, UK primary care researchers, GP trainers, and postgraduate tutors, coordinated by university departments of general practice, have agreed to share expertise and resources. As these and similar groups share the tasks of searching for and appraising evidence, they can electronically collate their critical appraisals in agreed-on formats (such as that used by this journal) and make them available on the Internet to all family practitioners. The result could form a key element of a multi-faceted information package, led by a list of key clinical questions. This question list could be annotated to indicate which questions have already been answered (pointing to the relevant critical appraisals), which are currently being searched and appraised (and how to join in), and which are still unanswered (providing a research agenda for primary care investigators). This collaborative approach, which permits individual practitioners to access critically appraised evidence on a large scale while keeping their individual requirements for finding, appraising, and sharing evidence on a small scale, may constitute the best way to achieve the widespread practice of evidence-based primary care.

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References