that policy cannot be effectively or safely applied without the active collaboration of practitioners who understand the basis for the policy as well as the circumstances and wishes of the patient. On the other hand, practitioners cannot continue to be so informal and idiosyncratic in dealing with individual clinical problems. Fortunately, emerging evidence shows that involving local practitioners in policy development, coupled with responsive local systems, can succeed where the creation of national guidelines fails (21).

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References

This EBM note was also published as an editorial in ACP Journal Club. 1997;126:A-14-16.

One recurring criticism of evidence-based medicine is that no one has sufficient time to practice it (the irony should not be lost when this criticism is juxtaposed with the counter-claim that "everyone is already doing it"). How much time do we have for practising evidence-based medicine? Readers of this EBM note will not be surprised to discover that data on this important issue are thin, highly variable, and more than a bit suspect, even for so circumscribed a step in the evidence-based medicine process as tracking down and examining the evidence.

At the optimistic end of the scale, results from one survey of self-reported reading time among housestaff* in a U.S. teaching hospital showed an average weekly reading time of 8.7 hours (1). But when the self-reports of housestaff at another U.S. teaching hospital were challenged by page counts, it was found that even at random intervals to find out what they were doing, it was discovered that they read only about one third as much (2.7% of a working day) as they claimed (8.4%) (2). That comes to about 100 minutes for a 6-day week of 10-hour days in the latter study and about 170 minutes per week in the former. At the pessimistic end of the scale are surveys of self-reported reading times among medical students and housestaff at 13 university and district general hospitals in the United Kingdom (3). When asked to report the number of minutes they had spent in the previous week reading with the restricted objective of learning about patients in their care, the median reading times were 90 minutes for medical students; 0 minutes for house officers; 20 minutes for senior house officers; 30 to 45 minutes for registrars; 45 minutes for consultants who graduated from medical school after 1975; and 30 minutes for older consultants.* While waiting for better evidence, we can safely reckon that the time available for the evidence-seeking and reading steps of evidence-based medicine will be highly variable and generally scarce, and we might usefully think of it in "chunks" of, say, 30 minutes. For many of us, that will mean just one chunk per week; others may have several chunks; and some (e.g., house officers and interns) may have none at all.

What can be accomplished in 30 minutes? Not much, if we have to travel to the evidence, as reported by Leicester, United Kingdom, general practitioners who usually spend twice as long (and sometimes 6 times as long) travelling to their medical library as reading in it. Even for hospital-based physicians with short travel times to the library, the probability of interruption (by sleep or sleep) during the time required to search both MEDLINE and the library stacks and then digest the results may discourage the initial attempt.

On the other hand, when the evidence can travel to us, our efficiency can increase to the point where a single chunk of time can yield an answer to an important clinical question. Bringing the evidence to the clinician is the idea behind the electronic publication earlier this year of Best Evidence, which is available on compact disc and floppy disc. It is driven by a friendly searching engine and contains all of the first volume of Evidence-Based Medicine and all 6 years of ACP Journal Club. Prescreened for methodological soundness and presented in the form of evidence (the abstracts) and clinical expertise (the commentaries), Best Evidence can reside on the home or surgery or office computer or can be added to bedside information systems in hospitals. The same sites can carry a wide range of other instant sources of evidence as well as increasingly friendly MEDLINE searching software, refereence retrieval systems, and software that helps busy clinicians generate, store, and share clinically useful measures and summaries of the effects of diagnostic tests and treatments (4).

Our time for practising evidence-based medicine will not increase, at least not in any future I can envision. But we are already witnessing increases in the efficiency with which we can use that time. Indeed, you are using a more efficient method now. Reading this journal, which reduces the contents of its source journals by 98%, takes up about one 20-minute chunk of time for London, United Kingdom, general practitioners every 8 weeks in "keeping up-to-date." For many of them, this opens up the other 7 chunks for answering the important clinical questions that will help them practise evidence-based medicine in their daily work.

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Reference

* In the United Kingdom and many other countries, house officers are in their 1st postgraduate year (like North American interns); senior house officers their 2nd to 6th years (like North American residents); registrars and senior registrars (now being combined into a "uniform training grade") are in their 3rd and highest postgraduate years (like North American subspecialty residents).