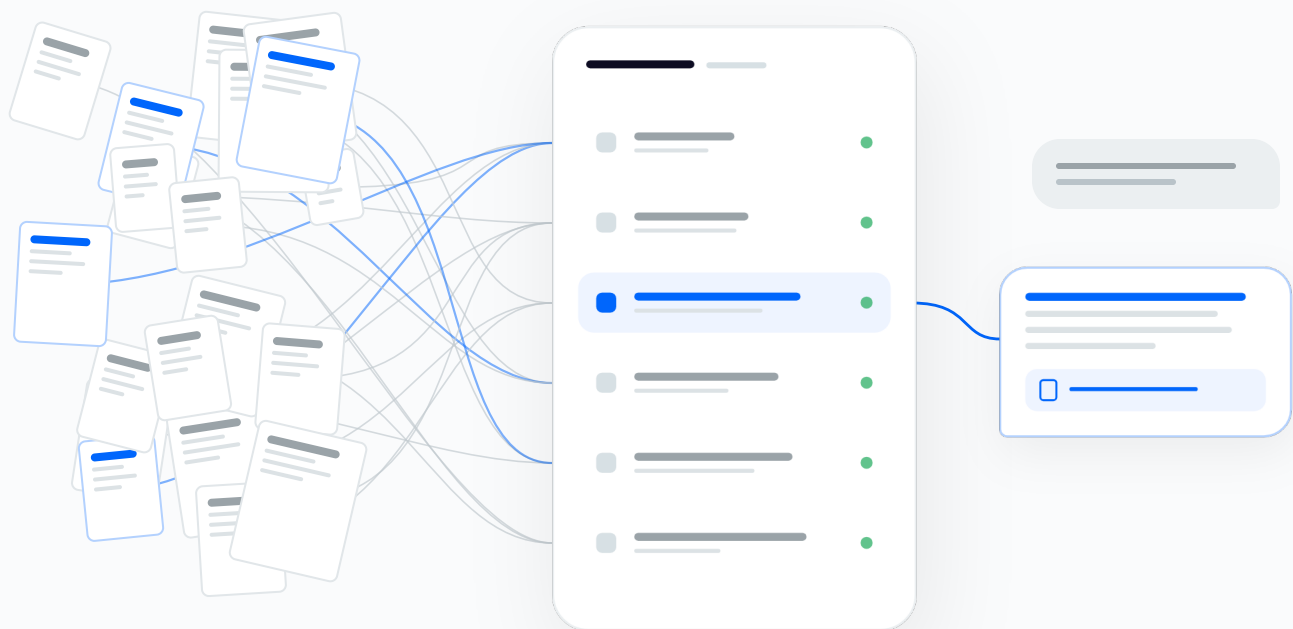

THE STATE OF CLINICAL KNOWLEDGE MANAGEMENT 2026

THE CLINICAL KNOWLEDGE GAP

How health systems can turn evidence into trusted answers at the point of care



FRAGMENTED INFORMATION

GOVERNED KNOWLEDGE

TRUSTED ANSWER

Healthcare does not have an information shortage.

It has a knowledge-delivery problem.

Medical evidence has never been more abundant.

Clinical guidelines, journal articles, drug references, pathways, local protocols and digital tools continue to expand.

Artificial intelligence is making access faster still.

But availability is not the same as usability.

When a clinician needs an answer during care, the central question is not whether relevant information exists somewhere.

It is whether the right, trusted and locally applicable answer can be reached in the moment it is needed.

Aggregate Eolas platform activity shows a consistent set of patterns:

- Clinical guidance is opened well beyond office hours.
- Within Eolas, local protocols are opened far more often than national and global references.
- Clinicians move between mobile devices and workstations.
- Natural-language questions now sit alongside document navigation.
- And as AI makes answers easier to retrieve, some answers are still followed by a click to the underlying referenced document.

Together, these patterns point toward a larger shift:

Clinical knowledge management is moving beyond document storage.

It is becoming infrastructure for delivering governed knowledge into clinical workflows.

AGGREGATE PLATFORM ACTIVITY

Surveys and research describe what clinicians and health systems report. These figures describe aggregate activity on the Eolas platform.

38.7%

of UK protocol opens occur outside weekday 8am–6pm hours or at weekends.

5.5x

5.5 times as many local-protocol opens as national/global-reference opens.

59.5%

of protocol opens in the analyzed dataset occurred on mobile devices (iOS, Android, iPad).

Source: Eolas aggregated platform activity, approximately October 2025–September 2026. UK-led where indicated. See Methodology.

The challenge is no longer simply access to information. It is shortening the distance between:



More information. More AI. Less time to navigate it.

Public institutions and professional bodies describe the environment clinicians now work in.

EXTERNAL CONTEXT

01

DIGITAL ACCESS
EXPANDED

82%

OECD reports that average availability of online digital health services relating to electronic health records reached 82% in 2024, compared with 79% in 2023 among countries with comparable data.

The indicator concerns citizens' online access to electronic health records. It does not measure clinician access to clinical guidelines.

OECD notes that interoperability is an organizational and governance challenge as well as a technical one.

Source: OECD, Health at a Glance 2025: Data and Digital

02

CLINICAL WORK
REMAINS
PRESSURED

NHS STAFF IN ENGLAND · 2025 SURVEY

31.5% reported feeling burnt out because of work.

35.1% reported finding their work emotionally exhausting.

Workforce context for NHS staff in England, shown because much of the Eolas activity in this report is UK-led. It is not an explanation of platform activity.

Source: NHS Staff Survey 2025, National Results Briefing (published 2026)

03

AI ADOPTION
ACCELERATED

72%

of respondents to the AMA's 2026 physician survey reported incorporating at least one AI use case into their practice.

Research summarization and documentation were prominent applications. The measure covers AI use generally, not generative AI or clinical decision support specifically.

Source: AMA, Physician Sentiment Report on AI, 2026, p. 5. Use-case chart n = 1,342; total survey n = 1,692.

04

NATIONAL AI
READINESS
REMAINS UNEVEN

8%

of responding WHO European Region countries have a health-specific national AI strategy.

Country-level responses from 50 of the WHO European Region's 53 Member States, 2024–2025 survey. Explored further in Part 06.

Source: WHO/Europe, Artificial intelligence is reshaping health systems: state of readiness across the WHO European Region, 2025

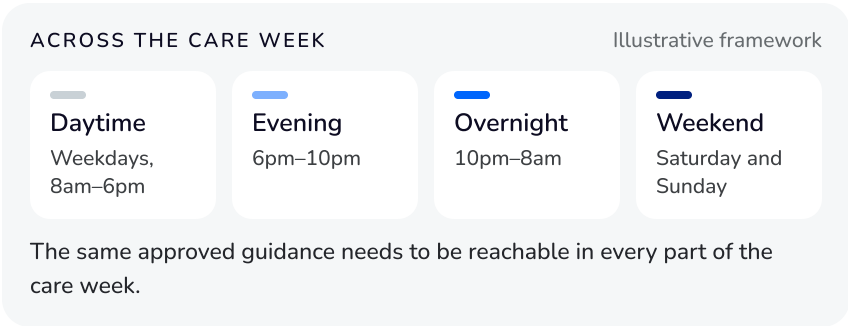
The healthcare information environment has changed faster than the systems used to govern and deliver knowledge inside it.

Clinical questions don't keep office hours

Care runs around the clock. So does the need for guidance.

Clinical work continues through evenings, nights and weekends. Across UK Eolas protocol activity, 38.7% of opens occurred outside weekday 8am–6pm hours or at weekends. 16.3% occurred between 10pm and 8am. Weekend activity represented 17.6%.

Access activity describes when guidance was opened. It does not establish staffing levels, availability of support, unmet need or clinical outcomes.



AGGREGATE PLATFORM ACTIVITY

38.7%

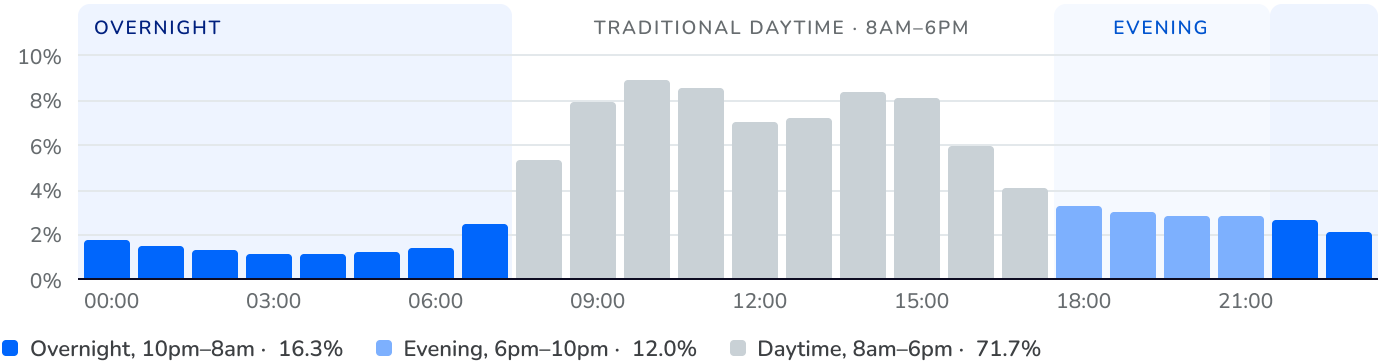
of UK protocol opens occurred outside weekday 8am–6pm hours or at weekends.

16.3% occurred between 10pm and 8am.

17.6% occurred at weekends.

Share of UK protocol opens by hour of day

All seven days combined, UK time; the three shares sum to 100%. The 38.7% headline also counts daytime opens at weekends, so it is larger than the evening and overnight shares combined. Weekend opens (17.6%) fall within these hours and are not a separate category.



Source: Eolas aggregated platform activity, UK protocol opens (12.3M), approximately October 2025–September 2026; hourly values rounded to the nearest thousand.

Clinical knowledge infrastructure has to work on the clinician's schedule.

A QUESTION TO CONSIDER

Can your guidance be reached whenever care is delivered?

Evidence is global. Care is local.

Evidence tells clinicians what works. Local knowledge tells them what to do here.

National and global sources establish evidence, standards and best practice. But care is delivered inside specific health systems.

Local formularies differ.

Escalation routes differ.

Available services differ.

Referral processes differ.

Approved pathways differ.

EXTERNAL CONTEXT

Guidelines exist, but published evidence shows they are not always the most frequently used information source.

Pooled estimates of reported information-source use among medical specialists.

Digital databases (e.g. PubMed)	74%
Textbooks	71%
Point-of-care websites	49%
Clinical practice guidelines	38%

Source categories overlap; estimates vary across studies and are not shares of all searches.

Source: Weller et al., BMJ Open, 2026. Systematic review of 25 studies; 6 studies (8,641 participants) were eligible for meta-analysis.

AGGREGATE PLATFORM ACTIVITY

5.5x

5.5 times as many local-protocol opens as national/global-reference opens.

~85% Local

~15% National / global

Relative share across these two measured categories only, not a share of all Eolas activity. This comparison describes activity within Eolas. It does not measure clinicians' overall use of national guidance or establish a preference independent of content availability and platform design.

Source: Eolas aggregated platform activity, 14.2M local-protocol opens vs 2.58M national/global-reference views (BNF, NICE, WikEM, Medusa, SmPC), approximately October 2025–September 2026. Local protocols may include copies or adaptations of national guidance.

INTERPRETATION

This does not mean national evidence matters less. Local protocols often carry national evidence into practice, adding the formularies, pathways, services and escalation procedures that apply in a specific organization:

“What do we do here?”

The practical question is often not whether evidence exists, but whether it has been translated into local context a clinician can act on.

The review and Eolas activity describe different populations. The review does not explain the Eolas pattern.

Clinical knowledge becomes actionable when evidence meets local context.

A QUESTION TO CONSIDER

How does national evidence become locally applicable?

Knowledge has to travel with the clinician

Guidance is opened on phones and on workstations. It should be the same on both.

Point-of-care questions are often highly practical. A dose. A renal adjustment. An interaction. A pathway.
An escalation route. A locally approved procedure. Illustrative examples

The usefulness of clinical knowledge therefore depends not only on what information exists, but how much friction sits between the question and the answer.

FOUNDATIONAL RESEARCH, PUBLISHED 2014

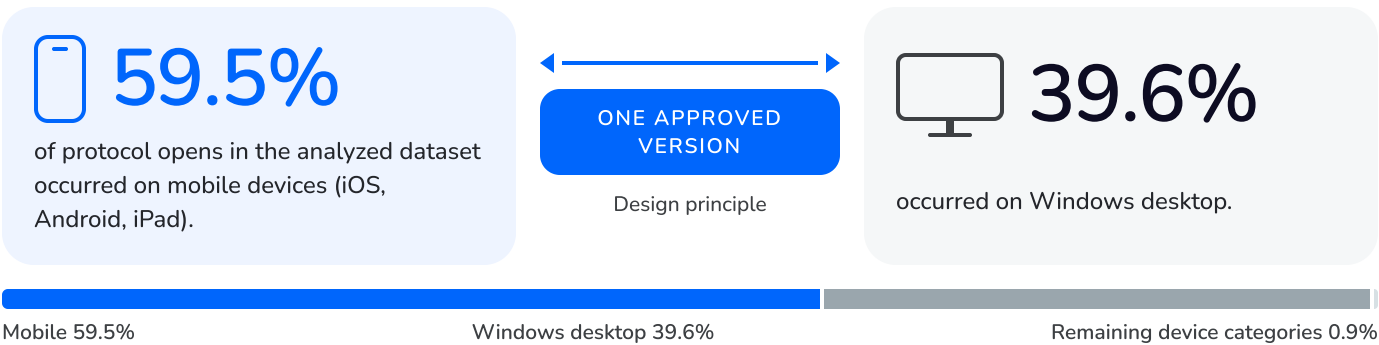
Del Fiol, Workman and Gorman · JAMA Internal Medicine · literature searched to May 2011; not a measure of current practice



Lack of time and doubt that a useful answer existed were major barriers to pursuing questions. Whether an answer is pursued depends partly on the effort required to reach it.

AGGREGATE PLATFORM ACTIVITY

Share of protocol opens by device type



Device type describes where guidance was opened, not where care took place. A mobile open does not establish use at the bedside.

Source: Eolas aggregated platform activity, protocol opens by device type, approximately October 2025–September 2026.

Clinical knowledge has to move between the workstation and the pocket without changing the answer.

A QUESTION TO CONSIDER

Can clinicians reach the same approved guidance on every device they use?

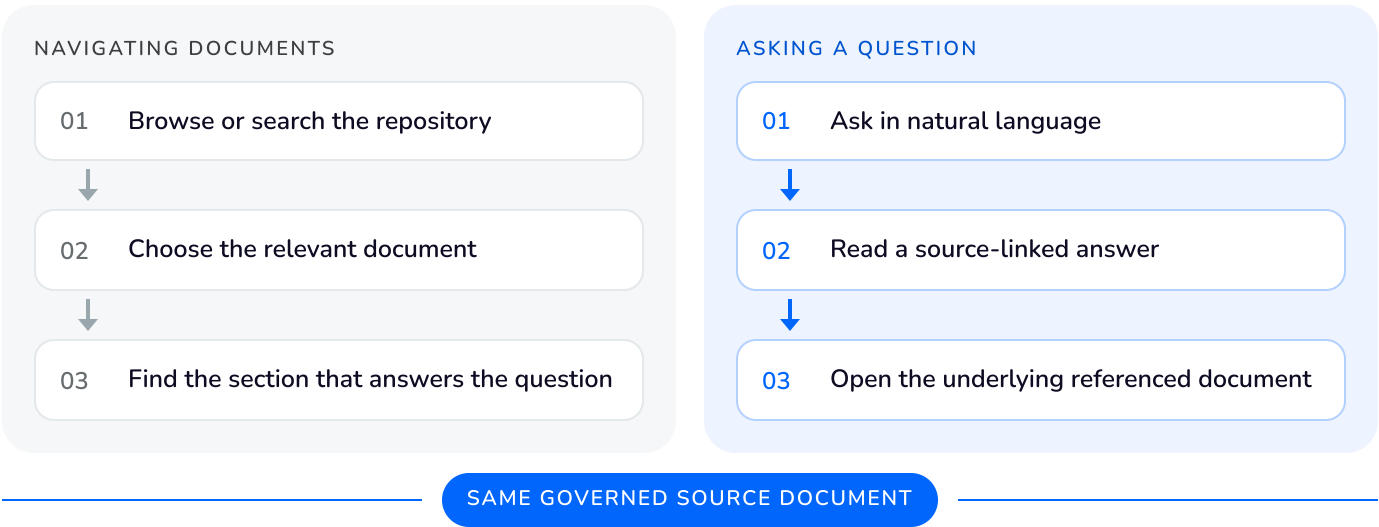
From finding documents to asking questions

The question hasn't changed. The interface has.

Digital clinical information retrieval has traditionally meant navigating repositories, selecting documents or entering keywords. Natural-language interfaces are beginning to change that interaction model.

Two routes to the same approved guidance

Illustrative framework



Natural-language questions add a route to guidance. They do not replace the underlying documents, which remain the reference point for both.

EXTERNAL CONTEXT

72%

of respondents to the AMA's 2026 physician survey reported incorporating at least one AI use case into their practice. Research summarization and documentation were prominent applications.

Source: AMA, Physician Sentiment Report on AI, 2026, p. 5 (use-case chart n = 1,342)

INTERPRETATION

Clinical knowledge interfaces are beginning to expand from navigating content to asking questions.

The AMA figure covers AI use generally among U.S. physicians. It is not a measure of generative AI, clinical decision support or Ask Eolas use.

Clinical information retrieval is beginning to expand from finding documents to asking questions.

A QUESTION TO CONSIDER

When clinicians ask a question in natural language, which approved sources should the answer draw from?

The answer is only part of the story

Faster answers make the source more important, not less.

Generative AI can reduce the effort required to retrieve information. But clinical confidence depends on more than speed. Clinicians also need to understand where an answer came from and whether it applies locally.

AGGREGATE PLATFORM ACTIVITY

Ask Eolas answers, approximately
October 2025–September 2026

Some natural-language answers were followed by a click to the underlying referenced document.

A source click shows interaction with a reference. It does not establish whether an answer was verified, trusted or used in a clinical decision.

A useful answer should make its supporting sources easy to inspect.

DESIGN PRINCIPLES

01

See the reference

Which document the answer draws on, named clearly alongside the answer.

→

02

Open the original guidance

One step from the answer to the underlying document, in full.

→

03

Understand local applicability

Whether the source is a local protocol or a national/global reference, and who owns it.

Interpretation. These are recommended principles, not an assessment of every Eolas answer.

EXTERNAL CONTEXT

INDUSTRY SURVEY

77%

of surveyed U.S. doctors and nurses reported taking an additional step to verify AI outputs.

Source: Wolters Kluwer Health, Future Ready Healthcare survey, conducted by Ipsos, 11–14 Mar. 2026 (355 clinicians: 203 doctors, 152 nurses). Self-reported; does not measure how often individual answers are verified.

EXTERNAL CONTEXT

88%

rated safety and efficacy validation as important for facilitating AI adoption; 86% rated data privacy assurances as important.

Source: AMA, Physician Sentiment Report on AI, 2026, p. 10. Ratings of 4 or 5 on a five-point importance scale (n = 1,490).

“In clinical knowledge, convenience and provenance have to coexist.”

A QUESTION TO CONSIDER

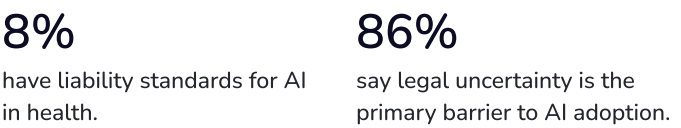
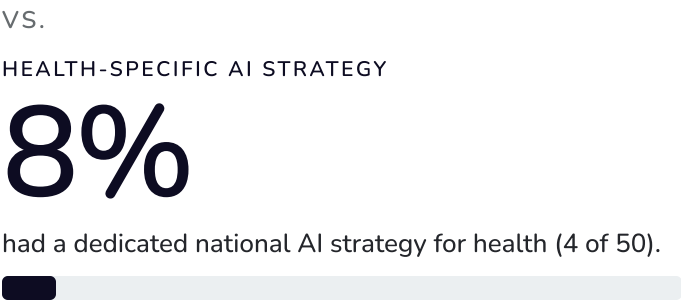
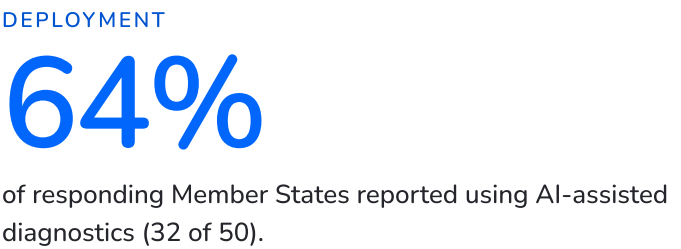
What should a clinician be able to see behind an AI-generated answer?

What governs the knowledge beneath AI?

As AI enters more healthcare workflows, health systems face a practical question: how should the knowledge supporting those tools be governed?

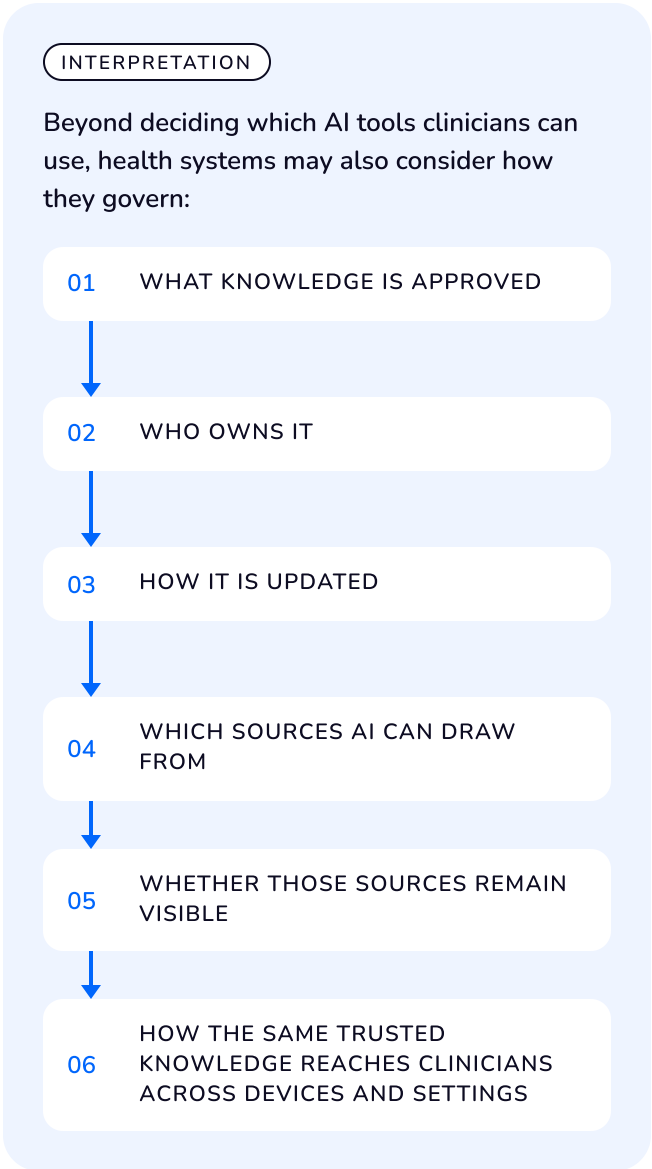
EXTERNAL CONTEXT

WHO European Region · 50 of 53 Member States responding · 2024–2025 survey



Country-level findings provide context for AI readiness; they do not directly assess governance within individual hospitals.

Source: WHO/Europe, Artificial intelligence is reshaping health systems: state of readiness across the WHO European Region, 2025; WHO/Europe news release, 19 Nov. 2025



The next clinical knowledge challenge is not simply AI adoption. It is governing the knowledge beneath the AI.

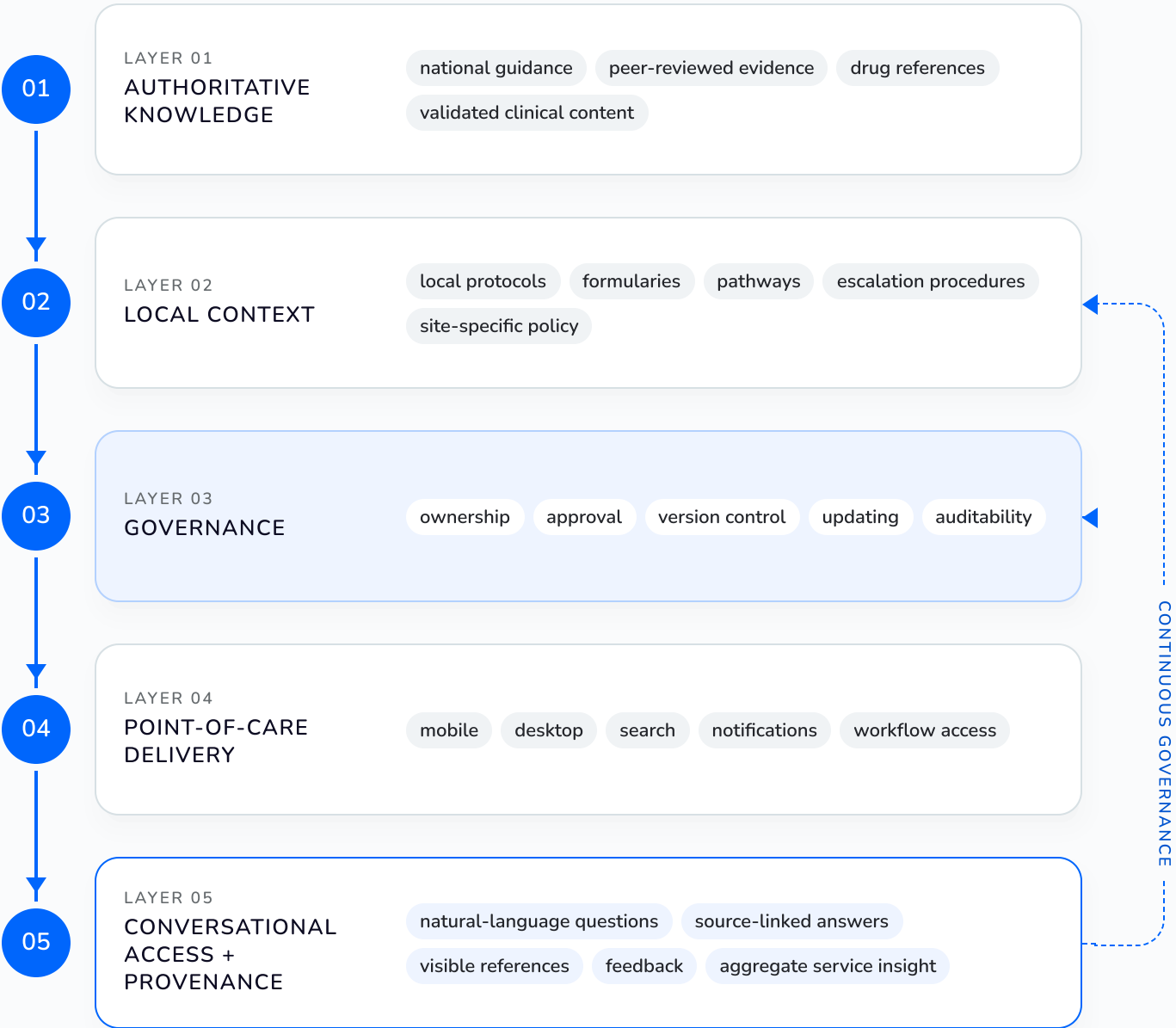
A QUESTION TO CONSIDER

Who in your organization is accountable for the knowledge your clinical AI draws from?

From digital library to governed clinical knowledge infrastructure

External sources describe the environment. Aggregate Eolas platform activity adds observations about how guidance is accessed in practice. The framework sets out the capabilities we recommend health systems consider, based on those combined signals.

Interpretive framework based on the findings in this report; not an independently measured clinical outcome.



Clinical knowledge management is increasingly the layer connecting evidence, local policy, workflow and AI.

Is your clinical knowledge infrastructure ready for AI?

Before adding another clinical AI interface, health-system leaders can ask whether the knowledge environment underneath it is ready.

☐ 01 Can clinicians reach locally approved guidance outside normal working hours?

☐ 02 Is there one governed version of each important local protocol?

☐ 03 Is ownership and review responsibility clear?

☐ 04 Can clinicians access the same approved knowledge across mobile and desktop?

☐ 05 Can updated guidance actively reach clinicians rather than waiting to be rediscovered?

☐ 06 Can conversational AI distinguish locally approved policy from general medical evidence?

☐ 07 Can every AI-supported clinical answer expose its underlying source?

☐ 08 Can aggregate usage trends help identify where guidance is difficult to reach?

Aggregate access patterns

Content availability

Navigation friction

Update reach

Workflow fit

☐ 09 Is someone accountable for the knowledge layer underneath clinical AI?

☐ 10 Can the organization see when knowledge was approved, changed and by whom?

Usage analytics should be interpreted as signals about the knowledge service, not as measures of individual clinical competence or performance.

AI readiness is not only a model question.
It is a knowledge-governance question.

The next era of clinical knowledge is not about having more information.

It is about shortening the distance between the question and the trusted answer.

Healthcare has spent years digitizing information. Now it is entering a different phase.

Clinicians are beginning to expand from navigating repositories and documents to asking questions directly.

But the fundamental requirements of clinical knowledge remain.

The answer still has to reflect how care is delivered locally.

It has to be available when the question occurs.

It has to move across the devices clinicians already use.

It has to remain current.

And increasingly, it has to make its provenance visible.

The organizations best positioned for the next phase will therefore treat clinical knowledge not as a library of documents, but as:

GOVERNED INFRASTRUCTURE FOR CARE DELIVERY.

EVIDENCE

— LOCAL CONTEXT

— TRUSTED ANSWER

— CLINICAL
WORKFLOW

The interface may change.

The need for trusted knowledge does not.



EXTERNAL CONTEXT

What national and global research tells us about the healthcare environment.

AGGREGATE PLATFORM ACTIVITY

How guidance was accessed across the Eolas platform.

INTERPRETATION

What these findings may mean for clinical knowledge management.

PART 1 · EOLAS DATA

Eolas findings are descriptive summaries of aggregated platform usage analytics for approximately October 2025–September 2026. They describe recorded access activity within Eolas, rather than clinical outcomes or the behavior of all clinicians. No individual-user or organization-level behavior is reported in this publication.

- 01 Time-of-day figures cover UK protocol opens in UK time. The UK grouping uses the country attributed to the device in the source analytics; it does not establish the clinician’s employer, workplace or nationality.
- 02 The 38.7% figure counts opens outside weekday 8am–6pm or at weekends. The hourly chart combines all seven days; weekend opens overlap its categories.
- 03 The 5.5× ratio compares two measured categories: 14.2M local-protocol opens and 2.58M national/global-reference views. Local protocols may include copies of national guidance uploaded locally.
- 04 Mobile covers iOS, Android and iPad.
- 05 Event counts are not equivalent to clinician counts.
- 06 Findings reflect the platform’s user and content mix.
- 07 Usage activity does not establish motivation, clinical competence or clinical outcomes.



ABOUT EOLAS MEDICAL

Eolas Medical provides clinical knowledge management infrastructure that helps health systems organize, govern and deliver trusted local clinical knowledge at the point of care.

PART 2 · SOURCES BY TYPE

GLOBAL AND PUBLIC INSTITUTIONS

WHO Regional Office for Europe.
Artificial intelligence is reshaping health systems: state of readiness across the WHO European Region. 2025.
Used in: Why now; Part 06.
<https://www.who.int/europe/publications/i/item/WHO-EURO-2025-12707-52481-81028>

OECD.
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https://www.oecd.org/en/publications/2025/11/health-at-a-glance-2025_a894f72e/full-report/data-and-digital_fd9fbb54.html

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American Medical Association.
Physician sentiment report on augmented intelligence. Mar. 2026. n = 1,692; use-case chart n = 1,342; importance ratings n = 1,490.
Used in: Why now; Parts 04–05.
https://www.ama-assn.org/sites/ama-assn.org/files/2026-03/physician-ai-sentiment-report_0.pdf

NHS England.
NHS Staff Survey 2025: National Results Briefing. Published 2026. NHS staff in England.
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<https://www.nhsstaffsurveys.com/static/98fbf017ea18aad1523254e02072cd02/National-Results-Briefing-2025.pdf>

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Systematic review and meta-analysis of information source usage. BMJ Open. 2026;16(3):e099887. 25 studies; 6 (8,641 participants) in meta-analysis.
Used in: Part 02. <https://doi.org/10.1136/bmjopen-2025-099887>

Del Fiol G, Workman TE, Gorman PN.
Clinical questions raised by clinicians at the point of care: a systematic review. JAMA Intern Med. 2014;174(5):710–718. Searched to May 2011.
Used in: Part 03. <https://doi.org/10.1001/jamainternmed.2014.368>

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Wolters Kluwer Health, with Ipsos.
Future Ready Healthcare survey. 355 U.S. clinicians (203 doctors, 152 nurses), 11–14 Mar. 2026.
Used in: Part 05.
<https://www.wolterskluwer.com/en/news/future-ready-healthcare-ai-adoption-patient-clinician-insights>

ORIGINAL PLATFORM DATA

Eolas Medical.
Aggregated platform activity, approximately October 2025–September 2026.
Used throughout.