A Tale of Two Countries: How I Saw More Patients With More Joy in Internal Medicine Practice

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After 14 years in Australia and Canada, I dreaded my return to practice in the United States. In 2003, after 10 years of academic practice in Seattle, I moved to Australia to develop rural and regional clinical training for the University of Melbourne. Practicing and teaching internal medicine in Australia was much easier and more rewarding than in the United States. My experience reinforces that complexity, fragmentation, and unnecessary documentation are driving physician burnout, patient dissatisfaction, high costs, and suboptimal outcomes in this country. Simplifying our system could save money, preserve patient choice, and improve outcomes.

The data are clear—countries with a primary care provider base, single-payer system, and national ethic supporting universal health coverage have the best health outcomes (1). In Australia, general practitioners provide most primary care. As a general internist, I was a consultant, managing complex patients referred by their general practitioners. I practiced at the top of my license most of the time, whereas only 25% of U.S. internists do so approximately 75% of the time (2). I loved practicing as a medical "specialist" focusing on complex issues. My initial wistfulness about not practicing primary care and concerns about my ability to access appropriate care for my patients in a single-payer system quickly disappeared. If the United States adopted this model, family physicians and midlevel clinicians could provide routine care while internists could focus on patients' more complex care needs.

That more than half of U.S. physicians report burnout (3) is no surprise given the time they must spend on administrative activities. Sadly, primary care physicians spend only 27% of their time on direct patient care; 49% of time in the examination room with patients is spent interacting with the electronic health record, and 1 to 2 hours of personal time is often spent on documentation each day (4). Medical residents similarly spend far more time with computers than with patients (5). The expansion of administrative tasks has been palpable during my career. Finishing my residency in 1993, I felt well-trained, inspired, and prepared to practice general medicine. In 1997, the government began to require double documentation for learners. Then came electronic health records, productivity requirements, reporting systems for primary care quality measures, and insurer demands for preauthorizations. Billing requirements forced me to complete charts at home after work. By 2001, electronic editing of resident notes consumed more time. Patient loads increased, and resident work rules drove frequent team turnover; I began to mourn the joy of continuity with my team and time with my patients. Mounting administrative burdens tested my love of practice.

In Australia, documentation was focused on patient care rather than minutiae related to billing requirements. My consult letters contained recommendations for my general practitioner colleagues. Students and housestaff completed inpatient notes with my careful oversight, but I did not have to repeat documentation. Transcriptionists complained that my American-style notes were too long. Australia's single-payer system and national formulary simplified patient care enormously. Prescribing was straightforward with infrequent need for preauthorizations; I estimate that I spent 5 to 10 minutes per day on authorizations for 20 complicated medical patients. I realized that U.S. clinicians spend a huge amount of (demoralizing) time documenting things that do not help patients.

Persons in the United States worry about limited choice in single-payer systems, but the Australian formulary (determined by physicians) proved to be worry-free. Prescriptions were $30 (or cost) per month for most patients, $5 for low-income patients, and free for indigenous Australians. Many U.S. patients on limited budgets must choose food over medication, whereas my Australian patients' adherence markedly improved blood pressures and hemoglobin A_{1c} levels. Expensive therapeutics, such as chemotherapy, must be initiated by a subspecialist but can be comanaged by a general internist. In 9 years, I experienced only 1 problem regarding formulary availability. A patient with repeated hypertensive emergencies and bilateral adrenal hyperplasia developed severe hives while receiving spironolactone, and I failed to obtain approval for eplerenone (listed as "special authority" for heart failure only). Yet, the medical director of the hospital, which operates on a fixed yearly budget for services that include emergency care, agreed to pay for the eplerenone when I calculated its cost versus that of multiple emergency visits. Australia does have waiting lists for expensive tests and elective procedures, such as magnetic resonance imaging, knee replacement, and back surgery. Although waiting was frustrating at times, I perceived that it limited unnecessary care.

What did this mean for my patients and for me? Even with a fragmented computerized record system, I routinely saw 40% more complicated internal medicine patients than I had in the United States without stressing. I started my afternoon "complex-care" clinics at

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1:00 p.m. with 2 students and would leave the clinic–letters and telephone calls finished–by 5:30. Meanwhile, I was amazed at how many times patients would say, "Thanks for taking the time to explain things, doc . . . ." I had time to talk with my patients and to teach–awesome!

Physicians in the United States spend substantial time each week dealing with administrative tasks that do not contribute demonstrably to better patient outcomes. If I rated my practice on a pain scale between 1 and 10, Australia would be a 2 and the United States a 10–ouch! The simplified Australian system meant more time with patients. I spent my time listening to patients and advising them, helping them prioritize their health concerns, instead of justifying small differences in payment and arguing over preauthorizations. The Australian system enables physicians to do more of what we love and what we are trained to do.

The American College of Physicians' position paper on reducing administrative burdens in health care (6) offers recommendations that I believe will bring joy back to patient care. Freeing clinicians and patients from needless administrative tasks will decrease burnout, improve patient outcomes and satisfaction, and bring dollars back into the health care system.

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