## Andrew Auerbach, M.D., '92: The reluctant hospitalist

*By Lauren Ware*

Andrew Auerbach had a ringside seat on medicine from the very beginning. His father was a general internist in Norwalk, Conn., and his mother was a registered nurse. "My dad, Neil Auerbach, was a huge influence on me, as well as his best friend, J.P. Dow, who was a traditional general practitioner in Pittsfield, Maine," Auerbach says. "Private, solo practice in a small, rural community is a tough business, but I loved how they were pillars of the community. I found both of them very inspiring."

**Grew up:** Norwalk, Conn.

**Education:** Bowdoin College '88 (B.A. in biochemistry), Dartmouth Medical School '92 (M.D.), Harvard School of Public Health '98 (M.P.H. in clinical effectiveness)

**Training:** Yale-New Haven Hospital (residency in internal medicine), Harvard's Beth Israel Deaconess Medical Center (research fellowship in general internal medicine)

**Family:** Wife Kristina Rosbe, DMS '93, a pediatric ENT doctor at UCSF; son Benjamin, 9; and daughter Maggie, 6

**What he does for fun:** "We enjoy all the great things the Bay Area has to offer, especially food. I actually love to cook."

**It's surprising to learn that at first Auerbach had reservations about the specialty. "Initially," he says, "I was actually kind of horrified by the hospitalist idea."**

Even so, Auerbach harbored doubts about following in their footsteps until he was actually accepted to medical school. He'd gotten his undergraduate degree at Bowdoin and was drawn to the idea of attending a smaller medical school like Dartmouth. "I wanted something more like my undergraduate campus experience—lots of proximity to the faculty, smaller courses, not being buried or swamped at a larger school," he says. "I really liked the more intimate and connected feeling at Dartmouth." When his DMS acceptance letter arrived, he knew medicine was the right choice for him.

At first, Auerbach intended to be a general practitioner in Maine, just like his father's friend, J.P. Dow, who, Auerbach recalls, "delivered every kid in town." But he discovered that he really enjoyed working in a hospital environment and soon found himself wavering between going into either cardiac surgery or gastroenterology. To keep his options open, he decided to do his residency in internal medicine and was accepted to the program at Yale. That next stage of his career was upon him before he knew it. "There was almost no transition time," he recalls. "I graduated from DMS on Sunday and was on call in the ER at Yale on Tuesday night."

During residency, Auerbach had trouble narrowing down exactly what kind of medicine he wanted to practice. Toward the end of his time at Yale, "I had four different fellowship application piles on my desk," he says. "A huge one for cardiology, a medium pile for pulmonology, a slightly smaller stack for gastroenterology, and then the smallest pile—that contained just two applications—in general medicine." In the end, Auerbach picked the smallest pile. It turned out to be the right decision. "I got really excited about general medicine and the research that I do," he says. "It's been a wonderful ride."

While he was a research fellow at Beth Israel Deaconess Medical Center in Boston, he also enrolled in the master's degree program at the Harvard School of Public Health. And it was during the second year of his fellowship that Auerbach came across a paper—a discussion of the hospitalist model of health care—that led him to where he is today. At that time, the late 1990s, it was a brand new model for delivering care in hospitals, but in the years since then it has grown more rapidly than any other medical specialty. There are now more than 30,000 hospitalists practicing in over 3,300 hospitals all across the U.S.

A hospitalist is a physician who coordinates the care of patients once they enter the hospital. The complexity of care in hospitals today, with many specialists often providing care to a single patient, is what has driven the specialty's rise. Hospitalists try to reduce the fragmentation of hospital-based care, helping patients have a better experience and, ideally, improving their outcomes.

As he learned more about it, Auerbach eventually came to the conclusion that the hospitalist model might be a good match for his interests. He loved teaching and practicing in the hospital—working in perioperative medicine and managing medical complications. "Working in the hospital feels like a natural fit for me," he says.

Intrigued by the emerging specialty, Auerbach wrote to the chair of the Department of Medicine at the University of California at San Francisco (UCSF) to ask if there were any jobs available there in the institution's newly formed hospital medicine group. Robert Wachter, M.D., a pioneer in hospitalist medicine and the division chief for hospital medicine at UCSF, called Auerbach a week later to let him know that they were, indeed, looking for someone. "That was 14 years ago, and here I am," Auerbach says. "I moved to San Francisco in 1998, and I've been here ever since."

At UCSF, Auerbach both practices as a hospitalist and conducts research on the hospitalist model, examining whether the specialty helps to improve patient outcomes. At first, he focused primarily on basic measures, such as the cost of hospitalizations, patients' length of

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NORBERT VON DER GROEBEN

**Alumnus Auerbach, who has been a hospitalist at UCSF ever since he completed his training, was recently named editor of the *Journal of Hospital Medicine*.**

stay, and readmission rates for patients cared for by hospitalists. "I was very proud of the work we did," he says. "We showed that, if anything, outcomes improved in terms of mortality, with no impact on readmission."

But research on hospital medicine has evolved in the ensuing years. "We quickly moved past those kinds of questions to begin to ask deeper questions," Auerbach says. "Did we provide good quality of care? Did we do a better job of giving the right medicine at the right time?"

The answers that Auerbach and his colleagues have come up with have at times been surprising. One study suggested that there is not much difference between a hospitalist and a non-hospitalist model in the quality of care provided to patients with heart failure. But for end-of-life care, Auerbach has found that there is "a pretty important difference—there seems to be a difference in the amount of time hospitalists spend talking with patients, and there is a higher level of control of symptoms with a hospitalist involved when people are close to the end of life."

As hospital medicine has grown as a field, Auerbach has remained as motivated as ever to answer questions about its effectiveness. "Our overarching question is, 'How do you improve quality of care?'" he explains. "More specifically, how do you measure quality of care, and how do you use those measures to change the system to work better for patients?"

To get answers to those questions as quickly as possible, Auerbach and a colleague, Peter Lindenauer, M.D., are developing a national consortium, called the Hospital Medicine Reengineering Network, or HOMERUN, that is focused on researching and evaluating the quality of care in hospitals. Sixteen hospitals are involved so far, and the Association of American Medical Colleges has contributed funding to the effort. The network will rely on hospitalists to study the implementation of new health-care practices to see whether patient outcomes improve as a result. If a new practice produces better outcomes, that knowledge can be spread through the network and applied in other hospitals.

Auerbach is optimistic that HOMERUN can be a powerful way to improve the delivery of care. "A common thread nationally is that hospitalists are often asked to play a leadership role in quality improvement in the hospital, for things like medication safety and infection prevention," he explains. "We have had an opportunity to have a really long lever, with HOMERUN, to change health care for the better using hospitalists."

Auerbach has strong feelings about the importance of conducting research on interventions intended to improve the quality of care. "I think we should be rigorous about what we're telling physicians in every hospital in the United States to do," he says. That said, he admits that actually putting that belief into practice is not quite as simple as it sounds. "We can't not try to improve just because we don't have the research done yet," he says. "But in the context of improving, we need to make the investment in evaluating our practices to show definitively that, in the end, we've achieved our intended aim—that is, actually saved lives." Ideally, he adds, changes to patient care will be rolled out on a small scale—and evaluated to measure whether they actually improve outcomes—before they're implemented on a larger scale.

Auerbach is involved in spreading the word about hospital medicine in another way as well. This past summer, he was named editor of the peer-reviewed *Journal of Hospital Medicine*, the leading hospitalist publication. "I'm really excited about this opportunity," says Auerbach. "The journal is a beacon for the field. I will get to reflect on what's going on in hospital medicine, as well as push the way forward a little bit."

Given Auerbach's commitment to hospital medicine, and his leadership in the field, it's surprising to learn that at first he had reservations about the specialty, just as he once hesitated about going into medicine before his acceptance to DMS. "Initially," he says, "I was actually kind of horrified by the hospitalist idea, because my father and his friend did house calls and they were at the hospital caring for their patients morning and night. These are the people who taught me that medicine is about playing all the positions on the field."

But although Auerbach's day-to-day work looks very different from

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## Letters

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much is certain. What I particularly loved about her article was her ability to so succinctly identify the key element of our program and to work it into a beautiful narrative—about scientific haves and have-nots and how we at DMS are addressing a statewide concern.

The story reinforced for me the central meaning of the program; this is why I accepted the job and why I enjoy the work we do. I was fascinated, even awed, to see it captured in print. Thank you—a million thanks, really. I'll be keeping this article with me for many years to come!

Charles Wise
*Thetford, Vt.*

*Wise is the project manager at DMS for NH-INBRE—the New Hampshire IDeA (Institutional Development Award) Network of Biomedical Research Excellence. The program, funded by a $15-million federal grant, aims to improve scientific research and education at eight undergraduate institutions in the state.*

## Faculty Focus: Black

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gerate benefits or exaggerate risks," he says. "You wouldn't want overly aggressive follow-up of findings."

So one lesson the former math major took from the NLST is that, as with everything else in radiology, it's essential to take a rigorous approach. "There should be a logic," he says. "There should be a method for reporting our observations, for interpreting our observations, and for making decisions."

## Alumni Album: Auerbach

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that of his father and Dow, he, too, plays a lot of different positions—from caring for hospitalized patients to teaching residents to conducting research on patient outcomes to spreading the word about his specialty.

So Auerbach might be working in a different environment than those early mentors, but, like them, he has become a pillar of his own community.