

courage the trainee beyond his or her apparent abilities are usually the rotations most highly sought and most fondly remembered. In my view, both teachers and trainees would be better off if we focused on identifying, supporting and multiplying such teachers rather than concentrating on the specifics of what is taught where.

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#### Reference

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To ensure that residents are given opportunities for patient encounters that will be more meaningful to their future practice, Kenneth Flegel and Anita Palepu<sup>1</sup> recommend that trainees spend more time in the outpatient or community setting. Clearly, that is vital, but how is it to be accomplished, given that universities do not seem willing to address this point in any meaningful way?

Traditionally, the training of medical students and specialists has depended on volunteer clinical faculty, who donate their time and often their offices to the cause. However, with increasing workloads and rising overhead costs, clinical faculty are becoming reluctant to reduce their incomes by seeing fewer patients, which is the inevitable result of mentoring residents.

Western society can no longer depend on this model and must accept the financial responsibility associated with medical training. The massive subsidy that clinical faculty have been providing, in the form of both time and facilities, can no longer be sustained, and, as is the case with all subsidies, its disappearance could end in the collapse of the system. The true costs of a medical education are as yet unknown, but eventually they must be recognized — by paying clinical teachers for their time and by providing the facilities needed for appropriate training.

Flegel and Palepu have identified

the problem. It is now up to the universities, which are responsible for medical education, to develop realistic solutions.

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I could not agree more with Ken Flegel and Anita Palepu<sup>1</sup> that the primarily in-hospital education that house staff receive leaves them less than fully prepared for their future careers. However, this is not something new. I vividly recall my first day in internal medicine practice almost 20 years ago. I felt like I was on top of my game and, with complete confidence, I attended my in-hospital patients, treating acute myocardial infarctions, strokes, pneumonia — the whole gamut of acute care medicine. That afternoon, I returned to my brand new office. My very first patient walked in, sat down in my consulting room and told me his chief complaint. To this day I hope that he did not see the blank look on my face as I listened to his story, knowing full well that I had not a clue how to even begin addressing his concern, never mind trying to formulate a differential diagnosis. Certainly my 4 years of residency hadn't trained me for the complexity of his problem.

This patient's presenting symptom? Fatigue.

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## An Oasys for occupational asthma

Susan Tarlo and Gary Liss, in their clear, concise review of the under-

recognized problem of occupational asthma,<sup>1</sup> suggest that peak expiratory flow rate (PEFR) be measured 4 times a day. We have found that obtaining 2-hourly measurements of PEFR and analyzing these data by means of a computer-assisted diagnostic aide (OASYS)<sup>2</sup> is the best way of using serial peak flow readings in the diagnosis of occupational asthma.<sup>3,4</sup> This technique, developed primarily by Sherwood Burge in the United Kingdom, reportedly has a sensitivity of 75% and a specificity of 94% in the diagnosis of occupational asthma.<sup>2</sup> We find that the greater frequency of recording PEFR is helpful in identifying the relation of asthma to work, although it does entail considerable extra effort on the patient's part. However, if the purpose of the serial readings is explained, compliance is generally good.

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#### [The authors respond:]

We agree that the Oasys method of interpreting serial peak expiratory flow readings is an objective scoring system. This and other methods<sup>1</sup> are