www.journal? Revisited

In the June 1997 issue of CHEST, I asked for comments from our readers about the prospect of publishing the journal electronically. Many of you responded, often by email. Several respondents suggested that we electronically publish the table of contents of each issue and allow the abstracts to be read by clicking on the title of the paper. This was a surprising suggestion since we already provide this service on the ACCP home page (http://www.chestnet.org), as I mentioned in the June editorial. We also provide full text of editorials and a search engine to allow the user to compile lists of articles about a subject of their choice. Perhaps we have not adequately publicized these features of the home page.

I have selected several representative Communications to the Editor to publish in this issue which express various opinions about electronic publishing. I perceive that there are three camps in which readers have pitched their tents. First, there are those who would love to read everything on their computer and want to interconnect to the Index Medicus and read the references too. Second, there are those with Internet capability who would rather sit in a chair by a roaring fire and read a paper journal. Third, there are many with no Internet capability who claim they would not read CHEST on the web. I pitch my tent in the second camp, although one rarely needs a fire in Florida.

What is the solution? For now, we will continue to publish on paper. We will continue to electronically post the table of contents, abstracts, and editorials each month on the ACCP home page. In addition, every 6-month volume of CHEST will be available on CD-ROM for storage. If you want to discard or recycle the paper, the contents of the journal will still be available on your computer.

In the future, “if we build it, they will come.” The future of publishing clearly resides in some electronic process. But most of the readers of CHEST do not have current Internet access. Despite Dr. Stringer’s advice (see page 1711), we must not assume that everyone has the capabilities nor the desires that we ourselves have. I would predict that by the year 2000, we will have solved many practical problems noted in the June editorial on this subject. If computers still keep accurate time in the next millennium, we will probably publish CHEST in toto both on paper and on the Internet.

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Reference
1 Block AJ. www.journal [editorial]? Chest 1997; 111:1477

Flawed Paradigms Drive Aerosol Device Selection

How should we respond when a patient with asthma or COPD presents to the emergency department (ED), dyspneic with severe bronchospasm, complaining that they have been using their metered-dose inhaler (MDI) all day and that the “puffer” hasn’t helped? Selection of an appropriate aerosol device in the ED has implications that extend well beyond the efficacy of the treatment, reflecting a paradigm of health care that the clinician adopts.

A variety of considerations impact the clinician’s selection of an aerosol device.1 The unadorned MDI is not a fool-proof device, and its proper use requires education and the ability of the patient to follow instructions and coordinate their breathing with actuation of the device.2,3 As simple as the MDI seems, many physicians, nurses, and (alas) respiratory care practitioners have been shown to be unable to demonstrate its proper use.4 Even when the health-care team has the knowledge of how to properly use the device, current economic constraints reduce the likelihood that physicians (or other clinic and office staff) will have the time or resources to properly instruct, demonstrate, and