a hospital visit by a patient would result in a higher probability of infection by a resistant strain than would a visit to a physician's office. Because a disproportionate number of hospital emergency-room visits are from individuals without regular access to health care, infection with resistant strains of bacteria may occur disproportionately among those with the least resources to cope with them. Indeed, total population mortality from these resistant strains could easily be enhanced because of the reduced availability of health care available to these individuals after the hospital visit during which infection occurred.

Another reasonable assumption is that locations with a greater flow of patients would have a higher probability of maintaining a resistant strain. This implies that foci of infection could develop more readily before detection in multiphysician partnerships and clinics than in smaller clinics or those with a single physician. The dwindling number of single-physician practices therefore could have a significant epidemiologic impact on the spread of resistant strains.

Similar hypotheses can readily be tested from epidemiologic data on resistant strains and could have important public health consequences and provide further motivation for the expansion of infectious disease surveillance, as Ruth L. Berkelman *et al.* suggest (Policy Forum, 15 Apr., p. 368). It would be prudent at this stage for epidemiologists to ensure that observational designs are being developed to track these and other implications of antibiotic resistance.

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Statistical Medicine

With respect to the articles "Problems in clinical trials go far beyond misconduct" and "Ignorance is not bliss" by Rachel Nowak (Special News Report, 10 June, p. 1538), I agree with Richard Peto that "ignorance is the biggest form of misconduct," and it has been for *n* generations of doctors and others. Physicians often receive no training in conducting clinical trials, and the budding physician-cum-researcher is usually offered only *a* course in biostatistics "covering everything you ever wanted to know."

The symptoms are old, hence the patent medicine being offered (one good course for every doctor) is patently wrong. And the syndrome is worse than that because (i) there are long gaps between the course and the need for its lessons, and (ii) most statistics courses focus only on statistical analysis, not on how to collect good data in surveys, experiments, and clinical trials. Specialists in statistics are needed to guide the path to good data, and the doctors should be led to those paths.

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Corrections and Clarifications

In the Perspective by Donald G. York (8 July, p. 191), figure 1 was printed incorrectly. The correct figure and caption appear below.

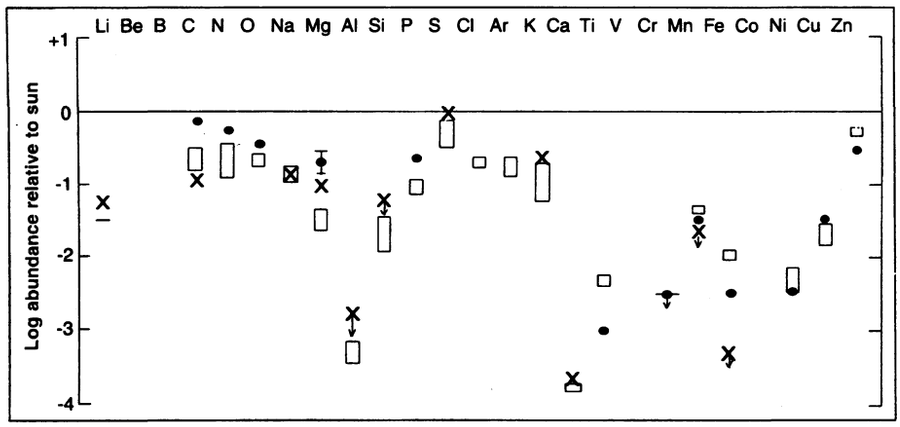

Fig. 1. Abundances compared to atomic number for the main dust cloud in the spectrum of ζ Oph. Open rectangles are from Copernicus data (*11*). Solid dots are new values from HST or high-resolution results from ground-based data (in the case of Ti II). The ×'s represent results from trace ionization stages (*12*), relative to neutral sulfur. Data for Na, Li, K, Al, and Ca, not covered by Cardelli's summary, are included.