cannot have it both ways. In front-runner institutions like the Cleveland Clinic, we should not criticize the report-card process, but rather should try to define and validate the standards we intend to follow. In our profession, which is very costly and which is going to go through great upheaval in the next several years, physicians must take the lead. I can guarantee that if it is done by the government, the local chamber of commerce, or the local newspaper, it is going to be done very poorly.

REFERENCES

1. **Ellerbeck EF, Jencks SF, Radford MJ, et al.** Quality of care for Medicare patients with acute myocardial infarction. A four-state pilot study from the Cooperative Cardiovascular Project. JAMA 1992; **273:**1509–1514.
2. **Gunnar RM, Bourdillon PDV, Dixon DW, et al.** Guidelines for the early management of patients with acute myocardial infarction: a report of the American College of Cardiology/American Heart Association Task Force on Assessment of Diagnostic and Therapeutic Cardiovascular Procedures (Subcommittee to Develop Guidelines for the Early Management of Patients with Acute Myocardial Infarction). JACC 1990; **16:**249–292.
3. **Hilborne LH, Leape LL, Kahan JP, et al.** Percutaneous transluminal coronary angioplasty: a literature review and rating of appropriateness and necessity. Santa Monica, Calif: RAND; 1991. JRA-01.
4. **Vogel RA, Lauer MA, Ziskind AA.** A new revascularization appropriateness score for coronary angioplasty and bypass surgery. Clin Res 1994; **42:**290A. Abstract.
5. **Lauer MA, Ziskind AA, Lemmon CC, Vogel RA.** Prospective assessment of revascularization appropriateness scoring systems: a comparison of RAND expert panel ratings, ACC/AHA guidelines, and the University of Maryland revascularization appropriateness score. JACC 1995; **25:**344A. Abstract.
6. **Ziskind AA, Lauer MA, Lemmon CC, Vogel RA.** Prospective application of RAND expert panel ratings, ACC/AHA guidelines, and the University of Maryland revascularization appropriateness score (RAS): Only RAS predicts clinical outcome. JACC 1995; **25:**344A. Abstract.
7. **Hannan EL, Kilburn H Jr, Racz M, Shields E, Chassin MR.** Improving the outcomes of coronary artery bypass surgery in New York State. JAMA 1994; **271:**761–766.
8. **Clough JD, Kay R, Gombeski WR, Nickelson DE, Loop FD.** Mortality of patients transferred to a tertiary care hospital. Cleve Clin J Med 1993; **60:**449–454.

Correction

A table in the article "Lipid-regulating and antiatherosclerotic therapy: current options and future approaches" (*Cleveland Clinic Journal of Medicine* 1996; 63:31–41) contained an error. In *Table* 6 on page 37, the values for the effects of the various drugs on HDL-C and LDL-C were reversed through an editing error. The corrected table appears below.

TABLE 6
APPROVED DRUGS FOR DYSLIPIDEMIA*

Bile-acid sequestrants		
Lipid effects:†	LDL-C:	↓ 15%–30%
	HDL-C:	↑ 3%–5%
	TG:	↑ or no effect
Drugs and daily dose:	Cholestyramine	4–24 g
	Colestipol	5–30 g
HMG-CoA reductase inhibitors		
Lipid effects:	LDL-C:	↓ 20%–40%
	HDL-C:	↑ 5%–15%
	TG:	↓ 10%–20%
Drugs and daily dose:	Fluvastatin	20–40 mg
	Lovastatin	10–80 mg
	Pravastatin	10–40 mg
	Simvastatin	5–40 mg
Nicotinic acid (NA)		
Lipid effects:	LDL-C:	↓ 10%–25%
	HDL-C:	↑ 15%–35%
	TG:	↓ 20%–50%
Drugs and daily dose:	Crystalline NA	1.5–6 g
Fibric-acid derivatives‡		
Lipid effects:	LDL-C:	↓ 10%–15% (may↑)
	HDL-C:	↑ 10%–15%
	TG:	↓ 20%–50%
Drugs and daily dose:	Gemfibrozil	1200 mg
	Clofibrate	2000 mg
	Fenofibrate	300 mg

*Adapted from information in the second Adult Treatment Panel report, reference 24, and Yeshurun and Gotto, reference 25
†LDL-C, low-density lipoprotein cholesterol; HDL-C, high-density lipoprotein cholesterol; TG, triglyceride
‡Clofibrate is not considered a first-line agent because of associated toxicity; fenofibrate is approved but not currently available in the United States