exception of the 70- to 74-year-old group, whose mean temperature was 35.9°C (96.7°F).

Wicks (1978) identified two groups in his survey. Those individuals whose temperature was between 35.5°C (95.9°F) and 35.1°C (95.1°F) were considered to be "true" hypothermics. In comparing our findings with those of Wicks, we find that 13.5% of the British sample of 1,020 had oral temperatures between 35.5°C (95.9°F) and 35.1°C (95.1°F); in contrast, 7.8% of our sample of 730 had temperatures in this range. The "true hypothermics" of the two surveys were similar. The Kansas sample had 3.4% with temperatures of 35.0°C (95°F) or less, whereas the British sample had 5.1%.

COMMENT

At the outset, the lower mean oral temperature among the Kansas elderly reflects the general reduced metabolic rate that accompanies aging. Particularly interesting is the fact that the mean oral temperature remained fairly uniform for all age groups.

This lower body temperature is believed to be associated with the general "sluggishness" of the thermoregulatory system that appears to accompany the aging process. In short, as we get older we do not sweat as much in the heat, nor do we shiver or have "goose bumps" in the cold. This fact is also relevant to hyperthermia, and it should be considered when studying the causes of death during the heat wave in the summer of 1980, in which the same general segment of the population who suffer from hypothermia also appear to have been susceptible to hyperthermia.

It should be pointed out that the temperatures reported in this paper were taken under field conditions. While the subjects were indoors, no attempt was made to control the ambient temperature of the room. In one sense, this is a shortcoming of the study; in another, it is more representative of the conditions that prevail in the clinic, hospital, nursing home, or residence. Because of this, the data may be considered a standard for interpreting the oral temperatures of the U.S. elderly. They are based on a meaningful sample of 730 and are comparable to the British National Survey.

One additional item is worthy of note. It is the opinion of the author that the qualifying adjective "accidental" that precedes hypothermia is a misnomer, because it implies a low body temperature brought about by an accident. It is our belief that there are at least three types of hypothermia: accidental, which may be used to describe the low body temperature that a seaman might exhibit when swept overboard into Lake Superior; induced, the conventional surgical protocol; and noninduced, or spontaneous, the type described in this paper. Adopting this nomenclature not only would appear more appropriate and meaningful but would also demonstrate to the lay public that lower body temperature may occur independently of the environmental temperature and without an intervening accident.

REFERENCE NOTE

1. National Institute on Aging. *Accidental hypothermia: Winter hazard for the elderly* (DHEW Publication No. NIH 78-1464). Bethesda, Md: Author, 1978.

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WICKS, W. *Old and cold: Hypothermia and public policy.* London: Heinmann, 1978.

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ERRATUM

Solso, R. L., & McCarthy, J. E. Prototype formation: Central tendency model vs. attribute-frequency model. *Bulletin of the Psychonomic Society,* 1981, 17(1), 10-11. Page 11, Column 1, Paragraph 2, Lines 4-12, the sentence should read: In order to make specific comparisons among the groups, a protected least-significant difference (l.s.d.) test for proportional means was calculated, with the following results: P_f vs. $P_{\bar{X}}$, $t(42) = 3.47$ ($p < .001$); P_f vs. new items, $t(130) = 4.50$ ($p < .001$); P_f vs. old items, $t(130) = 1.70$ ($p < .10$); old items vs. $P_{\bar{X}}$, $t(130) = 2.09$ ($p < .05$); and old items vs. new items, $t(218) = 4.23$ ($p < .001$).[1]