To the Editor:

Several programs did not offer M&M conferences. Medical school-based programs were more likely than community-based programs to have M&M conferences, 82.1% versus 42.3%, respectively ($P<.001$). In general, residents attended conferences more than faculty. The proportion of intern, postgraduate year (PGY)-2, and PGY-3 classes present at a conference were similar (63.3%, 68.6%, and 69.6%, respectively), whereas about half of the faculty (55.6%) typically attended a given M&M conference. Conference attendance at military programs was the exception to this pattern, with military faculty (75.0%) having similar or greater attendance than their residents (71.8% for interns, 68.2% for PGY-2s, and 75.0% for PGY-3s).

Trends were apparent in who planned and presented M&M conferences. Of the residents, PGY-3s planned and presented most often, with PGY-2s the next most frequent. Faculty were involved in planning more than any resident group but presented less often than PGY-3s. Other categories of presenters (students, chief residents, invited speakers) participated at lower rates than residents or faculty overall.

M&M conferences have been used to target a variety of content areas. Diagnostic challenges (29.9%, standard deviation [SD]=24.6) and adverse events (25.9%, SD=24.2) were the most commonly addressed topics. Other topics included medical errors (17.7%, SD=18.0), therapeutic interventions (14.6%, SD=19.4), problems with health care delivery systems (10.6%, SD=16.8), ethics (5.7%, SD=11.4), prognosis (4.6%, SD=11.4), and other (4.5%, SD=16.9).

Respondents indicated that systemic or educational changes occurred at 57.1% (113) of the programs that offered M&M conferences. Changes in protocol were the most common change noted. How laboratory results were followed and how discharge plans were arranged by residents were noted by several directors. How protocols were disseminated, implemented, and evaluated was another frequently mentioned institutional change.

For programs not holding M&M conferences, directors offered the following reasons: time constraints/demands (49.1%), “other” (47.4%), low faculty interest (19.8%), low resident interest (15.5%), and low educational value (4.3%). Write-in “other” responses were grouped by the authors and included: (1) M&M issues being addressed in other arenas, (2) content raised discoverability concerns, (3) diffusion of responsibility prevented coordination of conferences, (4) never considered before, (5) being considered now or pending implementation, and (6) discounted value of conferences (eg, “I find the concept [M&M conferences] anachronistic . . . “).

The majority of family medicine residencies conduct M&M conferences. However, the term “morbidity and mortality” may be antiquated given the expanded range of topics covered at these meetings (eg, ethics, systems, protocol problems) and given that traditional M&M topics are being covered in other forums (eg, morning report, chart reviews, journal club). Rebranding M&M conferences as “quality improvement” forums (or some other broader descriptor) for education and professional development may serve to encourage expansion of discussion topics, inclusion of a greater variety of data sources, and further align with IOM and ACGME goals.

**References**

used with them to promote behavioral changes.\textsuperscript{2-3} Thus, we evaluated the effects of a brief canned coffee cessation intervention using a coffee can-shaped model with SCCD behaviors in T2DM Japanese subjects.

This study included T2DM males with habitual SCCD of $\geq$ two cans of coffee/day (we provisionally determined the criteria of high levels of drinking, while there were a small number of such subjects). Twenty-six subjects (mean age: 47.8±7.1 standard deviation [SD] years) were randomly assigned to either the Conventional Approach Group ([CG], n=13, age: 48.8±7.9 years) or to the Intervention Group ([IG], age: 46.8±6.4 years) using the canned coffee model in outpatient clinic settings.

The mean age was insignificantly different between the CG and IG (Student’s $t$ test, $P=.48$). The study was conducted under the ethical guidelines of the Helsinki Declaration, and each subject gave informed consent. The CG was given a brief lesson on the amount of energy contained in sweetened canned coffee beverages. The IG received the same lesson, followed by further instruction using a canned coffee model (similar to the popular canned coffee beverage).

Subjects were asked the following question: “There are a certain number of calories in this canned coffee model. If the total calories are converted to lumps of sugar (sugar cubes), how many lumps of sugar do you think there are in this can?” After they answered, the canned coffee model was opened to display the correct number of lumps of sugar corresponding to the total energies.

Six months after the intervention, subjects in the IG had significantly more cessation or reduction rates (defined as a reduction by at least half the subject’s intake per day) in SCCD by self-reports than those in the CG (69.2% [n=9] in the IG versus 15.4% [n=2] in the CG, Fisher’s exact probability test, $P=.015$).

Thus, when the brief intervention was combined with the canned coffee model feedback, more subjects made SCCD behavioral changes than when using a brief lesson alone. Though the data collection by self-reports of SCCD might be a study limitation, our results suggest that informational methods, which help them visualize and become aware of the amount of energy in the canned coffee, could provide motivation for some subjects to modify their SCCD habits. Until now, the color-classified hemoglobin A1c graph has been applicable as an educational method in DM self-care.\textsuperscript{2} Use of these visualization tools appears to be useful and effective as an educational component to cause behavior changes in T2DM subjects. Our data warrant further investigation, with a larger sample size and a longer follow-up, including the monitoring of glycemic indices.

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