Letters to the Editor

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Editor, Letters to the Editor Section

Editor’s Note: Send letters to the editor to karl.miller@erlanger.org or to my attention at Family Medicine Letters to the Editor Section, University of Tennessee, Chattanooga Unit, Department of Family Medicine, 1100 East Third Street, Chattanooga, TN 37402. 423-778-2957. Fax: 423-778-2959. Electronic submissions (e-mail or on disk) are preferred. We publish Letters to the Editor under three categories: “In Response” (letters in response to recently published articles), “New Research” (letters reporting original research), or “Comment” (comments from readers).

In Response

Breaking Through the Glass Ceiling

To the Editor:

I am writing a letter in response to the article by Smith et al regarding nondisparities in promotion rates between whites and nonwhites. The authors used a follow-up survey to obtain information on promotion rates after completion of a primary care faculty development program.

I agree with several points made in the article. Without taking multivariate analysis into account, the authors found that promotion rates for men and women were equivalent, but there was a discrepancy in the promotion rates of minorities compared with whites. After accounting for age, initial rank at the start of the faculty development program/fellowship, and type of appointment (academic versus clinical), the authors stated the discrepancies were minimal.

The authors limited the study by only analyzing promotion rates of participants in academia less than 5 years and more than 6 years. Previous studies demonstrated less-frequent promotion rates of minorities when compared to whites. It would therefore have been extremely informative if the authors had included data making direct comparisons of whites versus nonwhites with the same number of years in academia and recorded the time to promotion. Though the promotion rates were equivalent by follow-up, the following question arises—what was the time in years to promotion for whites versus nonwhites?

The authors also made an interesting point that women and minority participants in clinical roles were less likely to be promoted given that they had fewer publications and less research time and opportunity. I believe that as educators, it is our role to make students and residents aware of research opportunities and adequately prepare them to pursue their areas of interest and enhance advancement in their specialties. Faculty development programs/fellowships will play a vital role in the future for women and minorities by increasing these very opportunities.

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New Research

Do Morbidity and Mortality Conferences Still Have a Role in Family Medicine Residencies?

To the Editor:

Morbidity and mortality (M&M) conferences are utilized in family medicine residencies for educational purposes, but do they address the Institute of Medicine’s (IOM) concerns for quality improvement or the Accreditation Council for Graduate Medical Education’s (ACGME) learning objectives (ie, practice management and quality improvement)? To begin to answer this question, we surveyed 456 program directors of accredited US family medicine residency programs to ascertain the current state of M&M conferences. We asked if programs offered these conferences, how often, what topics were typically covered, and who planned, presented, and attended them. By gathering this information, we hoped to be more informed to comment on the role of M&M conferences in quality improvement.

Seventy-one percent (322) of the directors responded, and 63.6% (205) of the responding directors reported having M&M confer-

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Enes. Most programs that offered M&M conferences did so monthly (61.1%, 124), and another 21.7% (44) did so quarterly. 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.

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**References**


**Sweetened Canned Coffee Cessation Intervention for Subjects With Type 2 Diabetes Mellitus: A Preliminary Study**

**To the Editor:**

Japan is the third-largest importer of coffee in the world behind the United States and Germany. Canned coffee beverages can be found in vending machines everywhere. Many Japanese people like canned coffee with cream and sugar added, and the canned coffee most popular in Japan typically contains 95 kilocalories.

In our experience, sweetened canned coffee drinking (SCCD) can be associated with deteriorated glycemic control in type 2 diabetes mellitus (T2DM). There may also be ethnic differences in the effects of SCCD on the pathophysiology of DM. Japan has a higher prevalence of soft drink ketosis, one of the disorders in T2DM induced by soft drink intake, than in other countries. One possible reason for the difference in prevalence among populations is the readily accessibility of canned drinks, including coffee. It is possible that the excessive intake of drinks containing sugar predisposes Japanese to higher glucose toxicity.

T2DM patients have difficulties in modifying their daily behaviors. Various education tools have been