

medicine when combined with the infrastructure principals described in your article become the medical home concept. So although the high-tech documentation of care may be new, the basic concept of the medical home is not.

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Reference

1. Rogers JC. The patient-centered medical home movement—promise and peril for family medicine. *J Am Board Fam Med* 2008;21:370–4.

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The above letter was referred to the author of the article in question, who offers the following reply.

Reponse: Re: The Patient-Centered Medical Home Movement – Promise and Peril for Family Medicine

To the Editor: I was pleased to read that Dr. Mambu's personal experience with transforming his practice into a patient-centered medical home validated points I made in the commentary. I also received positive comments from others who share similar perspectives.^{1,2} I agree that the 6 points Dr. Mambu highlights are crucial considerations to guide refinement and implementation of the patient-centered medical home model of care and the recognition (accreditation if you will) and financing of practices. The emerging relationship among health care providers, insurance health plans, and health care purchasers is especially critical to the success of this innovation. I thank Dr. Mambu for his kind reply.

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References

1. Rittenhouse DR, Casalino LP, Gillies RR, Shortell SM, Lau G. Measuring the medical home infrastructure in large medical groups. *Health Affairs* 2008;27:1246–58.
2. Berenson RA, Hammons T, Gans DN, Zuckerman S, Merrell K, Underwood WS, Williams AF. A house is not a home: keeping patients at the center of practice redesign. *Health Affairs* 2008;27:1219–30.

doi: 10.3122/jabfm.2009.01.080221

Re: Outcomes From Treatment of Infertility With Natural Procreative Technology in an Irish General Practice

To the Editor: We read with interest the paper by Stanford et al¹ describing results from infertility treatment

using a “systematic medical approach for optimizing physiologic conditions for conception.” Although the authors make some good basic observations and their minimalist approach will no doubt appeal to many patients, extolling “Natural Procreative Technology” (NPT) as a general treatment philosophy for infertility is worrisome at several levels.

Considerable experience in subspecialty infertility practice has confirmed the age of the female is the single most important factor influencing a couple's reproductive outcome.² Early diagnosis and treatment is therefore critical to optimize success. But NPT's investigation phase alone requires 4 months to complete, and total deployment of NPT consumes 2 years. With their “biological clocks” ticking, it is not surprising that >50% of NPT patients dropped out.

Sadly, many probably never go back to their primary care provider. Patient satisfaction with the referring doctor is often related to timely referral to the fertility specialist. Some patients who conceive after in vitro fertilization (IVF), particularly if their primary physician failed to facilitate a prompt subspecialty referral, express deep resentment due to the patient's perception that their referral was needlessly slow.³ This patient frustration has even triggered formal legal action seeking damages against doctors thought responsible for delayed infertility treatment.⁴

Studies of effectiveness of NPT against IVF in couples with unexplained infertility are welcomed. But curiously, Stanford et al assessed efficacy by cohort rather than the standard “per-cycle” pregnancy rate methodology, as followed by recognized registries in Europe and the United States. These patient registries have been collecting data on per-cycle pregnancy rates for many years. One reason they do not use longitudinal cohort analysis is because the further in time from intervention that a pregnancy occurs, the less likely that it actually resulted from treatment.⁵ Although a cohort approach can have merit, its use by Stanford et al puts their conclusions outside the mainstream of relevant datasets and greatly diminishes the impact of their work.

It would be unfair to discount the potential usefulness of diagnostic tests collected during NPT. Cervical mucous monitoring, urinary luteinizing hormone surge testing, and reviewing timed intercourse schedules are all important patient education interventions and probably do help some women conceive. Yet the net effect of NPT seems closely allied to expectant management, reminiscent of a distant era where pregnancy rates rarely drifted above 25% per cycle.

The application of a structured infertility treatment program for use in general practice settings to improve care is not entirely new.⁶ However, we strongly disagree with diverting 2 years of an infertility patient's time into a scheme where per-cycle pregnancy rates are unknown and where most patients, even when ideally selected, will quit treatment.

Providing comprehensive information to patients about treatment options is a cornerstone of the patient-physician relationship. NPT may warrant consideration