test reproducibly and nondiscriminately for those requirements, further validating the results.

Some of the past problems we have had when evaluating preemployment work fitness will be lessened by this law. The majority of employers, however, have not even begun to detail work-fitness job descriptions and profiles for their own work force. Many of us will be called on to help employers develop such criteria and to help these organizations not only comply with the law, but also establish a fair and responsible preemployment evaluation process. I would encourage all physicians involved with preemployment evaluations to familiarize themselves with the ADA and begin to assist industries in developing and implementing these provisions. Guidelines regarding implementation of the ADA should be available in July 1991. I hope that future articles in the *JABFP* will address such issues.

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The Need for Family Medicine in the Academic Medical Center

To the Editor: I recently had personal experience with care provided in the academic medical center that highlighted both the shortcomings of technical excellence and the importance of family medicine in university hospitals. I suffered a severe hand injury that resulted in hospitalization on the Plastic and Reconstructive Surgery Service in my own university hospital. During my stay, I counted a minimum of 7 different physicians (attending physicians and house staff) who included me in their rounds every morning for a total of 5 to 10 minutes per visit. During their rounds, there was a great deal of concern over the mobility, circulation, and sensation of my hand and fingers. Only on the last day of hospitalization did one of my own colleagues in the Department of Family Medicine ask me how I was coping with such a severe and potentially permanent disability.

During my hospital stay, I was visited by colleagues, house staff, and medical students—all of whom provided kind words of support during a difficult time. More powerful for me, however, were the many visits and calls I received from patients and their families who showed up in my hospital room with flowers, cards, and gifts that some could little afford. Those who work in academic medical centers understand that such relationships are not the norm in this otherwise impersonal environment. I spent some time wondering whether other physicians and surgeons in my university would have received similar support from their own patients.

Much has been written of and by physicians as patients. In my own academic medical center, the lack of attention to me as a person had little impact on the outcomes that are usually measured by researchers, federal agencies, or utilization review committees. I would contend, however, that the technically superior care I received was inadequate inasmuch as my feelings, my "personhood," were left unaddressed.

Schmidt[1] has described power in academic medical centers in several contexts: strength in numbers, control and influence, ability to accomplish a mission, and unique contributions to the institution. My recent experience has reemphasized that there is a compelling need for the family physician in a tertiary care medical center who is sensitive to both patient and family and who can "be there" for that patient throughout the hospital stay. Our inherent strength as family physicians is what we represent in what has increasingly become a confusing maze of technologic innovation. I have rediscovered that another strength is our own patients, who frequently care as much about us as we do for them.

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Contraception—Natural Family Planning

To the Editor: Dr. Woolley's review of new developments in contraception[1] provides valuable insights into the possible applications of new technology to natural family planning (NFP). It is, however, incomplete and misleading in its assessment of present methods of natural family planning in several respects.

Dr. Woolley states, ". . . it is not obvious that [methods of NFP] are inherently more 'natural' than other methods of contraception."[p 41] For users of NFP, there are at least two obvious rationales for the descriptive adjective "natural": (1) the absence of exogenously administered drugs, devices, or surgical interventions that alter the natural processes of fertility; and (2) the conscious awareness of the natural processes of fertility and application of that awareness, rather than the suppression of both fertility and fertility awareness.

To compare total pregnancy rates from studies of NFP with total pregnancy rates in studies of other contraceptive methods is to compare apples with oranges,[2] because NFP is the only method of contraception that can be used both to achieve or to avoid pregnancy. Understanding user intent is absolutely critical to understanding outcome studies of NFP. For example, if NFP is used to achieve a pregnancy, the resulting pregnancy is not a "failure," but a "success." Obviously, there are many areas of motivation that lie between the intent to avoid pregnancy completely and the intent to achieve it as soon as possible. Further, motivations can be mixed, and often they change with time. User intentions can be