

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.

Schmidt¹ 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 contraception¹ 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

difficult to quantify and study, but they are clinically very significant.

In support of his assertion, "The most prominent disadvantage to current natural family planning techniques is the high failure rate,"^{p 41} Dr. Woolley quotes total pregnancy rates from a review³ of use-effectiveness studies of NFP that range from 0.4 to 39.7 for the cervical mucus method of Billings and from 4.9 to 34.4 for the symptothermal method (Pearl Index). The same review³ gives "method failure" rates for the same studies that range from 0 to 5.7 for the cervical mucus method and from 0 to 13.1 for the symptothermal method (Pearl index). Even if one sets aside the issue of user intent, these figures compare very favorably with both use and method effectiveness rates for other methods of contraception,⁴ including those quoted for spermicides earlier in Woolley's review.¹

In fact, pregnancies among NFP users are probably better described as (1) "method-related pregnancies," which occur despite correct application of the rules to avoid pregnancy; (2) "teaching-related pregnancies," which occur because of inadequate instruction or inadequate learning of the rules to avoid pregnancy; (3) "informed choice pregnancies," which occur when a couple chooses to have coitus on a day they know to be potentially fertile; and (4) unresolved pregnancies," when there are insufficient data to classify a pregnancy.⁵ Klaus² has retrospectively reevaluated major use effectiveness studies using these categories, and the major multinational World Health Organization study of the cervical mucus method used similar categories in reporting its results.⁶

The concern of a potential link of "the increased relative fraction of conceptions occurring at the margins of the fertile period" with "higher rates of congenital defects and alterations of the sex ratio at birth"^{1 p 42} is not supported by the results of the previously mentioned World Health Organization Study.⁷

Finally, although Dr. Woolley correctly identifies the importance of the skill of the instructor teaching natural family planning, he does not elaborate on his concern for the "intensity of training requirements" as a serious flaw. When taught by professional instructors, NFP does not require inordinate effort to learn.² The motivation for use is, of course, prerequisite. There are definite criteria to consider in identifying instructors and programs that are qualified to teach NFP.⁸

In conclusion, I quote from Labbok and Queenan's review⁸:

The clinical support of a user of periodic abstinence methods demands a clear understanding of the methods. These methods have an efficacy equivalent to or better than many barrier methods, are highly acceptable among certain groups, and, after the teaching phase, are basically cost-free. Such methods should be given due consider-

ation in offering a patient an informed choice of family planning methods.^{p 399}

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

To the Editor: I appreciate the opportunity to respond to the criticisms raised in the above letter. Dr. Stanford seems to believe that the published pregnancy rates for NFP methods are artificially large because a significant number of the couples enrolled are actually attempting to achieve, rather than avoid, pregnancy. He cites no evidence for this assertion. It seems unlikely that researchers include couples desiring pregnancy in their studies of contraceptive efficacy. Certainly, there are varying degrees of motivation to avoid pregnancy. But this situation is hardly unique to NFP; in fact, the methods that are *not* significantly motivation-dependent (e.g., IUD, subdermal implants, and surgical sterilization) are the exceptions. If a method requires an unwavering commitment to difficult and restrictive rules, then it should be recommended to only highly selected couples, rather than excused for its poor performance in clinical trials.

The classification scheme of pregnancies advocated by Dr. Stanford (an objection I anticipated and addressed in my article) is useful for research. In clinical practice, however, such distinctions among failures obscure the simple, unarguable fact that users of NFP, as a group, experience many more unwanted pregnancies than users of hormonal, surgical, or barrier methods. In terms of the impact on the couple, a failure is a failure is a failure.