

identified as being for “medical diagnosis.” And yet, there is no research that has been done to support the use of either of these 2 methods as a diagnostic tool. This is not to say that clinical experience might allow 1 or another of these 2 systems to provide some fairly simple diagnostic input, it is important to recognize that the *Creighton Model FertilityCare System* is the foundational system upon which a whole new women's health science has been developed (*NaProTechnology*). This has been published in a 1244-page medical textbook entitled, “*The Medical & Surgical Practice of NaProTECHNOLOGY*.”⁶ In this textbook, large volumes of research data are presented to support the *Creighton Model System* in its use with a whole variety of underlying medical and surgical conditions observed in women of reproductive age.

In the years of conducting use-effectiveness studies in the various natural methods of family planning, there has been very little effort placed into the better understanding of the statistical measures upon which family planning systems are actually studied. There has been an emphasis to try to match up a natural method with a contraceptive method with regard to statistical protocols. And yet, one system, the contraceptive method, can be used in only one way, and therefore, its measurement for use can be accomplished only from that point of view. A natural method can be used to both achieve and avoid pregnancy, and most achievers are successful users, not failures. Thus, they need to be looked at separately and we have published a life table protocol that helps accomplish this.⁷ There are many reasons why they should be evaluated separately, but these are too long to go into at this time. However, if

somebody would like more information on this, I would be happy to provide it to them.

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Response to letter to the editor of osteopathic family physician from Dr Thomas Hilgers

We read with interest Dr Hilgers' comments on our paper. The purpose of the paper was to establish the parameters that would define a robust cohort study. These parameters allowed us to use SORT criteria to review the literature and identify the modern FABMs that had sufficient evidence to support their recommendation to couples who are seeking to avoid pregnancy. Dr Hilgers disagrees with our definition of typical use pregnancies, criticizes the criteria for not further elaborating on the means of pregnancy evaluation and standardized counseling used within the studies, and takes exception to the idea that more than one FABM may be useful in medical diagnosis.

We agree with Dr Hilgers that natural methods are unique as they can be used both to achieve and avoid pregnancy. In contrast, a contraceptive method is only used to avoid pregnancy, so if a pregnancy results, it is reasonable to conclude that it is a failure of the method. As Dr Hilgers, and our review, point out, this is not the case for natural methods; couples have the freedom to use the

method as they choose—either to avoid or to achieve a pregnancy—at any time. This complicates the definition of typical use.

We chose to use the definition of “typical use” to include the analysis of all pregnancies in all cycles of use. This makes the conservative assumption that the pregnancy is unintentional if not declared prospectively as intentional by the couple (one of our critical study parameters). In contrast, the Creighton Model FertilityCare System (CrMS) studies cited a different definition of typical use relying on couples' behavior during the fertile window. Although this approach is logical, all the other literature does not evaluate pregnancies in this way. We pointed this difference out in the review text and factually stated “typical use effectiveness cannot be defined as in other trials” for the CrMS trials.

In developing the SORT criteria, we sought to set a robust standard yet not be so limiting as to exclude all but a few of the well-conducted studies. Although the precise approach to pregnancy evaluation can influence outcomes, we believe the combination of mechanisms to capture all pregnancies in all study participants, limiting intended pregnancies to the definition provided, and application of

the typical use analysis discussed earlier, gave sufficient strength to a study design. Similarly, in reviewing the various approaches to standardized counseling used in the FABM literature, we felt that use of a standardized method of instruction of the method being tested was critical. We reasoned that the quality of the standardization would be reflected in the pregnancy outcomes; less effective mechanisms of teaching should result in higher typical use unintended pregnancy rates. CrMS professionals use a very standardized approach. Dr Hilgers argues that only the CrMS approach is viable. Yet many hundreds of thousands of couples have learned other FABMs following a different standardized curriculum and successfully used them to plan their families with a high degree of satisfaction.

Finally, Dr Hilgers takes exception to our assertion in Table 1 that more than a single FABM may be used to help with medical diagnosis. We created the table to give some guidance to physicians and couples that might be helpful in choosing a method most suited to their individual circumstances. Although the CrMS is among the most developed and published for medical diagnosis and

applications, other FABM have also been used by physicians to help identify women who might need further medical evaluation and treatment.¹ More in-depth coverage of this aspect of natural methods is beyond the scope of this paper.

We hope that this conversation might prompt our colleagues to further investigate the modern FABMs as viable options for family planning and in some instances as an aide in addressing gynecological health problems. We encourage fellow primary care physicians to expand their knowledge, so they may provide current, accurate information to their patients.

Sincerely,
Authors

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