

Virtual Mentor

American Medical Association Journal of Ethics
March 2013, Volume 15, Number 3: 213-219.

STATE OF THE ART AND SCIENCE

*NaProTECHNOLOGY and Conscientious OB/GYN Medicine

Brooke E. Jemelka, MD, David W. Parker, MD, and Renee Mirkes, OSF, PhD

In the last 50 years, a surge of reproductive technology has revolutionized the practice of obstetrics and gynecology. First, effective hormonal contraceptives were made available to the public in the 1960s and, since their debut, have been used to treat almost every gynecologic abnormality [1]. Second, in the past 30 years, infertility has largely been managed using assisted reproductive technologies (ART), primarily intrauterine insemination (IUI) with recourse to in vitro fertilization (IVF) when insemination fails [2]. As a result, the modus operandi in mainstream gynecology has been to suppress, or to bypass, the woman's fertility cycle.

Physicians and patients who (1) conscientiously object to the therapeutic use of hormonal contraceptives on the grounds that it subjects patients to ineffective treatment of symptoms rather than treating their underlying disease and (2) morally oppose the ART approach to infertility on the grounds that it jettisons a loving act of marital intercourse, the one context worthy of the conception of a new human being, are now able to pursue an alternative approach that accords with their consciences. NaProTECHNOLOGY (an acronym for natural procreative technology) is a woman's health science that encompasses a unique medical and surgical application of gynecology. The foundation of NPT is the Creighton Model FertilityCare System (CrMS), the only prospective and standardized means of monitoring the various patterns of a woman's menstrual and fertility cycle for the natural regulation of fertility.

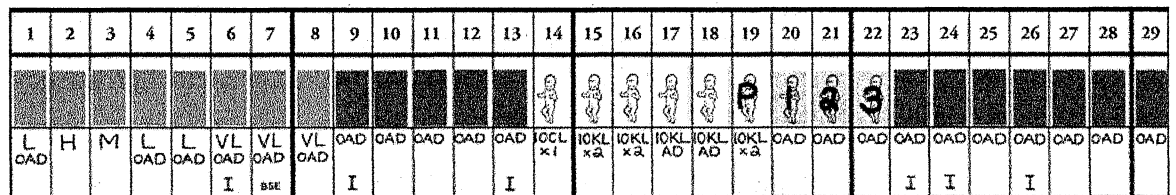


Figure 1. The chart of a woman who has a normal vulvar mucus cycle of regular length (i.e., between 21 and 38 days). The cycle begins with menses. The days of menses, marked on the chart with red stamps, are followed by infertile days, marked with green stamps, indicating the patient observes neither bleeding nor cervical mucus. The infertile days are followed by fertile days, marked with white baby stamps, indicating she observes cervical mucus at the vulva. The woman marks the last day of vulvar mucus discharge that is clear, stretchy, or lubricative with a "P" to indicate the peak day of cervical mucus and the peak day of her fertility. The fertile days are followed by infertile days, marked with green stamps, when the woman no longer observes cervical mucus.

neglected aspect of the treatment of endometriosis,” but the reviewers make no mention of the use of Gore-Tex as an adhesion barrier [9].

Other techniques of surgical NPT include laser vaporization and pelvic excision and repair surgery (PEARS) of peritoneal or ovarian endometriosis. PEARS is a form of plastic reconstructive surgery of the pelvis with the primary intent of removing diseased tissue within the pelvic organs and repairing organs in a way that does not form pelvic adhesions. PEARS can entail robot-assisted laparoscopy or laparotomy, minimizing postoperative adhesions and optimizing the patient’s chances for pregnancy.

The effectiveness of treating infertility with medical and surgical NPT is comparable to that of ART interventions. The cumulative live birth rate in patients receiving IVF is between 45-55% [10]. In a study population of 1,045 patients treated with NPT infertility protocols, more than 60 percent became pregnant within 24 months and nearly 70 percent within 36 months [11]. The overall “per-woman” NPT pregnancy rate is higher than that of ART due, in part, to the high rate of dropout or discontinuation in patients who undergo IVF treatment [12]. In addition, a meta-analysis comparing conventional surgery and IVF for treatment of endometriosis-related infertility found that the per-woman pregnancy rates with surgery were 55.3 percent while those with IVF were 9.9 percent [13]. However, while it is true patients treated with NPT have significantly lower overall fecundability (a 3.13 percent chance of conceiving within a given period) than those treated with IVF (13.3 percent), it is also true that the number of women who ultimately achieve a pregnancy with NPT is higher than the number who get pregnant using ART [14]. Thus, although achieving a live birth with NPT may take longer, it has a greater chance of occurring than with IVF.

For those interested in training in NPT, the Pope Paul VI Institute and Creighton University School of Medicine offer educational programs for those in primary care or ob/gyn (including fourth-year medical students) to train in the medical applications of NaProTECHNOLOGY [15]. They also offer a 1-year fellowship in the surgical applications of NPT for ob/gyns who have completed their residencies [16].

The Ethos Grounding NaProTECHNOLOGY

The previous thumbnail sketch of some of NPT’s protocols demonstrates NaProTECHNOLOGY’s distinctive medical and surgical infertility applications. But they are just one of its hallmarks. The ethical grounding of NPT’s infertility praxis is also distinctive.

NPT’s moral evaluation of fertility interventions is grounded in the following principles and values articulated by the Roman Catholic tradition, rooted in the nature of medicine, Aristotelian/Thomistic philosophical anthropology, and a personalist procreative ethics [17-27].

procreation from the marital act of intercourse, he or she should avoid it. NPT medical and surgical infertility protocols, on the other hand, accord with these concepts of the personal and procreative dignity of the infertile couple, since they enable them to conceive within their own acts of intercourse.

So, the good news is this: It is possible for physicians who hold the beliefs we detail here to practice medically sound obstetrics and gynecology in line with their well-formed consciences and those of their patients. It is possible to provide medically effective reproductive interventions that also genuinely promote this concept of bodily-spiritual well-being for both patient and physician. In other words, it is possible for physicians who hold these beliefs to honor the capital principle of beneficence that medical codes of professional ethics insist is central to the physician-patient relationship.

References

1. ACOG Practice Bulletin No. 110: Noncontraceptive uses of hormonal contraceptives. *Obstet Gynecol.* 2010;115(1):206-218.
2. *Fertility: Assessment and Treatment for People with Infertility Problems.* National Institute for Clinical Excellence; 2004.
<http://www.nice.org.uk/nicemedia/pdf/CG011niceguideline.pdf>. Accessed November 30, 2012.
3. Stanford JB. Outcomes from treatment of infertility with natural procreative technology in an Irish general practice. *J Am Board Fam Med.* 2008;21:375.
4. Adashi EY. Fertility following bilateral ovarian wedge resection: a critical analysis of 90 consecutive cases of the polycystic ovary syndrome. *Fertil Steril.* 1981;36:320.
5. Mais V, et al. Prevention of postoperative abdominal adhesions in gynecological surgery. Consensus paper of an Italian gynecologists' task force on adhesions. *Minerva Ginecol.* 2011;63(1):47-70.
6. Hilgers, TW. *The Medical & Surgical Practice of NaProTECHNOLOGY.* Omaha, NE: Pope Paul VI Institute; 2004;1001-1005.
7. Hilgers TW. Near adhesion-free reconstructive pelvic surgery: three distinct phases of progress over 23 years. *J Gyn Surgery.* 2010;26:31.
8. Somigliana E, Vigano P, Benaglia L, Busnelli A, Vercellini P, Fidele L. Adhesion prevention in endometriosis: a neglected critical challenge. *J Minim Invasive Gynecol.* 2012;19(4):415-421.
9. Somigliana, et al., 415.
10. Moragianni VA, Penzias AS. Cumulative live-birth rates after assisted reproductive technology. *Curr Opin Obstet Gynecol.* 2010;22(3):189-192.
11. Hilgers, *The Medical and Surgical Practice of NaProTECHNOLOGY*, 679.
12. Hogan JW. Identifying and addressing data-analytic challenges in IVF and ART. International Symposium on Frontiers and Reproductive Technology Serona Symposia USA; March 27-31, 2001: Washington, DC.
13. Campbell JS, Pasta DJ, Adamson GD. Preliminary meta-analysis comparing in-vitro fertilization with surgical treatment for moderate and severe endometriosis. *J Am Assoc Gynecol Laparosc.* 1995;2:s6-s7.

David W. Parker, MD, is a 2012-2013 medical and surgical fellow at the Pope Paul VI Institute for the Study of Human Reproduction in Omaha, Nebraska. He got his medical degree from the University of Texas Medical School at Houston and completed his residency training in obstetrics and gynecology through the University at Buffalo at the Sisters of Charity Hospital in Buffalo, New York. His research interests are premenstrual syndrome, infertility, and reproductive ethics.

Renee Mirkes, OSF, PhD, is director of the Center for NaProEthics, the ethics division of the Pope Paul VI Institute for the Study of Human Reproduction in Omaha, Nebraska. She has a doctor of philosophy degree from Marquette University and completed an ethics internship at the Pope John XXIII Medical-Moral Research and Education Center, now the National Catholic Bioethics Center. Her interests are in education and publications relating to procreative and birth ethics and rights of conscience in health care.

Related in VM

The American Medical Association *Code of Medical Ethics*' Opinions on Physician Participation in Abortion, Assisted Reproduction, and Physician-Assisted Suicide, March 2013

The viewpoints expressed on this site are those of the authors and do not necessarily reflect the views and policies of the AMA.

Copyright 2013 American Medical Association. All rights reserved.