INVITED COMMENTARY

JRRM JOURNAL OF RESTORATIVE REPRODUCTIVE MEDICINE

Understanding Restorative Reproductive Medicine

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https://doi.org/10.63264/f0b0xh81

Recently, editorials have been published in reproductive medical journals that have misunderstood and misrepresented the origin and meaning of "restorative reproductive medicine" (RRM).[1,2] This term was first used in 2000 when a group of physicians established the International Institute for Restorative Reproductive Medicine (IIRRM, iirrm.org). I am a founding member and am currently president of the IIRRM.

The IIRRM was founded as a secular, not a faith-based organization. We adhere to time-honoured medical principles to understand and treat underlying factors responsible for infertility. We are always seeking to improve our diagnosis and treatment of those factors, the training of clinicians who offer RRM, and the quality of clinical practice of RRM. We believe that in the clinical realm, in vitro fertilization (IVF) is often offered quickly without sufficient efforts first made to help couples conceive naturally.

IVF was originally developed to treat patients with bilateral tubal occlusion who could not conceive through sexual intercourse. Most patients who undergo IVF today do not have blocked fallopian tubes. Intracytoplasmic Sperm Injection (ICSI) was developed for patients with severe male factor infertility. Most patients who undergo ICSI today do not have severe male factor infertility. Remarkably, the most recent Cochrane review of IVF indicates ongoing uncertainty about whether IVF improves the live birth rate compared to expectant management for previously untreated couples with "unexplained" subfertility.[3]

I am an active RRM clinician since 1998 and I have treated thousands of couples. When patients present for fertility treatment, I do not ask them what religion, political view, or philosophy they support, because that is irrelevant to people who want a solution for their infertility. If they have a condition that is better treated by IVF, I tell them that at the first appointment. If natural conception is possible with RRM, I explain what is involved and outline the treatment process which can take up to 12 cycles (most often less) to reach a healthy ongoing pregnancy, or a full course of treatment.

RRM honours patient autonomy. We do not seek to prohibit patient access to IVF. Patients seek us out. RRM expands their choices and options. Many of my patients were previously seen in fertility clinics that offer IVF. Patients repeatedly tell me they did not receive the same depth of investigation or non-IVF treatment in the IVF clinics. I recently received these comments from patients, "RRM empowered us in our fertility journey. It provided a personalised approach. We are so grateful." And "even if we didn't conceive, we'd never regret trying RRM as my health improved immeasurably…"

The World Health Organization states that "Infertility is a disease of the male or female reproductive system defined by the failure to achieve a pregnancy after 12 months or more of regular unprotected sexual intercourse".[4] As RRM physicians, we respectfully suggest a slight but essential alteration: "Infertility is a medical condition defined by failure to achieve a pregnancy after 12 months or more of regular sexual intercourse without contraception, which is caused by one or more underlying diseases and conditions involving the male or female reproductive system." This definition indicates that infertility is not a singular condition to be treated solely by treatments to generate a pregnancy and birth. Rather, it is "a canary in the coal mine" for human health, indicating the need to identify and address underlying health concerns. [5,6]

As RRM physicians and clinicians we have training and backgrounds that allow us to treat infertility patients with a focus on treatments and approaches that restore and optimize natural function. The specialty of reproductive endocrinology and infertility has extensive training with a particular focus on IVF and treatments to improve the success of IVF. But we can and should be in agreement to offer patients evidence-based information and treatments that meet the needs and preferences of patients.

Further research is needed and is currently ongoing on patient-relevant questions, such as: How does an RRM evaluation differ in process and results from a fertility evaluation before initiating IVF? How do the outcomes of RRM and IVF compare on multiple levels including live birth rates, premature delivery, patient satisfaction, health improvement, and repeat successful births?

Published: September 17, 2025.

For the sake of our patients with infertility, let us strive to be objective about the scientific facts, and meet all patients with respect. Surely as we challenge and learn from one another and strive for excellence, the patients will be the ultimate beneficiaries.

CONFLICTS OF INTEREST DISCLOSURE

The author declares that he has no conflicts of interest.

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How to cite this article: Boyle P. Understanding Restorative Reproductive Medicine. J Restorative Reprod Med. 2025 Sept. 17. 1:7:1-2. https://doi.org/10.63264/f0b0xh81