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Conventional "Reproductive Health Care" Compared to Restorative Reproductive Medicine

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Setting aside at once the phrases "reproductive health" and "women's health" as they are popularly used in the media (that is, often as a euphemism for abortion), let us turn to them as they are next most frequently employed: to collectively reference the hormones, pharmaceuticals, and devices used to manage women's menstrual cycles, whether for contraceptive purposes or to alleviate the symptoms of common gynecological disorders such as endometriosis, polycystic ovary syndrome (PCOS), and uterine fibroids, which often present as painful, heavy, and/or irregular periods (among other symptoms) in adolescence and if left untreated will likely lead to struggles with infertility as an adult.

Modern reproductive healthcare is a narrowly conceived vision of women's health. Restorative reproductive medicine (RRM), on the other hand, is an authentic, more comprehensive approach to women's health.

A Brief History of the Reproductive Health Industry's Reliance on Pharmaceuticals

That contraception has become synonymous with "women's health" is a phenomenon nearly eighty years in the making. Enovid, the first contraceptive pill to hit the U.S. market, was first approved in 1957 for the treatment of "gynecological and menstrual disorders," with the caveat that it could inhibit ovulation as a side effect.[1]

What was referred to as the "contraceptive activity" of the Pill almost immediately became so well known among women and their doctors alike that "a suspiciously large number of women [were] treated with the pill [beginning in] 1957 for 'severe menstrual disorders,'" as Nicholas Bakalar put it in a 2010 edition of *The New York Times*'s "First Mention" feature on contraceptive pills.[2]

But whether American women of the late 1950s were using Enovid as contraception or to control the symptoms of endometriosis, fibroids, or any of the other poorly understood gynecological disorders that have plagued women for centuries,[3] birth control's popularity upon its initial approval was staggering: As Lara Marks notes in *Sexual Chemistry: A History of the Contraceptive Pill*, by 1961 (one year after Enovid's approval as a contraceptive in 1960), half a million American women were regularly taking hormonal contraception.[4]

1 Lara Marks, *Sexual Chemistry* (Yale University Press, 2010).
2 Nicholas Bakalar, "Birth Control Pills, 1957," *The New York Times*, October 25, 2010, https://www.nytimes.com/2010/10/26/health/26first.html.
3 Camran Nezhat, Farr Nezhat, and Ceana Nezhat, "Endometriosis: Ancient Disease, Ancient Treatments," *Fertility & Sterility* 98, no. 6 Suppl. (2012): S1–62, https://doi.org/10.1016/j.fertnstert.2012.08.001.
4 Marks, *Sexual Chemistry*.

While Enovid's entry into the market could be considered a "soft opening" of sorts—intended to gauge women's interest in taking a daily medication with no therapeutic purpose—hormonal contraceptives *did* prove effective at managing the symptoms of certain gynecological disorders, chief among them endometriosis and fibroids, and, more commonly today, PCOS. Today, hormonal contraception is still used (often off-label) as a frontline treatment for these issues and, more generally, to "regulate" a woman's cycle when she presents with irregular and/or heavy, painful periods. By flatlining the ebb and flow of a woman's natural cycle with the synthetic versions of the female reproductive hormones estrogen and progesterone (progestin), modern hormonal contraceptives (whether in the form of a pill, patch, injection, ring, or intrauterine device [IUD]) still mask many of the symptoms of common gynecological disorders, just as Enovid once did.

How Hormonal Contraceptives Work

It's important to note that hormonal contraception does not treat the root causes of PCOS, endometriosis, or any of the gynecological disorders for which doctors commonly prescribe it. Hormonal contraceptives also come with their own side effects and risks, some as benign as nausea and bloating and others as serious as cancer, blood clots, and depression.[5] Many women and their doctors alike are ill informed about the extent of these risks.

It is a little-known fact—or a little-discussed one—that hormonal contraception functions by keeping women from having menstrual cycles. The synthetic hormones in hormonal contraceptives function primarily to prevent pregnancy by keeping women from ovulating and likewise from menstruating.[6] For many women afflicted with a variety of gynecological disorders, the overriding of their natural, cyclic hormonal fluctuations by hormonal contraception manages symptoms such as painful and/or heavy periods. The logic is simple: No menstrual cycle means no symptoms of a menstrual disorder.

It is undeniably quicker, cheaper, and easier for a physician to prescribe hormonal contraception to a female patient than it is for him to take the time to diagnose or investigate the underlying causes of her irregular and/or painful cycles (which may include, among other things, a detailed review of the patient's menstrual cycle history, hormone analysis, imaging studies, physical or surgical exams, etc.). For the busy physician, prescribing hormonal contraception is a quick solution that may also make his patient's life more manageable—at least until she discontinues it, for example if she wants to get pregnant or if side effects become intolerable. In fact, the very existence of hormonal contraceptives may be part of the reason why these disorders remain chronically underdiagnosed, undertreated, and under-researched despite impacting a significant percentage of the female population.

Perhaps this is why it takes, on average, between eight to twelve years for a woman to receive a diagnosis of endometriosis[7]—a condition that affects more than six million American women—making it a condition as common as diabetes[8] (PCOS has a similar prevalence, and uterine fibroids may actually affect as many as 80 percent of women). These conditions also represent the leading causes of infertility in the United States. Strikingly, an estimated 70 percent of teenage girls who present with dysmenorrhea (painful menstrual cramps) are eventually diagnosed with endometriosis.[9] But that diagnosis often comes after years of needless suffering, with pharmaceutical "Band-Aids" placed over symptoms and the heartbreak of miscarriage and/or infertility.

5 "Citizen Petition from Contraceptive Study Group," Food and Drug Administration, Regulations.gov, May 10, 2019, https://www.regulations.gov/document/FDA-2019-P-2289-0001.

6 It's true that women on the Pill still bleed, but it is breakthrough bleeding and not true menstruation, which by definition must be preceded by ovulation. See Madison Ayers, "Can You Ovulate on Birth Control?," *Natural Womanhood*, July 14, 2023, https://naturalwomanhood.org/can-you-ovulate-on-birth-control/.

7 Zoë Pugsley and Karen Ballard, "Management of Endometriosis in General Practice: The Pathway to Diagnosis," *British Journal of General Practice* 57, no. 539 (2007): 470–76, https://pmc.ncbi.nlm.nih.gov/articles/PMC2078174/.

8 "Endometriosis," U.S. Department of Health and Human Services, Office of Women's Health, last updated February 22, 2021, https://womenshealth.gov/a-z-topics/endometriosis.

9 Robert N. Taylor, Lone Hummelshoj, Pamela Stratton, and Paolo Vercellini, "Pain and Endometriosis: Etiology, Impact, and Therapeutics," *Middle East Fertility Society Journal* 17, no. 4 (2012): 221–25, https://doi.org/10.1016/j.mefs.2012.09.002.

Why Women Need Healthy Cycles

The problem with the immediate recourse many physicians take towards prescribing hormonal contraceptives for painful and/or irregular cycles is twofold. It not only fails to address the root causes of these issues but also blithely ignores the fact that *women need their cycles* for the good health and proper development of nearly every major organ system of the body.[10] This is precisely why, since 2015, the American College of Obstetricians and Gynecologists has said that the menstrual cycle should be treated as a "vital sign" (alongside the other four measurements of the body's essential functions: body temperature, pulse rate, respiratory rate, and blood pressure).[11]

To illustrate this point by means of an analogy: Consider that we do not shut down a patient's heart when her heartbeat is irregular. We understand, correctly, that the irregular heartbeat calls for investigation, indicating that it says something important about the patient's cardiac health. We likewise understand that issues with cardiac health do not stay within the heart; instead, they have far-reaching implications for a patient's overall well-being.

Why, then, have we decided to shut down women's menstrual cycles when their periods are irregular?

What Authentic Women's Health Should Look Like

For far too long, doctors and patients alike have accepted the false belief that hormonal contraception is the best—indeed, the only—remedy for gynecological disorders. (For too long, women have also accepted that those same risks and side effects are a necessary trade-off for effective pregnancy prevention.) This mentality has arguably set back medicine's understanding of women's health in an untold number and manner of ways. But healthcare professionals who have embraced the field of restorative reproductive medicine, which uses the detailed knowledge of a female patient's menstrual cycles to gain information about a woman's fertility and overall health, have rejected the quick fix of contraception and are committed to investigating and treating the root causes of cycle issues—improving the patient's fertility and overall health in the process.

In other words, RRM-trained healthcare professionals are not content to simply override a woman's cycle by flooding her body with various pharmaceuticals and/or synthetic hormones via pills, injections, or devices. Instead, they are armed with training in natural procreative technology (NaProTechnology), fertility education and medical management (FEMM), NeoFertility, and other practices that are committed to the understanding that a woman's cycle (and likewise, her fertility) is not a disease to be cured but rather a fifth "vital sign"—that is, a biomarker that can indicate something about the overall health of a woman to the knowledgeable healthcare professional. In the hands of such a professional, a detailed accounting of a woman's menstrual cycles (commonly captured via digital or analog charts of fertility biomarkers such as menstrual bleeding, basal body temperature, cervical mucus, and/or hormonal tests) is as powerful and essential to good knowledge of a patient's health as an EKG tracing is in the hands of a cardiologist.

It is time to revolutionize women's health—to see it as more than a euphemism for abortion or pregnancy prevention but instead as a field of medicine that understands the truth that a woman's cycle impacts (and is, in turn, impacted by) her overall health. One's cycle is not an independent function of the body that can (or should) be shut down with little regard for the workings of the whole. Indeed, this has been the fundamental mistake of the majority of women's health solutions since 1957. But thanks to restorative reproductive medicine, the field of women's health is finally changing for the better. In the next essay, Dr. Marguerite Duane of FACTS About Fertility will explain how.

10 "Reasons Women Need Periods," *Natural Womanhood*, accessed March 3, 2025, https://naturalwomanhood.org/category/know-your-body/reasons-women-need-periods/.

11 "Menstruation in Girls and Adolescents: Using the Menstrual Cycle as a Vital Sign," American College of Obstetricians and Gynecologists, Committee Opinion No. 651, December 2015 (reaffirmed 2025), https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2015/12/menstruation-in-girls-and-adolescents-using-the-menstrual-cycle-as-a-vital-sign.

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