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ADULTERY BY DOCTOR: ARTIFICIAL INSEMINATION, 1890–1945

KARA W. SWANSON*

INTRODUCTION

In 1945, doctors and lawyers in the Chicago area planned their first Symposium on Medicolegal Problems. Limiting themselves to six topics, they included artificial insemination as one of the most pressing medicolegal problems of the day.¹ Although abortion had been a dominant medicolegal issue of the second half of the nineteenth century, by the middle of the twentieth century it was techniques of pregnancy initiation, rather than termination, that concerned the two professions.² Doctors and lawyers agreed that “there is no subject at this time which is more controversial.”³ The controversy was fueled by increasing popular attention to artificial insemination. Americans read in general interest magazines that medicine offered new hope to childless couples.⁴ As Americans learned that hundreds or perhaps thousands of babies had been conceived by this method in the past decade alone,

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1. *Contents*, in SYMPOSIUM ON MEDICOLEGAL PROBLEMS xvii–xviii (Samuel A. Levinson ed., 1948) [hereinafter SYMPOSIUM]. The other five problems discussed were: (1) medical expert witnesses, (2) medicolegal problems arising out of pathology and treatment of dead human bodies, (3) sterilization, (4) trauma and tumors in industrial medicine, and (5) use of laboratory test results as courtroom evidence. Samuel A. Levinson, *Preface*, in SYMPOSIUM, *supra*, at xii–xiii.

2. For the dominant nature of abortion as a medicolegal problem in the nineteenth century, see JAMES C. MOHR, *ABORTION IN AMERICA: THE ORIGINS AND EVOLUTION OF NATIONAL POLICY, 1800–1900*, at 200–25 (1978). For its subsidence into less controversial status in the first half of the twentieth century, see KRISTEN LUKER, *ABORTION AND THE POLITICS OF MOTHERHOOD* 40 (1984). By the 1950s, abortion would again become a dominant medicolegal problem. *Id.* at 41; LESLIE J. REAGAN, *WHEN ABORTION WAS A CRIME: WOMEN, MEDICINE, AND LAW IN THE UNITED STATES, 1867–1973*, at 217 (1997). The relationship between abortion and artificial insemination as medicolegal problems over the course of the twentieth century is the subject of a planned future article.

3. B. Fain Tucker, *Legal Problems of Artificial Insemination*, 33 *WOMEN’S L. J.* 57, 58 (1947).

4. See, e.g., Marie Beynon Ray, *Fathers Anonymous*, *WOMEN’S HOME COMPANION*, Jan. 1945, at 20; Greta Palmer, *Plan for Parenthood*, *LADIES HOME J.*, Sept. 1941, at 28.

doctors and lawyers realized that this new hope posed many “delicate questions” for the law.⁵ Was assisted conception legal, and who were the lawful parents of these “test-tube babies”?⁶

What bothered lawyers and doctors alike as artificial insemination became more common was that the law offered no direct answers to these delicate questions.⁷ The only reported judicial opinion on the subject in the Anglo-American world was a Canadian case from 1921, *Orford v. Orford*.⁸ In this alimony proceeding, Mrs. Orford claimed that her child, born while she and her husband had been living on opposite sides of the Atlantic Ocean, was the result of artificial insemination.⁹ The judge disagreed, finding the child a product of an extramarital affair, and therefore addressed the legal status of artificial insemination only in dicta.¹⁰ That dicta was troubling, however, as the judge found no legal difference between adultery and insemination using non-husband sperm.¹¹ Even if he had accepted Mrs. Orford’s testimony, she still would have been guilty of adultery, and her child would be illegitimate.

While the number of assisted conceptions was increasing in the 1940s, doctors had been using this technically simple technique of family formation for decades. Artificial insemination is the use of instruments to deposit semen in a woman’s reproductive tract, either at the cervix or within the uterus, a technique sometimes described as giving sperm a three-inch boost on a six-inch journey.¹² Also called “instrumental impregnation,” this technique can be performed either with semen from a woman’s husband or from another donor.¹³ Doctors had been practicing artificial insemination both with husband and do-

5. Ray, *supra* note 4, at 20; Palmer, *supra* note 4, at 57.

6. J.P. Greenhill, *Artificial Insemination: Its Medicolegal Implications—Medical Aspects*, in SYMPOSIUM, *supra* note 1, at 43.

7. Samuel A. Levinson, *Preface*, in SYMPOSIUM, *supra* note 1, at xii (“no law thus far which can be of assistance”).

8. *Orford v. Orford*, [1921] 49 O.L.R. 15.

9. *Id.* at 16–18.

10. *Id.* at 19.

11. *Id.* at 22–23.

12. Alan Frank Guttmacher, *Practical Experience with Artificial Insemination*, 3 J. CONTRACEPTION 74, 75 (Apr. 1938) [hereinafter Guttmacher, *Practical Experience*].

13. During this period, the two variations of artificial insemination were often referred to as “artificial insemination by husband,” or “AIH,” and “artificial insemination by donor,” or “AID.” Other terms in use since the nineteenth century include “artificial fertilization,” “instrumental insemination,” and “artificial fecundation.” A brief review of the multiple nomenclature schemes is provided in WILFRED J. FINEGOLD, *ARTIFICIAL INSEMINATION* 3–4 (1st ed. 1964) and A.M.C.M. SCHELLEN, *ARTIFICIAL INSEMINATION IN THE HUMAN* 3–6 (M.E. Hollander trans., Elsevier Pub. Co. 1957).

nor semen in the United States since the nineteenth century. The resulting children were sometimes called “test tube babies” or “laboratory babies,” reflecting the technical nature of their conception.¹⁴ All such babies were controversial,¹⁵ but it was donor insemination that was the focus of the perceived medicolegal problem of the mid-twentieth century. As the *Orford* court had concluded, donor insemination could be understood as the equivalent of an extramarital affair, adultery by doctor. That a medical technique practiced by reputable doctors could be cast in such a negative light by the law was the crux of the problem.

After 1945, assisted conception emerged onto the American legal scene. Courts in Illinois and New York heard the first United States divorce cases involving children allegedly conceived by artificial insemination.¹⁶ These cases received nationwide newspaper coverage. By the late 1940s, state legislatures began to consider bills to clarify the legal status of such children.¹⁷ This new medicolegal problem, once identified, was not quickly solved. While artificial insemination was the first successful technique of assisted conception, new assisted reproductive technologies have supported the persistence of the problem in American law and society to the present.¹⁸

The Chicago symposium was so not much an attempt to *resolve* the problem, as an early attempt to *define* the problem. It was a signal

14. See sources cited *supra* note 6 and *infra* note 90.

15. HERMANN ROHLEDER, TEST TUBE BABIES: A HISTORY OF THE ARTIFICIAL IMPREGNATION OF HUMAN BEINGS 139–62 (1934) (detailing opposition to any form of artificial insemination based on religion, nature, medical ethics, and morality); MARGARET MARSH & WANDA RONNER, THE EMPTY CRADLE: INFERTILITY IN AMERICA FROM COLONIAL TIMES TO THE PRESENT 163 (1996) [hereinafter MARSH & RONNER, THE EMPTY CRADLE].

16. The cases include *Hoch v. Hoch* (Ill. 1945) (unreported, but discussed in Ronald S. Jacobs & J. Peter Luedtke, *Social and Legal Aspects of Human Artificial Insemination*, 1965 WISC. L. REV. 859, 875 (1965)); *Strnad v. Strnad*, 190 Misc. 786, 78 N.Y.S.2d 390 (Sup. Ct. 1948); *Doornbos v. Doornbos*, 139 N.E.2d 844 (Ill. App. Ct. 1956).

17. Legislative efforts included bills introduced in New York, Minnesota, and Illinois. See Thurston A. Shell, *Artificial Insemination—Legal and Related Problems*, 8 UNIV. FLA L. REV. 304, 314 (1955) (describing bills introduced unsuccessfully in six states before 1955, including four attempts in New York between 1948 and 1951); Jacobs & Luedtke, *supra* note 16, at 881–82 n.117.

18. For example, the Leahy-Smith America Invents Act of 2011 (signed Sept. 16, 2011) includes a provision designed to prohibit the patenting of human clones, an anticipated technology of human reproduction. Pub. L. No. 112-29 § 33, 125 Stat. 340. For aspects of the later legal history of artificial insemination, see Kara W. Swanson, *‘Adultery by Doctor’: Law and the Treatment of Infertility in the 20th-Century United States* (May 1, 2011) (paper presented at the American Association for the History of Medicine, Philadelphia, PA); Gaia Bernstein, *The Socio-Legal Acceptance of New Technologies: A Close Look at Artificial Insemination*, 77 WASH. L. REV. 1035, 1067–98 (2002). This subsequent history is the subject of Kara W. Swanson, *How Americans Learned to Love the Sperm Bank: Artificial Insemination and the Law, 1945–2000* (work in progress) (on file with author).

that the medical profession could no longer confine the discussions about the suitability and effects of artificial insemination to itself. The symposium revealed a wide range of opinions on the subject, from condemnatory characterizations as “adultery in the test tube,” to support for the practice as “humanitarian efforts” on behalf of infertile couples.¹⁹ While doctors and lawyers could agree that the practice was controversial, there was no consensus within either law or medicine about artificial insemination. It would take decades to enshrine a consensus about artificial insemination in law and practice.

This Article focuses on artificial insemination during the years in which its status was largely a matter for deliberation by doctors.²⁰ It traces the transformation of assisted conception from a medical issue of the best treatment for involuntary childlessness to its current status as a problem in American law and society. I argue that donor insemination became a pressing medicolegal problem at mid-century because of three intertwined reasons, all related to use of the technique by doctors. First, by the 1940s, after decades of trial and error, doctors were able to achieve high rates of conception using artificial insemination. Second, because donor insemination often worked as a means of giving a baby to the involuntarily childless, and because in the post-World War II focus on domesticity and parenthood, patients increasingly asked for the procedure, there was a growing number of doctors willing to perform it. Third, because of the first two reasons, there was an increasing number of test tube babies being born, making the legal uncertainty surrounding their origins and status increasingly intolerable.

In examining the history of a medical procedure becoming a legal problem, I am also tracing the development of a medical practice in the face of legal uncertainty and fear of illegality. I argue that doctors modified the way they treated patients in response to perceived social and

19. Greenhill, *supra* note 6, at 53, 56. Note that the conference proceedings were published *in toto* in a volume which included two papers on artificial insemination and the moderated discussion among the attendees on the subject. See SYMPOSIUM, *supra* note 1, at 43–87. The artificial insemination papers and discussion were also published in a medical journal at 1 AM. PRACTITIONER 227–41 (1947). The conference volume was widely reviewed in law journals. See, e.g., Book Reviews, 11 GA. B. J. 217–18 (1948); William H. Baker, Book Reviews, 14 MO. L. REV. 131, 132 (1949); Harry L. Kozol, Books Reviewed, 48 COLUM. L. REV. 973, 979–80 (1948); Thomas A. Gonzalez, Book Review, 34 VA. L. REV. 743, 743–44 (1948).

20. The extent to which artificial insemination was unknown to the law and to lawyers in this period is illustrated by a recent history of law and the family, which suggests that the successful use of artificial insemination began in the 1950s—which was when the law took cognizance of the issue. JOANNA L. GROSSMAN & LAWRENCE M. FRIEDMAN, INSIDE THE CASTLE: LAW AND THE FAMILY IN 20th CENTURY AMERICA 286 (2011).

legal condemnation. Further, doctors' persistence in meeting patient demand for fertility treatments despite such condemnation helped create the medicolegal problem of artificial insemination, transforming it from a narrow medical question into a broad social question.

In Part I, I examine the development and use of artificial insemination within medicine in the United States from the late nineteenth century until 1945, explaining its increasing, but limited, acceptance amongst medical professionals, the growing reliance on donor insemination by the 1940s and how the secrecy surrounding this medical treatment shaped both who was able to access it and how it was performed. The changes in medical knowledge and practice in the first decades of the twentieth century helped transform artificial insemination from a curiosity into a medicolegal problem. In Part II, I turn to the identification of this medicolegal problem. Worries about the law surfaced among medical professionals by the 1930s, and I examine the development of these worries, and the varied responses within medicine, including adjustments to medical practice designed to minimize legal problems. Only after doctors had been discussing artificial insemination as a medicolegal problem for about a decade did lawyers and legal scholars begin to consider the issue. In Part III, I trace the legal discourse surrounding artificial insemination in the 1940s and the burgeoning dialogue between law and medicine illustrated by the Chicago symposium. That dialogue revealed a profound rift between supporters and opponents of the practice, setting the stage for the public battles to follow.

I. ARTIFICIAL INSEMINATION AS A MEDICAL TECHNIQUE

A. *Test Tube Babies: Artificial Insemination to 1934*

In 1934, Americans could buy a copy of a slim volume by German physician Hermann Rohleder titled *Test Tube Babies: A History of the Artificial Impregnation of Human Beings*.²¹ First published in German in 1921, Rohleder's book provides a glimpse of the status of artificial insemination in the first decades of the twentieth century. As indicated by his subtitle, even by 1921 this technique was not new, but a medical practice with a long history. Further, according to Rohleder, by 1934 the phrase "test tube babies" was "commonly used" in English-

21. ROHLEDER, *supra* note 15. The German version was published as Hermann Rohleder, *Die künstlich Zeugung (Befruchtung) im Tierreich*, MONOGRAPHIEN ÜBER DIE ZEUGUNG BEIM MENSCHEN, VOL. 7 (1921).

speaking countries to describe the desired results of “artificial impregnation.”²² Artificial insemination of humans had been a topic of discussion and experimentation in the medical community since at least the eighteenth century, and, by 1934, it was entering popular consciousness in the United States, even as it remained controversial among doctors.

1. Developing the Technique, 1799–1934

Involuntary childlessness is an age-old problem, the focus of biblical stories and royal intrigues. There is no way to pinpoint the first attempts to cure this condition or the numerous approaches that women and men have tried. People have been motivated to treat sterility for centuries. By the eighteenth century, the development of a culture of sharing experimental results through circulated publications, fostered by the *Philosophical Transactions of the Royal Society*, established a means of tracing such attempts in the published record. This early scientific literature contained reports of experimentation with artificial insemination in animals, and by 1799, Englishmen were claiming that John Hunter had performed the first successful assisted insemination in a human decades previously.²³ Throughout the nineteenth century, there were numerous published reports in Europe and the United States about the technique, as curious doctors and desperate would-be parents experimented.²⁴

By 1866, doctors interested in treating infertility could read a detailed description of the artificial insemination technique used by American physician J. Marion Sims, later considered the “father of gynecology” for his contributions to the treatment of women’s reproductive problems.²⁵ Sims discussed artificial insemination in his book

22. ROHLEDER, *supra* note 15, at xvi.

23. Everard Home, *An Account of the Dissection of an Hermaphrodite Dog*, 89 *PHIL. TRANSACTIONS ROYAL SOC’Y* 162 (1799). The English claimed that Hunter’s efforts predated the Italian Lazzaro Spallanzani’s publication of results in a dog in 1780, which are often cited as an origin point for artificial insemination research, although there has been considerable discussion in the medical literature of fourteenth century records of artificial insemination in mammals. F.N.L. Poynter, *Hunter, Spallanzani, and the History of Artificial Insemination*, in *MED., SCI., AND CULTURE: HIST. ESSAYS IN HONOR OF OWSEI TEMKIN* 97, 99–100 (Lloyd G. Stevenson & Robert P. Multhauf eds., 1968). See also SCHELLEN, *supra* note 13, at 9–13.

24. There are reports of human artificial insemination performed in France, England, Italy, Germany, and the United States during the nineteenth century. Poynter, *supra* note 23, at 101, 104–05, 109, 112; SCHELLEN, *supra* note 13, at 14–18; ROHLEDER, *supra* note 15, at 42–44.

25. Sims, a member of a wealthy slave-owning family in the antebellum South, controversially honed his expertise in gynecological surgery on slave women. He then moved north and established a women’s hospital in New York City and his reported cases of artificial insemination involved free white patients, both charity and private patients. DEBORAH KUHN MCGREGOR, *SEXUAL*

devoted to uterine surgery, his preferred method of treating female sterility.²⁶ His focus on women's fertility coincided with a campaign by American doctors to define childbirth as a medical matter for trained obstetricians who sought to replace midwives and other informally educated practitioners.²⁷ Like the simultaneous movement to criminalize abortion, the nineteenth-century medicalization of childbirth supported the goal of strengthening the weak position of regular physicians by pushing other medical practitioners out of lucrative practice areas.²⁸ It is not surprising that, having turned their attention to obstetrics, physicians also began to consider involuntary childlessness.

To the new "women's doctors" like Sims who dominated the medical treatment of infertility in the nineteenth century, artificial insemination was a minor technique of secondary importance. Sims focused on correcting perceived flaws in female anatomy, reflecting a belief that childlessness was almost exclusively a female problem.²⁹ For centuries, the dominant belief had been that any potent man was fertile.³⁰ Further, sperm was considered by many to be relatively unimportant to conception. There was a long-standing medical belief that sperm merely stimulated the development of a preformed embryo already complete within the ovum.³¹ It was not until late in the nineteenth century that there was a medical consensus that sperm played a crucial role in conception and passed hereditary material to the resulting offspring.³² Sims was an early convert to the position that male sterility

SURGERY AND THE ORIGINS OF GYNECOLOGY: J. MARION SIMS, HIS HOSPITAL, AND HIS PATIENTS 1-2, 257-58, 273-74 (1990); RANDI HUTTER EPSTEIN, GET ME OUT: A HISTORY OF CHILDBIRTH FROM THE GARDEN OF EDEN TO THE SPERM BANK 35-48 (2010). See also, generally, J. MARION SIMS, THE STORY OF MY LIFE (reprinted, De Capo Press 1968) (1884).

26. J. MARION SIMS, CLINICAL NOTES ON UTERINE SURGERY: WITH SPECIAL REFERENCE TO THE MANAGEMENT OF THE STERILE CONDITION 369 (1866).

27. RICHARD W. WERTZ & DOROTHY C. WERTZ, LYING-IN: A HISTORY OF CHILDBIRTH IN AMERICA 29-76 (Yale Univ. Press 1989) (1977); JUDITH WALZER LEAVITT, BROUGHT TO BED: CHILDBEARING IN AMERICA, 1750-1950, at 36-63 (1986); Judith Walzer Leavitt, 'Science' Enters the Birthing Room: *Obstetrics in America since the Eighteenth Century*, 70 J. AM. HIST. 281, 281-304 (1983).

28. For the role of medical professionalization in the nineteenth century criminalization of abortion, see MOHR, *supra* note 2, at 147-70; Carroll Smith-Rosenberg, *The Abortion Movement and the AMA 1850-1880*, in DISORDERLY CONDUCT: VISIONS OF GENDER IN VICTORIAN AMERICA 217, 217-44 (1985).

29. See ROHLER, *supra* note 15, at xii-xiv (discussing persistent transnational belief that childlessness was a female problem).

30. ELAINE TYLER MAY, BARREN IN THE PROMISED LAND: CHILDLESS AMERICANS AND THE PURSUIT OF HAPPINESS 43-44 (1995).

31. JOHN FARLEY, GAMETES AND SPORES: IDEAS ABOUT SEXUAL REPRODUCTION, 1750-1914, at 17-20, 29 (1982) (a belief that existed alongside another long-standing but less common belief that placed the preformed homunculus in the sperm).

32. *Id.* at 160.

and impotence were not the same condition, referencing what he called the recent conclusive proof that “sterility in the male does positively exist.”³³

Yet Sims, like his contemporaries, concentrated almost exclusively on curing childless wives, as the cause of any barren marriage. Sims’s volume reflected his understanding that sterility was most often caused by malpositions or malformations of the uterus, and that the best treatment was usually uterine surgery. Sims saw a use for artificial insemination only in cases in which the intended father was unable to deposit semen near the cervix of his wife, due to a malformation in the wife that she was too “timid” to allow Sims to correct by surgery.³⁴ His experiments with artificial insemination were not encouraging. He reported fifty-five attempts to artificially inseminate six women by intrauterine injection of their husband’s semen, with only one resulting pregnancy.³⁵ Given these results, he announced that he was giving up on the practice.³⁶ Artificial insemination remained a poor step-sister to surgical methods to correct the major perceived source of involuntary childlessness, infertile women.³⁷

Despite Sims’s poor results, there is evidence that a geographically scattered handful of American practitioners continued to attempt artificial insemination during the next half century.³⁸ By the first years of the twentieth century, their various reports could be collected and applied. In 1912, Dr. Eliza Mosher, one of the few female gynecologists,³⁹ reviewed the medical literature on the technique in the *Wom-*

33. SIMS, *supra* note 26, at 364–65.

34. *Id.* at 376.

35. *Id.* at 380.

36. *Id.* at 365.

37. For nineteenth century medical views of and treatments for sterility, see Margarete J. Sandelowski, *Failures of Volition: Female Agency and Infertility in Historical Perspective*, 15 SIGNS: J. OF WOMEN IN CULTURE AND SOCIETY 475, 480–86 (1990).

38. Although there are no known records of such use, it likely that some couples tried do-it-yourself insemination as well. Dr. Edward Bliss Foote published a home medical advice book in 1870 describing artificial insemination and advertised an “impregnating syringe” by mail order for home use. MARSH & RONNER, *THE EMPTY CRADLE*, *supra* note 15, at 69–70.

39. Obstetrics and gynecology was one of the few areas in which women physicians in early twentieth century tended to specialize, if they specialized at all. (Note that before World War I, most doctors did not consider themselves specialists). Women who did concentrate in that field were not admitted to the national societies until the 1920s, and it was 1970 before the American Gynecological Society admitted its second woman. ELLEN S. MORE, *RESTORING THE BALANCE: WOMEN PHYSICIANS AND THE PROFESSION OF MEDICINE, 1850–1995*, at 47–49, 55, 96 (1990). While acknowledging the existence of women doctors in this area, including Mosher and Frances Seymour, discussed *infra*, I use the male pronoun to refer to doctors in this Article, reflecting the gender of the vast majority of the doctors discussed.

an's Medical Journal.⁴⁰ While she reported that American publications on the subject were sparse, French physicians had more enthusiastically adopted the practice and had published more case studies.⁴¹ Based on her review, Mosher was much more optimistic than Sims. She estimated that doctors achieved success in about fifty percent of cases, albeit often after numerous attempts.⁴² Mosher considered artificial insemination both "proper" and "peculiarly adapted to women in medicine," and explained the "technic" she used in her Brooklyn practice in detail.⁴³

Artificial insemination in the first years of the twentieth century was not limited to eastern urban specialists. Five years later, Dr. Frank Davis, an Oklahoma practitioner, published a treatise titled *Impotency, Sterility and Artificial Impregnation*.⁴⁴ Unlike Sims and Mosher, Davis explicitly linked artificial insemination to eugenic policies, which enjoyed broad support among educated elites in the first decades of the twentieth century.⁴⁵ Davis, former superintendent of the Oklahoma State Hospital for the Feeble-Minded,⁴⁶ believed that while the "feeble-minded" needed to be confined and cured, superior persons needed to be encouraged to reproduce, and assisted as necessary. Davis, like many of his contemporaries, was concerned about "race suicide," by which he meant the declining birth rate among "Christian countries."⁴⁷ In order to correct sterility amongst this deserving population, Davis, like Sims a half-century earlier, advocated the correction of uterine malpositions in women, often by surgery.⁴⁸ Undeterred by Sims's poor results, he also performed artificial insemination and taught couples to perform the technique themselves, providing them with the necessary instruments.⁴⁹ Through this approach, Davis claimed to relieve "many cases of barrenness."⁵⁰

40. Eliza M. Mosher, *Instrumental Impregnation*, 22 *WOMAN'S MED. J.* 224, 224-25 (1912).

41. The extent of public discussion of artificial insemination in France and the evident frequency of the practice did not keep it from being controversial. Michael Finn, *Female Sterilization and Artificial Insemination at the French Fin de Siècle*, 18 *J. HIST. SEXUALITY* 26, 40-42 (2009).

42. Mosher, *supra* note 40, at 224.

43. *Id.* at 223.

44. FRANK P. DAVIS, *IMPOTENCY, STERILITY, AND ARTIFICIAL IMPREGNATION* (1917).

45. DANIEL KEVLES, *IN THE NAME OF EUGENICS: GENETICS AND THE USES OF HUMAN HEREDITY* 64 (1985).

46. DAVIS, *supra* note 44, at title page.

47. *Id.* at 8, 76-83.

48. *Id.* at 98.

49. *Id.* at 104-05.

50. *Id.* at 106.

Through publications such as Mosher's article and Davis's book, by the interwar years doctors throughout the United States had access to detailed directions for artificial insemination and reason to believe the technique worked in some cases.⁵¹ There is little question that the focus in treating the involuntarily childless remained on women and that doctors attempted a wide range of techniques to restore female fertility, including surgery.⁵² The extent to which doctors or couples performed artificial insemination and the numbers of children resulting are unknowable, but in 1920, the practice was given new prominence and official sanction. Dr. Robert Latou Dickinson, newly-elected president of the American Gynecological Society, used his first presidential address to urge his fellow gynecologists to study and pool their experience with what he called "artificial impregnation."⁵³ A few months later, Dickinson followed his own advice by presenting a paper discussing his decades of experience with artificial insemination, which he described practicing since the 1880s.⁵⁴

Dickinson advocated a reversal of the traditional surgery-focused approach to infertility, suggesting that if insemination held out "reasonable promise," it should become "the accredited procedure before turning to operation."⁵⁵ Based on his experience, he, like Mosher and Davis, provided his colleagues with detailed instructions, complete with diagrams.⁵⁶ He suggested using the treatment not only for the wives of impotent men, and for women with uterine malformations, but also for the wives of men whose sperm was "not vigorous," although he lamented that it usually failed in such cases.⁵⁷ Dickinson reported five pregnancies in cases of "normal pelvic organs and semen

51. See also Victor D. Lespinasse, *Clinic of Victor D. Lespinasse*, 1 INTERNATIONAL CLINICS, Series 28, at 47 (1918) (use of artificial insemination in Chicago practice).

52. The focus on women persisted for several more decades, causing fertility specialists frequently to lament the failure to examine male partners in involuntarily childless couples. See, e.g., Joseph Cohen, *Sterility*, 83 NEW ORLEANS MED. & SURGICAL J. 401, 401 (1930). See also MARGARET MARSH & WANDA RONNER, *THE FERTILITY DOCTOR: JOHN ROCK AND THE REPRODUCTIVE REVOLUTION* 121 (2008) [hereinafter MARSH & RONNER, *THE FERTILITY DOCTOR*] (Dr. John Rock did not extend his sterility clinic to include men as patients until late 1940s, twenty years after he became director, although the clinic did seek to examine the husband of each female patient); Sandelowski, *supra* note 37, at 489 (female responsibility for sterility).

53. Robert L. Dickinson, *Suggestions for a Program for American Gynecology*, 45 TRANSACTIONS AM. GYNECOLOGICAL SOC'Y 6-7 (1920).

54. Robert L. Dickinson, *Artificial Impregnation: Essays in Tubal Insemination*, 45 TRANSACTIONS AM. GYNECOLOGICAL SOC'Y 141-48 (1920).

55. *Id.* at 141.

56. *Id.* at 144-46.

57. *Id.* at 147.

showing multiple quick travelers.”⁵⁸ Dickinson’s stature and platform helped to transform the ongoing medical discussion from one in which artificial insemination was a curiosity into a discussion of the technique as a modern, scientific practice endorsed by highly trained specialists. After Dickinson’s report, other interested doctors were emboldened to join the professional discourse on the subject, which continued in the pages of various professional journals.⁵⁹ By 1927, the editors of the *Journal of the American Medical Association*, the publication of the largest professional medical organization, could provide a straightforward answer to an anonymous query from a doctor wishing to know how to perform artificial insemination. The editors recommended that he check the husband’s semen for live spermatozoa, and the wife for fertility, and then proceed using the technique as outlined in a simple paragraph.⁶⁰ When Dr. John Rock opened a fertility clinic at the Free Hospital for Women in Brookline, Massachusetts,⁶¹ he offered artificial insemination as one possible treatment for his patients through the 1920s.⁶²

Still, many doctors remained unconvinced. When Dickinson first presented his results, one audience member described himself as “skeptical.”⁶³ And with some reason. Artificial insemination remained a frustrating technique. The *Journal of the American Medical Association* editors, in their 1927 reply, noted that “[i]nsemination should not be undertaken lightly because the results have not been encouraging,” and sometimes required up to fifty attempts.⁶⁴ Part of the frustration, not generally discussed before 1920, was the failure of artificial insemination to assist many couples in which the wife was apparently normal and fertile, but the husband’s sperm was “not vigorous” or wholly absent.

58. *Id.* at 148.

59. ERNEST HENRY BREUER, *ARTIFICIAL INSEMINATION: A SELECTED BIBLIOGRAPHY OF THE MEDICAL, LEGAL, RELIGIOUS AND MORAL ASPECTS OF ARTIFICIAL HUMAN INSEMINATION 18–20* (1948) (cataloging one or more publications per year through the 1920s and 1930s). *See also* FINEGOLD, *supra* note 13, at 7 (listing the new investigators who worked on donor insemination in 1920s and 1930); SCHELLEN, *supra* note 13, at 22 (listing papers published in the 1920s).

60. Queries and Minor Notes, *Artificial Impregnation*, 89 J. AM. MED. ASS’N 1354 (Oct. 15, 1927).

61. MARSH & RONNER, *THE FERTILITY DOCTOR*, *supra* note 52, at 50–51.

62. Based on review of patient records, 1925–1931, John Rock Papers, Countway Library of Medicine, Harvard University, Box 10. *See also* MARSH & RONNER, *THE FERTILITY DOCTOR*, *supra* note 52, at 90.

63. *Discussion of the Symposium on Sterility (Papers of Drs. Charles G. Child, Jr. and Robert L. Dickinson)*, 45 TRANSACTIONS AM. GYNECOLOGICAL SOC’Y 149 (1920).

64. Queries and Minor Notes, *Artificial Impregnation*, *supra* note 60, at 1354.

2. Bringing in the Hired Man

When Dickinson put artificial insemination on the agenda of gynecology in 1920 and revealed his long experience with the practice, he glossed over the use of sperm other than from the patient's husband. As he knew from his own practice, however, some husbands lacked "quick travelers," and if so, a three-inch boost was unavailing. In the first decades of the twentieth century, doctors estimated that anywhere from 12 percent to 70 percent of involuntarily childless marriages were due to male infertility.⁶⁵ Male sterility could be congenital, or it could be the result of an earlier infection with mumps or gonorrhea.⁶⁶ If doctors were going to "cure" barren wives who were married to sterile men, artificial insemination using sperm from a third party was the only reasonably successful treatment doctors had to offer—the other choice was adoption.⁶⁷ Despite the plethora of surgical approaches to female sterility, doctors had virtually nothing effective to offer the sterile male.⁶⁸ As one nineteenth-century medical student had reportedly joked, the solution was to bring in the "hired man."⁶⁹

While the medical literature included numerous instructions about performing artificial insemination, it included almost no reference to artificial insemination by donor.⁷⁰ By 1920, Dickinson himself had performed donor insemination, but he almost certainly avoided discussing this practice because he knew it would be highly controversial.⁷¹ If some doctors were "skeptical" about artificial insemination in

65. SCHELLEN, *supra* note 13, at 31 (surveying literature). MAX HUHNER, *STERILITY IN THE MALE AND FEMALE AND ITS TREATMENT* 87 (1913) (59 percent).

66. Cohen, *supra* note 52, at 402 (surveying causes of male sterility); Alfred Koerner, *Male Fertility as Seen in Artificial Insemination*, 56 *J. UROLOGY* 133, 136 (1946) (describing gonorrhea and mumps as two of the most common causes of sterility among his patients).

67. Abner I. Weisman, *Studies on Human Artificial Insemination*, 2 *TRANSACTIONS CONF. ON STERILITY & INFERTILITY* 126 (1946) [hereinafter Weisman, *Studies*].

68. Doctors did try a variety of techniques to stimulate the production or improvement of sperm, but with little success. MARSH & RONNER, *THE FERTILITY DOCTOR*, *supra* note 52, at 135–36.

69. A.D. Hard, *Artificial Impregnation*, 27 *MED. WORLD* 163 (1909).

70. One exception was the case report of an artificial insemination by donor in G.W. Shidler, *Induced Pregnancy*, 15 *W. MED. REV.* 644–45 (Nov. 1910) and a suggestion of injecting donor sperm into the seminal vesicles of a sterile man in G.F. Lyston, *Preliminary Note on New and Physiologic Method of Artificial Fertilization*, 75 *J. AM. MED. ASS'N* 193 (July 17, 1920). Foote's self-help manual also mentioned the possibility. MARSH & RONNER, *THE EMPTY CRADLE*, *supra* note 15, at 69.

71. Dickinson's student, Dr. Sophia Kleegman, reported that Dickinson had told her he had performed his first donor insemination in 1890. Sophia J. Kleegman, *Practical and Ethical Aspects of Artificial Insemination*, 1 *ADVANCES SEX RES.* 112, 114 (1963). The official historians of the American Fertility Society would later claim that Dickinson was the second physician ever to perform donor insemination in the United States, after the Philadelphia episode in 1884, discussed *infra*. WALTER E. DUKA & ALAN H. DECHENERY, *FROM THE BEGINNING: A HISTORY OF THE AMERICAN FERTILITY SOCIETY* 3 (1994).

any form, many were outright hostile to the idea of donor insemination.

This hostility was grounded in broad social suspicion of the practice. Artificial insemination of any sort seemed unnatural and perhaps immoral to many. As early as 1897, the Catholic Church formally opposed any form of artificial impregnation.⁷² All aspects of the technique were seldom publicly discussed before 1920, reflecting its uncertain social acceptance. While doctors since Sims were willing to attempt it, and couples from Oklahoma to Brooklyn were willing to use it, artificial insemination remained largely unmentioned. Dickinson, in raising the issue in his presidential address to a prestigious, mainstream medical association, reflected his own willingness to stretch the boundaries of professional discussion with respect to sexuality and reproduction.⁷³ Introducing a third party between husband and wife through donor insemination was even more suspect. Separating biological and social paternity went against centuries of effort by the Church and the state to establish clear lines of paternity. It also triggered equally ancient anxieties among men in patrilineal societies that they might be deceived by women into claiming another man's child as their own. For these reasons, sexual intercourse between a married woman and a man not her husband was deemed adultery, a crime and a violation of Judeo-Christian religious teachings.⁷⁴ Further, adultery was grounds for divorce in most states.⁷⁵ While some doctors, including Dickinson, had been willing to try donor insemination since the nineteenth century, mainstream medical opinion was against the practice.

The medical hostility to donor insemination—as well as the history of clandestine attempts to practice the technique—had surfaced in the United States a decade previously. In 1909, a Minnesota doctor wrote the editor of *Medical World* to describe an artificial impregna-

72. GLANVILLE WILLIAMS, *THE SANCTITY OF LIFE AND THE CRIMINAL LAW* 129 (1966) (revised and expanded from the 15th Annual James S. Carpentier Series, Columbia University School of Law, Apr., 1956); FINEGOLD, *supra* note 13, at 77–79.

73. Dickinson's willingness to take controversial positions was evidenced by his support of the campaign to legalize contraception in the 1920s. Merriley Borell, *Biologists and the Promotion of Birth Control Research, 1918–1939*, 20 *J. HIST. BIOLOGY* 51, 64–73 (1987). He eventually left medical practice to focus full-time on social reform and education efforts. Sophia Kleegman, *Robert Latou Dickinson, 1861–1950*, 13 *MARRIAGE & FAMILY LIVING* 39 (1951).

74. Adultery is prohibited in all major world religions, although the conversation in the twentieth century United States about the morality of donor insemination in a religious context focused on the objections of the Catholic Church and some Protestant denominations. FINEGOLD, *supra* note 13, at 76–86.

75. See HENDRIK HARTOG, *MAN AND WIFE IN AMERICA: A HISTORY* 65 (2000).

tion by donor sperm that he had allegedly witnessed in 1884 at the Jefferson Medical College in Philadelphia, and which he believed to be the first successful donor insemination in the United States.⁷⁶ The author of the report stated that “the origin of the spermatozoa which generates the ovum is of no more importance than the personality of the finger which pulls the trigger of the gun,” reflecting the early nineteenth-century belief about the minimal role of sperm. Many readers disagreed and found his narrative repugnant. The details given portrayed artificial insemination by donor in a particularly unattractive light, as the author described the insemination of the wife while chloroformed, without prior discussion with her or her husband. The donor was one of the students present at the examination. The husband was supposedly later told, but at his request, the wife was left ignorant of the procedure.⁷⁷ This publication caused a series of critical letters published in *Medical World*.⁷⁸ While public discussion of any sort of artificial insemination, even among medical professionals, lagged behind private use of the technique, subsequent medical reports on artificial insemination through 1934 focused solely on artificial insemination using the husband’s sperm. Even after Dickinson provided some professional respectability for open discussions of artificial insemination, donor insemination remained a rarely broached topic.

B. Ghost Fathers and Scientific Babies: Artificial Insemination 1934–1945

Given the reluctance of the medical profession to discuss donor insemination after the *Medical World* controversy, it was left to the popular press to bring the practice into public view, which it did in 1934.⁷⁹ When the “test tube baby” burst into public consciousness in the 1930s, it did so in the context of a robust eugenic movement. Since the turn of the century, many social reformers, including Theodore Roosevelt, had joined Frank Davis in worrying about “race suicide,”

76. Hard, *supra* note 69, at 163. Note no supporting documentation of this claimed event, over twenty years past by the time it was reported, has been found. The truth of the account, and any of the details, cannot be confirmed.

77. *Id.*

78. For the six follow-on letters published in *Medical World* after the Hard article, and the controversy within professional medicine, see SCHELLEN, *supra* note 13, at 23 nn.30–35; A.T. Gregoire & Robert C. Mayer, *The Impregnators*, 16 *FERTILITY & STERILITY* 130, 132–33 (1965); Anne Lockhart Needham, *Artificial Insemination and the Emergence of Medical Authority in Twentieth Century America*, 17–20, 21–22, 24–34 (B.A. thesis, Harvard University 1988). See also MAY, *supra* note 30, at 65–69.

79. Note that Rohleder discussed donor insemination in his book, but the volume was intended for a medical audience, and was published as a limited edition. ROHLEDER, *supra* note 15, at 165–68.

and the swamping of the white, Protestant, native-born population by an influx of immigrants from southern and eastern Europe.⁸⁰ At the same time, the emerging science of genetics supported the popular movement for eugenic improvement of the United States population.⁸¹ Planned breeding of humans could improve the overall stock, both by discouraging the reproduction of undesirables through forced sterilization programs implemented during this period and by encouraging the scientific selection of mates.⁸² In this context, artificial insemination by donor was not just a treatment for childlessness, but also a cure for broader social ills. Dickinson had obliquely referenced this possibility in his address in 1920, describing artificial impregnation as having “enormous potentialities of betterment of the race.”⁸³ “Test tube babies” from donor insemination could be both appropriate and modern in ways that the practice had not been in the nineteenth century, or even in 1909.⁸⁴ Without public discussion, Dickinson and other doctors had been creating test tube babies by donor insemination through the 1920s, and in 1934, a broad range of the American public learned about these “laboratory babies.” The popular discussion increased demand for donor insemination, and led to increased medical reliance on the technique.

1. Popular Discussions, 1934

The public discussion started in a magazine designed to bring science to the non-specialist, the *Scientific American*. In an article titled “Babies by Scientific Selection,” the magazine announced:

Babies of extra-marital paternity are now being born of women who have sterile husbands, by artificial insemination with the life-giving germ from selected men. This is one of the most significant eugenic developments in the history of man.⁸⁵

The article was based on personal interviews with 200 physicians, located in seven cities across the eastern half of the United States, from

80. Fear of “race suicide” is discussed in MAY, *supra* note 30, at 61–93; KEVLES, *supra* note 45, at 72–76; MARSH & RONNER, *THE EMPTY CRADLE*, *supra* note 15, at 113–14; and throughout WENDY KLINE, *BUILDING A BETTER RACE: GENDER, SEXUALITY, AND EUGENICS FROM THE TURN OF THE CENTURY TO THE BABY BOOM* (2001).

81. KEVLES, *supra* note 45, at 69.

82. KEVLES, *supra* note 45, at 93–95, 100 (sterilization programs). See also Burke Shartel, *Legal Implications of Operations to Produce Sterility*, in SYMPOSIUM, *supra* note 1, at 140, 140–41.

83. Dickinson, *supra* note 53, at 6.

84. Cynthia R. Daniels & Janet Golden, *Procreative Compounds: Popular Eugenics, Artificial Insemination and the Rise of the American Sperm Banking Industry*, 38 J. SOCIAL HISTORY 5, 6–7, 9–11 (2004).

85. John Harvey Caldwell, *Babies by Scientific Selection*, 150 SCI. AM. 124, 124 (1934).

Chicago to New York.⁸⁶ The doctors were asked about the use of donor insemination in their practices. The *Scientific American* reported that at least a quarter of the doctors surveyed had received patient requests for donor insemination by 1934, with the requests increasing in frequency within the last decade.⁸⁷ Eighteen of the doctors were willing to state that they had tried donor insemination and nine claimed success. Based on his limited sample, and the extent to which doctors had been willing to discuss the matter with him, the author concluded that 50 to 150 “test tube” babies were being born each year, and that 10–20,000 involuntarily childless couples could benefit from this treatment.⁸⁸ Given that “our sterility is increasing” as we become “biologically weaker,” the author imagined a future in which a network of “fertility clinics” provided screened sperm donors in each city. Such clinics, while perhaps “first resented,” could become “accustomed and tolerated,” like other hallmarks of modern eugenics: “the baby show at the county fair; the boy or girl health contests; clinics to teach birth control; and artificial sterilization of the unfit.”⁸⁹ Anyone could then have “babies by scientific selection.”

The *Scientific American* article appeared in March, reaching its limited audience of Americans interested in scientific developments. But in May 1934, artificial insemination and donor insemination were discussed in newspapers and news magazines across the United States. In their morning papers, Americans learned about Mrs. Lillian Lauricella of Long Island, New York and her twin baby girls, the “blessed” results of artificial insemination.⁹⁰ The Lauricella family’s willingness to go public provided a rare glimpse into this practice. The reporters drew upon the *Scientific American* article, repeating that an estimated 150 “test tube babies” were being born each year in the United States.⁹¹ Mrs. Lauricella’s doctor, Frances Seymour, reportedly

86. The cities were Chicago, Milwaukee, Cleveland, Washington, Philadelphia, Newark, and New York (and Brooklyn). *Id.* at 124.

87. *Id.*

88. *Id.* at 124–25.

89. *Id.* at 125.

90. The story was reported, for example, in New York, Chicago, Washington, D.C., Los Angeles, and Billings, Montana, and also in the May 12 issue of Newsweek. ‘Synthetic’ Babies Born to 12 Mothers, N.Y. TIMES, May 1, 1934; 13 Babies in N.Y. Have Test Tube as Father, CHICAGO DAILY TRIBUNE, May 1, 1934; Parents of ‘Test Tube’ Twins Reveal Eugenic Baby Practice, WASH. POST, May 1, 1934; Laboratory Twins Born to Couple on Long Island, L.A. TIMES, May 1, 1934; Birth of ‘Test Tube’ Twins Reveals ‘Lab Baby’ Technique, BILLINGS GAZETTE, May 1, 1934; and ‘Ghost’ Fathers: Children Provided for the Childless, NEWSWEEK, May 12, 1934, at 16. See also MARSH & RONNER, THE EMPTY CRADLE, *supra* note 15, at 161–63.

91. ‘Ghost’ Fathers, *supra* note 90, at 16.

offered the treatment after Mr. Lauricella, a mechanic who rented Seymour a parking space, described the couple's eight years of efforts to have a child. Unlike almost all other physicians who had attempted artificial insemination, Seymour was willing to speak to the press, and described her success in impregnating women in the previous two years.⁹²

While the Lauricella babies reportedly were the result of artificial insemination using the husband's sperm, it was the "eugenic babies" that sparked the most interest, that is, those conceived using third party sperm.⁹³ Seymour was eager to use artificial insemination as a eugenic technique and worked as medical director of the National Research Foundation for the Eugenic Alleviation of Sterility, Inc., an organization devoted to reducing sterility in the "eugenically sound."⁹⁴ She disclosed to the press that within the past year she had inseminated two unmarried "prominent businesswomen" who wanted babies, using sperm from men she chose from a local blood donor list.⁹⁵ Seymour, as the physician, was the only one who knew the identity of the biological fathers, whom *Newsweek* called "ghost fathers."⁹⁶

The press sought comments from prominent physicians on the "new" technique of artificial insemination. Dr. Morris Fishbein, editor of the *Journal of the American Medical Association*, like other doctors interviewed, explained that the practice was not new, but known.⁹⁷ When journalists pressed their medical sources on whether the use of donor sperm to create "eugenic babies" was also "relatively common," the reporters found that "the doctors retreated into professional silence."⁹⁸ The *Chicago Tribune* found one local doctor, Dr. Victor Lespinasse, willing to say that he, like Seymour, had arranged donor

92. 'Synthetic' Babies Born, *supra* note 90.

93. *Laboratory Twins*, *supra* note 90 (using phrase "eugenic babies" to refer to babies created with donor sperm). Note that Marsh and Ronner argue that the Lauricella twins were born after donor insemination. MARSH & RONNER, *THE EMPTY CRADLE*, *supra* note 15, at 163. While that is quite plausible, I have not found any confirmation of this assertion in my review of the newspaper reports. The *Chicago Daily Tribune* and *Los Angeles Times* reported that all Seymour's inseminations were done with husband sperm except her two unmarried patients, and described the Lauricella babies as "truly of their own flesh and blood." *13 Babies In N.Y.*, *supra* note 90; *Laboratory Twins*, *supra* note 90.

94. *Handbook of Scientific and Technical Societies and Institutions of the United States and Canada*, BULLETIN OF THE NATIONAL RESEARCH COUNCIL, No. 106, Jan. 1942, at 221.

95. *13 Babies in N.Y.*, *supra* note 90.

96. 'Ghost' Fathers, *supra* note 90.

97. 'Test Tube Babies' Began Long Ago, *Check Up Shows*, L.A. TIMES, May 2, 1934.

98. *Id.*

insemination for couples.⁹⁹ *Newsweek* reported that the Marriage Consultation Center in New York City, staffed by Drs. Hannah and Abraham Stone, would refer couples to doctors who were willing to perform donor insemination if the husband signed a document indicating his consent to this procedure to preserve the “mutual happiness” of the couple and the “well-being” of his wife.¹⁰⁰ Americans who bought the Stones’ *Marriage Manual*, first published in 1935, could read about donor insemination in this popular book for couples.¹⁰¹

2. By Popular Demand, 1934–1945

Buoyed by this popular discussion, public demand for artificial insemination continued to grow. Persistent patients could find physicians willing to perform artificial insemination. If artificial insemination by husband was not possible or failed, knowledgeable couples requested donor insemination, sometimes called “semi-adoption,” as an attractive alternative to traditional adoption.¹⁰² Some persistence might be needed, however, as many doctors continued to find the practice distasteful or unethical. Fewer than 10 percent of the doctors surveyed by the *Scientific American* in 1934 admitted to using donor insemination, and the New York Academy of Medicine had moved quickly to counter the Lauricella story. The following day the Academy issued statements designed to dampen press hype and public enthusiasm, declaring that artificial insemination of any type was not new, was potentially dangerous, and was not very effective.¹⁰³ Artificial insemination of any type was not a mainstream medical practice.

In the next decade, however, some doctors worked to distinguish what is now called reproductive medicine as a medical subspecialty, separate from obstetrics, gynecology and urology. This group of doctors concentrating on fertility and sterility formed a nucleus of practitioners willing to include artificial insemination within their arsenal of treatments for the involuntarily childless. A group of such specialists

99. *Id.* Lespinasse had espoused artificial insemination using husband sperm as early as 1918. Lespinasse, *supra* note 51, at 49.

100. ‘Ghost’ Fathers, *supra* note 90. Note that this is the same language used in the Seymour & Koerner informed consent forms, described *infra* in text accompanying note 159.

101. HANNAH M. STONE & ABRAHAM STONE, A MARRIAGE MANUAL: A PRACTICAL GUIDE-BOOK TO SEX AND MARRIAGE 138–39 (1935).

102. See, e.g., William H. Cary, *Experience with Artificial Impregnation in Treating Sterility: Report of 35 Cases*, 114 J. AM. MED. ASS’N 2183, 2183 (June 1, 1940); Grant S. Beardsley, *Artificial Cross Insemination*, 48 W. J. SURGERY, OBSTETRICS & GYNECOLOGY 94, 94 (Feb. 1940).

103. *Doctors Frown on ‘Test-Tube Babies’ and Criticize Revelations on Them*, ATLANTA CONSTITUTION, May 2, 1934. See also MARSH & RONNER, THE EMPTY CRADLE, *supra* note 15, at 166.

founded the American Society for the Study of Sterility (“Society”) in 1944,¹⁰⁴ and began to hold annual meetings and publish a medical journal, *Fertility and Sterility*. Even among these doctors, the limited acceptance of donor insemination was evident. A survey taken in 1947 revealed that over 10 percent of Society members refused to perform donor insemination, and while the other 90 percent were not opposed in principle, only about half performed the technique.¹⁰⁵

Despite the popular enthusiasm of the 1930s, even those specialists who were willing to perform artificial insemination had much to learn in order to make the technique routinely successful. When the Society began meeting in 1944, the exact timing of ovulation, a crucial matter for successful insemination, was still unknown. The state of medical knowledge had improved significantly from the nineteenth century, when the best understanding of ovulation had the timing off by weeks. Yet predicting ovulation in advance remained a “perplexing problem.”¹⁰⁶ The viability of sperm also was not well understood—motility and form, it turned out, were only imperfect indicators of fertility. Treatment could drag on, and with the discomfort and embarrassment that the procedure afforded, a significant number of women simply gave up trying, opting to reconcile themselves to childlessness or adoption.

These patient “revolts,” as Dickinson called them, were understandable when some practitioners reported using artificial insemination up to seventy times to achieve pregnancy, with the average pregnancy requiring twelve attempts.¹⁰⁷ Seymour along with her husband, Dr. Alfred Koerner, published an article in the *Journal of the American Medical Association* in 1941, detailing the results of a survey that they had taken of 30,000 doctors about artificial insemination. While less than one-quarter responded, more than half the respondents admitted “personal knowledge” of artificial insemination.¹⁰⁸ While Society members may have been much more likely to perform artificial

104. DUKA & DECHENERY, *supra* note 71, at 1–2, 6, 34–35, 43. The Society changed its name to the American Fertility Society in 1965, and then in 1994, to the American Society for Reproductive Medicine. *Id.* at 13, 99–100.

105. Alan F. Guttmacher, John O. Haman & John MacLeod, *The Use of Donors for Artificial Insemination: A Survey of Current Practices*, 1 *FERTILITY & STERILITY* 264, 266 (1950).

106. Cary, *supra* note 102, at 2184.

107. Dickinson, *supra* note 54, at 147 (describing frequent patient “revolts”). Frances I. Seymour & Alfred Koerner, *Artificial Insemination: Present Status in the United States as Shown by a Recent Survey*, 116 *J. AM. MED. ASS’N* 2747, 2747 (June 21, 1941) [hereinafter Seymour & Koerner, *Artificial Insemination*].

108. Seymour & Koerner, *Artificial Insemination*, *supra* note 107, at 2747.

insemination often, and to publish in the medical literature on the topic, the survey indicated that significant numbers of doctors beyond the approximately one hundred self-identified fertility specialists were quietly familiar with the practice.¹⁰⁹ Seymour and Koerner found these practitioners in every region of the United States.¹¹⁰

Based on the survey evidence, Seymour and Koerner claimed that almost 10,000 babies had been produced to date by artificial insemination, about two-thirds by artificial insemination by husband and about one-third by donor insemination.¹¹¹ This estimate, one-hundred times greater than the estimate published in *Scientific American* a few years earlier, was startling even within the medical profession and drew attention from outside medicine.¹¹² Other practitioners of the technique questioned these results—the reported pregnancy rates seemed much too high to men who had been trying the technique, some, like Dickinson, for over forty years. The estimated total number of artificial insemination children also appeared high, as the previous medical literature had revealed fewer than one thousand births.¹¹³ The technique, however, was becoming more reliable, with practitioners in the 1940s claiming success rates from 50–85 percent.¹¹⁴ In fact, “bringing in the hired man” through donor insemination was probably the most effective treatment doctors could offer couples in which only the male was infertile.¹¹⁵ As fertility clinics increased in number during the 1940s, and the emphasis on domesticity and early child-bearing of the

109. Guttmacher et al., *supra* note 105, at 255 (ninety-six members in 1947).

110. Seymour & Koerner, *Artificial Insemination*, *supra* note 107, at 2749.

111. *Id.* at 2747.

112. For the response by lawyers, see *infra* text accompanying note 177.

113. Dickinson publically challenged the survey results as “extraordinary.” *Chairman’s Remarks*, preceding Alan F. Guttmacher, *IV. A Physician’s Credo for Artificial Insemination*, 50 W. J. SURGERY, OBSTETRICS & GYNECOLOGY 357, 358 (1942) [hereinafter Guttmacher, *A Physician’s Credo*]. He was joined by another New York doctor, who published attacks on the survey. Clair E. Folsome, *The Status of Artificial Insemination: A Critical Review*, 45 AM. J. OBSTETRICS & GYNECOLOGY 915, 916–17 (1943) [hereinafter Folsome, *Artificial Insemination*]; Clair E. Folsome, *Reply*, 47 AM. J. OBSTETRICS & GYNECOLOGY 726, 726–27 (1944).

114. See, e.g., Alan F. Guttmacher, *The Role of Artificial Insemination in the Treatment of Sterility*, 120 J. AM. MED. ASS’N 442, 443 (Oct. 10, 1942) [hereinafter Guttmacher, *The Role of Artificial Insemination*] (65 percent success rate for artificial insemination attempts, combining his data with that of Cary). By 1950, other practitioners agreed, using a literature survey to claim a 50–60 percent success rate for 3–6 treatments per month over 2–4 months. Guttmacher et al., *supra* note 105, at 270. Reviewing his own experiences from 1937 to 1942, Weisman reported a success rate of over 85 percent and believed that 100 percent of fertile women could become pregnant using donor insemination. Weisman, *Studies*, *supra* note 67, at 127. As discussed *infra*, there are also indications that many doctors engaged in artificial insemination without ever publishing their results, making it possible that the published cases represented only a small fraction of such children, and thus that Seymour and Koerner’s numbers were credible.

115. Guttmacher et al., *supra* note 105, at 266.

baby boom years increased the willingness of Americans to seek medical help for involuntary childlessness,¹¹⁶ both popular demand for and the number of practitioners of artificial insemination continued to increase. The uncertain social status of artificial insemination did not prevent doctors from continuing to use the technique. It did, however, influence the way doctors discussed the treatment with patients and performed the treatment.

C. Access and Practice in the Shadows

Whether there were 10,000 “test tube babies” growing up in the United States by 1941 can never be ascertained because artificial insemination, both by husband and by donor, remained a clandestine practice. The way doctors practiced artificial insemination, the strictures placed on patients, and patient access to the treatment were all shaped by fear of social opprobrium.

Even doctors willing to perform the technique and to publish case studies firmly believed that no one other than the doctor, the patient, and the patient’s husband should know that the procedure had occurred if donor sperm were used. The emphasis on secrecy was primarily motivated by the desire to protect the newly-formed family from emotional harm—not just the female patient, but also her husband and the resulting child. Seymour and Koerner, despite their public advocacy of donor insemination, believed that any revelation of the unusual origins of a donor child would present a “great danger.”¹¹⁷ Most doctors who published on the topic assumed that society at large would be so condemnatory that the artificially-formed family would be the subject of hurtful gossip. As one critical doctor described the risks of disclosure:

[T]he woman, made pregnant by donor insemination, who even whispers out of turn, on a single occasion, becomes a medical curiosity. She is envied by the primitive and wanton-minded, pitied by those gifted with easy fertility, shunned by her relatives and perhaps unfortunately by her own child.¹¹⁸

Gossip might label her an adulterer, as her community might refuse to believe the story of assisted conception or consider it no better than adultery. Disclosure risked damaging the pride of her husband,

116. MAY, *supra* note 30, at 140–41, 147–48; MARSH & RONNER, *THE EMPTY CRADLE*, *supra* note 15, at 187–89.

117. Frances E. Seymour & Alfred Koerner, *Medicolegal Aspect of Artificial Insemination*, 107 J. AM. MED. ASS’N 1531, 1533 (Nov. 7, 1936) [hereinafter Seymour & Koerner, *Medicolegal Aspect*].

118. Folsome, *Artificial Insemination*, *supra* note 113, at 923–24.

whose sterility would thus be publicized. Because of the tight link in the public mind between male fertility and potency, the knowledge of his infertility would impugn his masculinity. It almost certainly would damage the child's psyche as well. According to Seymour and Koerner, if a donor child were to learn of her origins, "[a]n inferiority complex would be set up with a root that psychoanalysis could not destroy and the child's maladjustment to society would result."¹¹⁹ Donor insemination was a secret that needed to be kept for the lifetime of the child.

This perceived need for long-lasting secrecy shaped the ways doctors practiced donor insemination. The subterfuge began with the selection of a donor. First, the would-be parents were kept completely ignorant of the identity of the donor. The selection was for the doctor alone.¹²⁰ The choice of the male biological parent was made into a matter of medical expertise, unsuitable for lay participation. Further, doctors exercised their expertise in a particular way. Rather than selecting the best available donor based on the contemporary criteria for the fittest baby, they usually sought to create the illusion of paternity by the husband.¹²¹ As a "treatment" for infertility, donor insemination should produce, not just a healthy baby, but a baby that appeared to be the result of marital sexual relations. The husband's infertility was not so much cured, as masked by a "ghost father," who was ghostly because he never fully materialized, and was supposed to fade away as soon as conception occurred. As one practitioner rather dramatically explained it, "the donor must always remain the *forgotten man*."¹²² To maintain the illusion, doctors sought donors whose hair, eye color, skin color and ethnic ancestry matched that of the would-be father, and sometimes sought blood type compatibility as well.¹²³ Given the un-

119. Seymour & Koerner, *Medicolegal Aspect*, *supra* note 117, at 1533.

120. Abner I. Weisman, *Selection of Donors for Use in Artificial Insemination*, 50 W. J. SURGERY, OBSTETRICS & GYNECOLOGY 142, 142 (1942) [hereinafter Weisman, *Selection of Donors*].

121. Note that this aspect of donor selection was not necessarily incompatible with eugenic goals, particularly for doctors who reserved artificial insemination for "fit" couples. *See infra* text accompanying notes 129-133 and Daniels & Golden, *supra* note 84, at 9-10.

122. Beardsley, *supra* note 102, at 96 (emphasis in original).

123. *See, e.g.*, R.T. Seashore, *Artificial Impregnation*, 21 MINN. MED. 641, 643 (1938); Cary, *supra* note 102, at 2184; Beardsley, *supra* note 102, at 96; S. Leon Israel, *The Scope of Artificial Insemination in the Barren Marriage*, 202 AM. J. MED. SCI. 92, 96 (1941); ABNER I. WEISMAN, SPERMATOZOA AND STERILITY: A CLINICAL MANUAL 172 (1941) [hereinafter WEISMAN, SPERMATOZOA]; Weisman, *Selection of Donors*, *supra* note 120, at 143-44 (1942); Guttmacher, *The Role of Artificial Insemination*, *supra* note 114, at 443. During this same period, the use of blood typing to determine the paternity of a child in divorce proceedings was just being accepted by the courts. *See, e.g.*, *Schultz v. Schultz*, 35 N.Y. Supp. 2d 218 (Sup. Ct 1942), as discussed in Augustin Derby, *Family Relations and Persons*, 1942 ANN. SURVEY AM. L. 772, 773 (1942). For the eugenic aspects of donor selection, *see* Daniels & Golden, *supra* note 84, at 9-11.

derstanding of race and genetics of the time, doctors also unquestioningly sought to match the father's race and religion. The goal was a baby who would elicit the life-long response: "s/he looks just like his father."¹²⁴ No one should suspect any "extramarital paternity."

While trusting their doctor to do his part to keep the secret through appropriate donor selection, patients had their own obligations. Doctors told their patients not to mention their treatment to friends, family, or the resulting child. To even admit seeking donor insemination would put the family at psychological risk.¹²⁵ For a woman who visited a doctor's office two to five times a month for inseminations around her predicted date of ovulation, and went back for treatments for months stretching into years, this prohibition must have been a serious burden. One practitioner even urged the couple not to discuss the matter with each other or their doctor: "after conception nothing should be said about it in order that the couple may more readily forget the artificial character of the conception."¹²⁶

Because of their understanding of the need to keep donor insemination a life-long secret, practitioners deliberately made the treatment not only clandestine, but also exclusive. Having found a doctor who performed donor insemination, a couple needed to persuade him or her that they were appropriate candidates. Male sterility and female fertility were not sufficient. What else was required varied by doctor. Rohleder indicated that he supported donor insemination only in "desperate, exceptional cases, and to avoid greater disaster."¹²⁷ By disaster, he meant the situation in which "sterility had engendered grave psychic disturbances and dangerous depressive states which threatened to become severe and incurable psychoses, or to eventuate in suicide, or at least divorce."¹²⁸ Dr. Alan Guttmacher, an early artificial insemination advocate and Society member, while not painting such a dire picture, felt that "it is a technique which should be restricted to the deserving, exceptional couple," who have been able to convince their physician that they were emotionally stable and in a permanent marriage.¹²⁹ Guttmacher wanted to ensure that the couple could keep their

124. Beardsley, *supra* note 102, at 95.

125. Seashore, *supra* note 123, at 643 ("for the good of the child, he should be kept in ignorance of the affair").

126. *Id.*

127. ROHLEDER, *supra* note 15, at 170.

128. *Id.*

129. Guttmacher, *Practical Experience*, *supra* note 12, at 75-76.

secret, and that their marriage would not collapse when confronted daily with a “semi-adopted” child.

Before World War II, many practitioners were also explicit about eugenic goals, joining Davis in his program of helping the right sort of Americans to produce and rear the right sort of children. Guttmacher looked for the “exceptional couple.” A Minnesota doctor suggested in 1938 that “we should use this procedure to practice good eugenics, and encourage the procedure only in those who are apt to improve society.”¹³⁰ An Oregon doctor, who had been in communication with Frances Seymour on the subject, agreed that eugenic principles were appropriate, and considered the treatable couple one of “high moral and intellectual type, and financially able to give the child the educational advantages demanded of the social station.”¹³¹ Seymour evidently went even further, requiring “a minimum I.Q. of 120 in all receptive mothers, and . . . [requiring] prospective parents [to] take out an educational insurance policy” to ensure that their eugenic child was appropriately educated.¹³² Using various selection criteria, some practitioners rejected as many as 50 percent of their patients who requested the procedure.¹³³

Other doctors were not so particular, and indeed, regarded it as their professional duty to perform either donor insemination or husband insemination for patients who insisted, even when the doctor felt the procedure was not advisable.¹³⁴ If patients in the New York City region were not intelligent or wealthy enough to meet Seymour’s criteria, they might meet with success at the public Sterility Clinic of the New York Hospital, where at least one patient unable to afford private treatment was successfully inseminated.¹³⁵ Still, access to the technique required persistence, and must have depended on luck and geography, as well as race and class. Even doctors who were not explicit about eugenic goals would have found it easiest to identify as deserving couples those who were white, native-born, well-educated and middle class.

130. Seashore, *supra* note 123, at 641.

131. Beardsley, *supra* note 102, at 95.

132. *Id.* (citing personal communication with Seymour).

133. Weisman, *Studies*, *supra* note 67, at 126 (reporting on cases from 1937 to 1942).

134. William Cary, although stating that he never recommended donor insemination, described cases in which he performed the technique against his better judgment, when he was concerned about the patient’s mental or physical unsuitability. Cary, *supra* note 102, at 2185–86.

135. *Id.* at 2183. Note that John Rock in his Brookline clinic also offered a similar range of fertility treatments to poor charity cases as to his better-off private patients. MARSH & RONNER, *THE EMPTY CRADLE*, *supra* note 15, at 191.

By 1945, there was a nation-wide, albeit unpublicized and loosely connected, network of doctors who would attempt artificial insemination by husband and by donor, to aid childless couples. These doctors and their patients had a reasonable expectation of success, and each success reinforced the practice and the demand. While the technique was accepted enough to be the subject of published case studies and medical meetings,¹³⁶ the majority of doctors who practiced artificial insemination worked without any public admission of their participation in assisted conception, keeping their involvement quiet even as they urged secrecy on their patients. One result of the persistence of doctors in the face of uncertain social acceptance was that doctors established themselves as gatekeepers, with sole authority to select donors and patients. This role was closely analogous to the role doctors had assigned themselves in pregnancy termination by this period. Abortion had been criminalized in the second half of the nineteenth century at the urging of professional medical associations. Most state criminalization statutes provided exceptions for “therapeutic” abortions, and it was doctors who controlled who could receive such a safe and legal procedure.¹³⁷ Similarly, as they developed a successful technique of assisted conception, doctors assumed the power to choose who might access this novel means of parenthood. The gatekeeper role in conception must have seemed natural and familiar to mid-century doctors, as yet another way they used medical expertise to exert control over female reproduction. Even as he was advocating for careful selection of couples for donor insemination, Guttmacher was considering the question of abortion access, and by the 1950s, was a leader in a movement to use formal boards to determine eligibility for therapeutic abortion.¹³⁸ Doctors like Guttmacher exercised professional judgment when deciding whether to give anxious, even desperate, women the help they sought to control their parental status, seeing the doctor’s role as supporting the emotional and mental stability of women, whether the issue was involuntary childlessness or an unwanted pregnancy.

136. See, e.g., *supra* notes 102 and 113.

137. REAGAN, *supra* note 2, at 5, 61–70; MOHR, *supra* note 2, at 147–70. Therapeutic abortions were usually defined as those necessary to preserve the health or life of the mother.

138. REAGAN, *supra* note 2 at 233.

II. MEDICAL WORRIES ABOUT LEGAL UNCERTAINTY

The parallel between medical control of artificial insemination and of safe, legal abortion is limited. The procedures differed in their legal status, as well as in other factors.¹³⁹ Unlike it had been earlier, and would be again by the late 1950s, pregnancy termination was not a medicolegal problem for doctors at this time. Abortion was clearly criminalized, yet the therapeutic exception to the abortion laws existed explicitly in nearly every state. Reputable doctors were rarely convicted of a crime for performing abortions as the abortions they performed were considered almost *per se* therapeutic, while legal crackdowns on non-mainstream practitioners varied by location and time.¹⁴⁰ Doctors and lawyers alike were largely satisfied with this state of affairs. Artificial insemination, however, was not only of questionable social acceptance, but had a very uncertain legal position. This uncertainty gave rise to worries about the gatekeeping role doctors were assuming. The combination of increased medical success with artificial insemination, growing, although limited, medical enthusiasm for the technique, and popular demand transformed this aspect of reproductive medicine not only into an accepted technique but also into a medicolegal problem by the 1940s.

A. Identifying Legal Problems

Once artificial insemination became a matter of discussion within the medical profession, rather than a topic too controversial to be addressed even in professional medical meetings, American doctors began to consider its legal implications. By the 1930s, they were already conscious of the risk of medical malpractice claims,¹⁴¹ as well as accustomed to the idea that certain reproductive choices could be foreclosed by the law. Not only were most abortions illegal, but providing contraceptives to patients was illegal in some states.¹⁴² As the medical com-

139. While the legal status of the procedures is of most relevance to this discussion, the options and health consequences to women denied access to the two procedures also differed. While doctors and patients often described the involuntarily childless as distraught and desperate, denial of access to artificial insemination did not involve life-threatening choices comparable to those among childbirth, safe abortion, or potentially unsafe self-abortion or criminal abortion.

140. REAGAN, *supra* note 2, at 116–18.

141. NEAL C. HOGAN, *UNHEALED WOUNDS: MEDICAL MALPRACTICE IN THE TWENTIETH CENTURY* 33 (2003).

142. See DAVID J. GARROW, *LIBERTY AND SEXUALITY: THE RIGHT TO PRIVACY AND THE MAKING OF ROE V. WADE* 10–15 (1994) (beginnings of advocacy campaign to legalize medically supervised birth control).

munity began to discuss the legal ramifications of artificial insemination, the general consensus was that artificial insemination using the husband's sperm did not pose any legal problems, even if it remained socially questionable and subject to religious condemnation.¹⁴³ Donor insemination, on the other hand, appeared to be a legal minefield. The medicolegal problem of artificial insemination was more accurately the problem of artificial insemination by donor.

Doctors developed a list of worries about donor insemination that they discussed in the medical literature of the 1930s and 1940s, often tucking a paragraph or two about legal concerns into an article focused on their technique of and results from artificial insemination.¹⁴⁴ The frequent reiteration of these concerns indicates that practitioners were constantly aware of the legal uncertainty. Some concerns were those familiar to obstetricians from a general medical malpractice perspective: What was the doctor's responsibility for the health of the resulting child? If he selected the donor, could he be sued for malpractice if the child was defective or undesirable in some way? What if a doctor told a couple the husband was sterile, and then, after successful donor insemination, the wife later bore a child without medical intervention?

These were questions to be answered by the applicable "standard of care," the age-old measuring stick for malpractice claims.¹⁴⁵ With respect to these questions, the uncertainty was largely what the standard of care for this procedure might be. This uncertainty began to dissipate by the early 1940s, as a standard of care was formulated through the medical literature. In articles, doctors discussed best practices for donor insemination, including donor selection guidelines and the recommended pre-insemination sterility work-ups of husband and wife, and the articles by individual practitioners were followed by discussion in standard treatises, reviewing and synthesizing the literature.¹⁴⁶

Other questions were new, specific to assisted conception itself. The *Orford* court had concluded that the "essence of adultery" was the "surrendering [of the] reproductive capacity" of a wife "to another

143. Folsome, *Artificial Insemination*, *supra* note 113, at 922; FINEGOLD, *supra* note 13, at 77-80.

144. See, e.g., Beardsley, *supra* note 102, at 97-98; WEISMAN, SPERMATOZOA, *supra* note 123, at 179-82; Folsome, *Artificial Insemination*, *supra* note 113, at 923.

145. HOGAN, *supra* note 141, at xii-xiii; KENNETH A. DEVILLE, MEDICAL MALPRACTICE IN NINETEENTH-CENTURY AMERICA: ORIGINS AND LEGACY 206 (2003) (use of standard throughout the nineteenth century).

146. See, e.g., SAMUEL L. SIEGLER, FERTILITY IN THE FEMALE: CAUSES, DIAGNOSIS AND TREATMENT OF IMPAIRED FERTILITY 401-12 (1944).

man,” “introducing a false strain of blood” into the family.¹⁴⁷ If this analysis was correct, then the married mother of a donor child was guilty of adultery, and perhaps the donor was as well. Maybe it was the doctor who committed adultery, as he injected the sperm. If he was not a direct party to adultery, perhaps the doctor’s involvement might fit under the legal definition of conspiracy to commit a crime.

Such arguments appeared a bit farfetched to many doctors. After all, adultery was almost never criminally prosecuted in the United States, although laws against it remained on the books in many states.¹⁴⁸ And despite the dicta of the Canadian court, “adultery by test tube” seemed like a distortion of the law.¹⁴⁹ Many state adultery statutes focused on fornication and had been interpreted by courts such that extramarital sexual behavior other than intercourse was not adultery.¹⁵⁰ Further, doctors argued that extramarital sexual intercourse while using contraception was still adultery, so that the Canadian judge had clearly gotten it wrong—the essence of adultery was not reproduction but fornication.¹⁵¹

Perhaps the most troubling and unanswerable set of legal concerns surrounded the family law implications of a third party intervention in conception. It was simply not clear that by merely acting as if a donor child was their natural child, a couple could make that child legitimate at law. While there was a strong legal presumption that any child born to a married woman was legitimate, the presumption was rebuttable by proof of her husband’s sterility.¹⁵² In the event of divorce or death, such a child, if illegitimate, would be ineligible for support or inheritance from its supposed father.¹⁵³ In families with significant wealth, other relatives might have a strong incentive to use the child’s artificial origins to argue for disinheritance.

Even more disturbing to doctors who believed they were fostering marital harmony by providing a donor child was the fact that at law, a

147. Orford v. Orford, [1921] 49 O.L.R. 15, 22.

148. Jeremy D. Weinstein, *Adultery, Law and the State: A History*, 38 HASTINGS L. J. 195, 225–26 (1986).

149. Beardsley, *supra* note 102, at 94.

150. See, e.g., Note, *Legal and Social Implications of Artificial Insemination*, 34 IOWA L. REV. 658, 664 (1948–49) (discussing Iowa law of adultery); Tucker, *supra* note 3, at 62 (Illinois law of adultery).

151. Alan F. Guttmacher, *The Legitimacy of Artificial Insemination*, 11 HUMAN FERTILITY 16, 17 (1946) [hereinafter Guttmacher, *Legitimacy*].

152. Derby, *supra* note 123, at 773, 784; Susan Frelich Appleton, *Presuming Women: Revisiting the Presumption of Legitimacy in the Same-Sex Couples Era*, 86 B.U. L. REV. 227, 231–33 (2006).

153. An illegitimate child might also be barred from collecting in a wrongful death action. See Derby, *supra* note 123, at 778. See also GROSSMAN & FRIEDMAN, *supra* note 20, at 287–88.

child born to the wife of a sterile man was clear evidence of adultery, and adultery was grounds for divorce. As Mrs. Orford found in 1921, courts and others were disinclined to believe tales of donor insemination when adultery seemed so much more likely. In the event that a marriage collapsed after a donor insemination, the husband might deny any knowledge of the secret insemination and accuse his wife of adultery, a strategy to obtain a divorce and avoid support obligations.¹⁵⁴ The very secrecy that doctors practiced in order to protect the child from emotional harm might prove to be a legal obstacle, preventing mothers from proving non-adulterous origins, with devastating financial consequences.

Although their primary legal concern was the fate of the family they were creating, doctors also worried about potential legal exposure of the donors they recruited for this procedure. A donor might be named as a respondent in a divorce or sued for parental support. The child might seek a share of the donor's estate. The donor's wife, if he were married, might accuse him of adultery for fathering an extramarital child, as grounds for divorce. Or the donor might cause legal problems for the inseminating physician, later accusing the doctor of using his semen without his consent.¹⁵⁵

The possible disasters seemed endless. Physicians contemplated not only lawsuits, but also the possibility that they were creating situations in which one party might blackmail another. The legal uncertainty surrounding the status of the child, in addition to the emotional reasons for keeping his or her origins secret, made the social parents vulnerable to blackmail by the donor, if he should know the child was his. Conversely, if the donor did not want it known that he had fathered an extramarital child, he was vulnerable to blackmail by the social parents.¹⁵⁶ In addition to worries about blackmail, doctors feared a transfer of affection of the wife to the donor. For this reason, doctors cautioned against using a family member, such as the husband's brother, as the donor.¹⁵⁷ To preclude all varieties of unpleasantness, the doctors again emphasized secrecy as an absolute requirement of donor

154. In subsequent decades, the status of donor insemination children was adjudicated most often in divorce cases, involving questions of support and custody. *See, e.g.*, *Strnad v. Strnad*, 190 Misc. 786, 78 N.Y.S.2d 390 (Sup. Ct. 1948); *Doornbos v. Doornbos*, 139 N.E.2d 844 (Ill. App. Ct. 1956); *Gursky v. Gursky*, 39 Misc. 2d 1083, 242 N.Y.S. 2d 406 (Sup. Ct. 1963).

155. WEISMAN, *SPERMATOZOA*, *supra* note 123, at 179.

156. Seymour & Koerner, *Medicolegal Aspect*, *supra* note 117, at 1533 (worries about blackmail).

157. Weisman, *Selection of Donors*, *supra* note 120, at 142-43; Seymour & Koerner, *Medicolegal Aspect*, *supra* note 117, at 1533.

insemination. Not only should the parents never mention the treatment, but they should have no opportunity to learn the identity of the donor, or vice versa. The medicalization of donor selection was not just a matter of medical authority, but an attempt to avoid legal complications.

B. Contemplating Solutions

Almost as soon as these legal worries began to surface in the medical literature, doctors began to propose solutions. Despite the perceived legal complexity, the doctors who were most prominent in advocating donor insemination also advocated for its legality. Even before Seymour and Koerner published their survey of artificial insemination practices, they published an article in 1936 in the *Journal of the American Medical Association* ("JAMA"), which focused on the medicolegal aspects of the technique. Koerner was a lawyer as well as a doctor and brought his legal expertise to bear to assure the medical community that the procedure could result in legitimate children if properly conducted.¹⁵⁸

Their analysis depended on written consent forms and good recordkeeping. Both the husband and wife should sign forms detailing their consent to donor insemination. Seymour and Koerner recommended having the signatures notarized, as well as obtaining fingerprints, if the couple was unknown to the inseminating physician. These measures to prove the identity of the signatories were designed to preclude a woman from bringing an accommodating male friend, pretending to be her husband, in order to gain access to the technique without her husband's consent.¹⁵⁹ Seymour and Koerner argued that, provided the husband's consent was genuine, these signed papers, kept by the doctor, would allow the wife to defend herself in the event her husband accused her of adultery. By including a release from liability, the forms might also protect the doctor against malpractice claims in the event of an unsatisfactory child.

Seymour and Koerner also advocated consent forms for the donor and his wife. While the authors preferred married donors, as a protection against "promiscuity" (by which they probably meant sexually transmitted diseases), they also thought that the written consent of the donor's wife was "essential" to prevent the later collapse of that mar-

158. Seymour & Koerner, *Medicolegal Aspect*, *supra* note 117, at 1532.

159. *Id.* at 1531-32.

riage on the grounds of adultery by the husband.¹⁶⁰ The physician was responsible for keeping the executed forms in a safe place, and, given the long timescale of possible problems, providing for their custody and access after the physician's death, perhaps through the physician's attorney.¹⁶¹ Seymour and Koerner included their model consent forms in their article, and the forms were then reprinted in the medical literature and espoused by other practitioners.¹⁶²

In addition to the forms, Seymour and Koerner discussed their techniques for keeping donors and patients in mutual ignorance. They described how they required the donor to "deliver his specimen at a different address or apartment or at a different time than the arrival of the patient."¹⁶³ Finally, Seymour and Koerner also suggested that the delivering obstetrician should never be the inseminating doctor, so that the obstetrician could in good faith put the husband's name on the birth certificate as the father and "give that child a document irrefragable in the eyes of the law."¹⁶⁴ This recommended procedure for a legally binding donor insemination thus involved a large cast of consenting characters: husband, wife, inseminating doctor, donor, and donor's wife. All five had to agree on the production of the sixth, the hoped-for child, and then rely on the uninformed help of the inseminating doctor's attorney and the delivering obstetrician. Secrecy was the first defense, and should that fail, the carefully safeguarded papers could be produced to show the intent of all the parties.

Seymour and Koerner's advocacy of formal consents failed to quell medical worries. Despite their arguments, in 1939, *JAMA* published a much more negative assessment of the legal problems with artificial insemination in an unsigned editorial. *JAMA* opined that offspring resulting from donor insemination were illegitimate, regardless of intent or consent forms. According to *JAMA*, there was no way that a child could be the legitimate offspring of a man who knew he was not the father of that child, whether that child was the result of an adulterous liaison by the wife, or of a procedure in a doctor's office. The only possible solution was formal adoption by the intended father.¹⁶⁵ The in-

160. *Id.* at 1533.

161. According to Beardsley, Seymour & Koerner kept two copies, each in a separate safe deposit box. Beardsley, *supra* note 102, at 97; WEISMAN, SPERMATOZA, *supra* note 123, at 181.

162. See, e.g., WEISMAN, SPERMATOZA, *supra* note 123, at 179-80 (explaining purpose of forms and reprinting them).

163. Seymour & Koerner, *Medicolegal Aspect*, *supra* note 117, at 1533.

164. *Id.*

165. Editorial, *Artificial Insemination and Illegitimacy*, 112 J. AM. MED. ASS'N 1832-33 (May 6, 1939).

tended parents needed to set aside “false pride or considerations of delicacy” and manifest their intent in this legally binding manner.¹⁶⁶

Adoption proceedings would defeat the secrecy of the procedure, as the adopting father would need to know the name of the donor, whose parental rights would be terminated by the adoption, and the donor would need to be notified and given a chance to object.¹⁶⁷ The whole procedure would become a matter of public record, greatly increasing the chance that the child, and/or family and friends, would learn of the child’s origins. While the *JAMA* proposal would ensure legal certainty, many doctors who practiced donor insemination joined Seymour and Koerner in believing such a legal cure would destroy the value of the medical cure they were offering because of the social and emotional consequences of the loss of secrecy.

Supporters of the procedure varied in their response to the negative tone of the editorial. One doctor engaged in personal correspondence with the Bureau of Legal Medicine of the American Medical Association and managed to get the Bureau to admit that “no act is illegal unless it is prohibited by some law . . . and society has . . . enacted no law regarding artificial insemination.” He then published excerpts from this correspondence in an article reporting on his experiences with donor insemination.¹⁶⁸ Legal uncertainty was not a reason to refrain from offering an effective “cure.”

How best to proceed was an open question, however. Dr. Abner Weisman not only reprinted Seymour and Koerner’s model consent forms in his treatise on sterility, but published his own systematic rules for donor selection in 1942, as he continued to practice and advocate for donor insemination after the editorial.¹⁶⁹ Guttmacher, who had practiced artificial insemination since the 1930s, declined to follow the Seymour/Koerner approach. He advocated for the use of “common sense” by the doctor when selecting appropriate couples, and “complete anonymity” of the donor. With these features, he preferred to “forget signed papers,” which “simply act as a permanent reminder for something which should be forgotten as quickly and

166. *Id.* at 1833.

167. J.C. Schock, *The Legal Status of the Semi-Adopted*, 41 *DICKINSON L. REV.* 271, 275 (1941-42).

168. Beardsley, *supra* note 102, at 94 (quoting personal communication from Bureau).

169. Weisman, *Selection of Donors*, *supra* note 120, at 142-44; WEISMAN, *SPERMATOZOA*, *supra* note 123, at 164-82.

completely as possible.”¹⁷⁰ The ghost father, according to Guttmacher, should leave no paper trail. In 1942, Guttmacher published his common sense approach as *A Physician’s Credo for Artificial Insemination*,¹⁷¹ both as a stand-alone article and as part of his own article in *JAMA*, thus allowing the countless doctors who had read the editorial to consider his robust response. His article, and the continuing inclusion of directions for the technique in medical treatises, made clear that some members of the medical profession continued to practice donor insemination despite the potential legal cloud over donor children, and ensured that the larger number of practitioners who kept quiet about their use of the technique had support and access to the latest information.

Weisman and Guttmacher, although they disagreed on the best approach, were both examples of doctors enthusiastic about donor insemination as a “cure” for the problem of infertility. The overall success rates for curing male infertility were so low,¹⁷² that they, like many colleagues, were simply unwilling to disavow one clear way they had to provide some patients with what they most wanted—a baby of their own. Although the extreme secrecy surrounding the procedure makes it difficult to investigate the doctor-patient relationships in these cases, in justifying their actions, the doctors wrote about the pain their patients faced, and the psychological harm suffered by involuntarily childless couples. Even twenty years later, an Oregon physician, Dr. Grant S. Beardsley, described two successful inseminations he performed in the 1920s as among the most satisfactory cases of his career.¹⁷³ Guttmacher ended his “common sense” credo, as well as his *JAMA* article, with the following reflection:

A successful artificial insemination is one of the most satisfying of all medical experiences. It would require a petrified heart not to warm to the scene of a sterile father doting on his two children, who, according to the neighbors, resemble him very closely.¹⁷⁴

The medical interpretation of the legal risks of donor insemination was heavily influenced by doctors’ perceptions of patient needs. Women wanted babies, and certainly it could not be illegal to provide a

170. Guttmacher, *A Physician’s Credo*, *supra* note 113, at 358 (also published in Guttmacher, *The Role of Artificial Insemination*, *supra* note 114, at 445).

171. Guttmacher, *A Physician’s Credo*, *supra* note 113, at 358; Guttmacher, *The Role of Artificial Insemination*, *supra* note 114, at 445.

172. See *supra* text accompanying notes 67–68.

173. Beardsley, *supra* note 102, at 98.

174. Guttmacher, *The Role of Artificial Insemination*, *supra* note 114, at 445; Guttmacher, *A Physician’s Credo*, *supra* note 113, at 359.

couple with a wanted child. If it was, the doctors wanted the matter fixed, although in the absence of clear evidence of illegality, many were willing to forge ahead.

III. A PROBLEM 'IN THE HANDS OF THE LAW'

Until about 1945, the medical profession was able to maintain control of the discussion about artificial insemination. During the 1920s and 1930s, individual doctors had evidently discussed their worries about artificial insemination in private conversations with lawyers,¹⁷⁵ but it was doctors who argued the pros and cons of legality in the pages of *JAMA* and discussed how patients and donors should be selected. Although noting the possibility of legal problems, writers in the popular press did not challenge the assumption that artificial insemination was a medical procedure subject to the professional discretion of doctors.¹⁷⁶ This situation began to change in 1945 as the legal profession began to consider artificial insemination. The discussion of the legal ramifications of artificial insemination among lawyers was just beginning when the Chicago symposium was held in 1945. By that date, the medical profession had a core of practitioners who had already decided that the technique, both with husband sperm and donor sperm, was ethical, socially valuable, and should be legal, despite the disapproval of the official publication of the AMA. Within law, however, the practice was barely mentioned in the 1930s and 1940s. Lawyers found the topic new and shocking in 1945, and their hesitancy to embrace how doctors were making law on the ground was a harbinger of the broader social discussion that followed shortly thereafter, when the hypothetical situations which had worried doctors became judicial verdicts in the first American test tube baby cases.

A. Legal Discouragement

The first law review article on donor insemination, a student note in the *Dickinson Law Review* published in 1941, drew inspiration from Seymour and Koerner's survey results, citing the doctors' statistic of 10,000 test tube babies as evidence of the need for legal attention to

175. See, e.g., *Discussion and Question Period*, in SYMPOSIUM, *supra* note 1, at 67, 77.

176. See, e.g., Anthony M. Turano, *Paternity by Proxy*, 43 AM. MERCURY 418, 421-22 (1938); Ray, *supra* note 4.

the practice.¹⁷⁷ Despite the decades of medical discussion of artificial insemination, the *Orford* case, and an existing European legal literature on the subject,¹⁷⁸ note author J.C. Schock described the practice as heretofore “unknown in the law,” “a problem the solution of which lies not only in the minds of science, but also equally in the hands of the law, and into the law’s lap science has unceremoniously dropped its burden.”¹⁷⁹

While agreeing with the medical consensus that artificial insemination using the husband’s sperm did not pose any legal concerns, Schock foresaw “many problems” with donor insemination.¹⁸⁰ The chief question, however, could be stated succinctly: could the consent of the husband to the insemination suffice to create full legal legitimacy of a resulting child?¹⁸¹ In addition to the discouraging *JAMA* editorial, Schock found a popular magazine article that quoted one New York magistrate as saying that she did not see how a child could be the legitimate offspring of a man who “knows that he is not the father.”¹⁸² The student author, however, was sympathetic to donor insemination as a “God-send to thousands of happy couples.”¹⁸³ He therefore presented an argument in support of the Seymour/Koerner approach, using existing Pennsylvania case law to argue that a court could find donor offspring legitimate without formal adoption, as long as they were born to the wife of a consenting husband. Recognizing the general policy that adoption was based on positive law, he also proposed statutory changes to the Pennsylvania laws of adoption to make such children explicitly legitimate without formal adoption proceedings.¹⁸⁴

Schock’s goal was not only to establish the legitimacy of donor children, but to do so without the need for formal adoption. This budding lawyer agreed with the medical profession that the trouble with adoption was publicity:

In all test-tube cases closest secrecy is the predominating feature. . . .
In the usual course of events only the husband, the wife and the acting physician have any knowledge whatever that this process has

177. Schock, *supra* note 167, at 271. My description of the article as the first in a law review is based on electronic searches for articles with “artificial insemination,” “artificial impregnation,” “semi-adoption,” or “test tube baby” in HeinOnline Law Journal Library electronic resource.

178. ROHLEDER, *supra* note 15, at 180–83, 185, 198–99.

179. Schock, *supra* note 167, at 271.

180. *Id.* at 271–72.

181. *Id.* at 272.

182. *Id.* at 272 (quoting 10 CORONET at 12).

183. *Id.* at 274.

184. *Id.* at 274, 279–80.

been employed. The child, to his own belief and to that of his family's friends, is the offspring of his mother's husband.¹⁸⁵

Because "the very life-blood of artificial insemination is secrecy," its "entire value" would be lost if a couple were forced to go through a traditional adoption proceeding. "The possible psychological repercussions are overwhelming to contemplate," and the effect of using the solution recommended by the AMA would be to return the procedure "to the laboratory whence it came."¹⁸⁶

Despite Schock's impassioned analysis, a more senior scholar who reviewed his note in 1942 doubted that there was any problem. While agreeing that children born from donor insemination were probably bastards at law, New York University professor Augustin Derby doubted that there was need for the statutory revision Schock proposed. Pointing out that it would be difficult, years later, to disprove the natural origins of such a child, Derby also noted that no cases involving donor insemination had yet arisen.¹⁸⁷ Perhaps because of this absence of legal disputes, during the next few years no state legislature considered any bills such as Schock had suggested. In 1942, artificial insemination was not yet perceived as a pressing medicolegal problem among non-physicians.¹⁸⁸

Still, the ongoing practice of donor insemination in New York City evidently drew the attention of city officials, at least one of whom spent some time thinking about the matter in the 1940s. Several of the most publicly visible practitioners of donor insemination practiced in the city, including William H. Cary, Abner Weisman, and Robert Dickinson. Perhaps the most famous New York-area practitioner was Seymour. In the early 1940s, Seymour was privately telling sympathetic doctors that she had successfully inseminated over 5,000 women.¹⁸⁹ It may have been her practice that was being disparaged when another New York City doctor referred to the known "abuses" of technique in New York City:

185. *Id.* at 273-74.

186. *Id.* at 274.

187. Derby, *supra* note 123, at 785.

188. See Turano, *supra* note 176, at 421-22 (discussing legal concerns as having little real world relevance).

189. Beardsley, *supra* note 102, at 95 (citing personal correspondence with Seymour). If she had only successfully inseminated thirteen women by 1934, as described in the newspaper coverage, *supra* note 90, this claim indicated staggering numbers of patients for the next ten years, lending support both to critics of her estimates, and to allegations of assembly-line insemination of multiple women.

We have one place, and I would call it an institution, where the inseminations are made at the supposed proper interval by simply having a nurse go around with a syringe full of semen, injecting three or four or five women, as long as there is enough spermatic fluid in that syringe.¹⁹⁰

Perhaps spurred by such rumblings among the medical community, Assistant Corporation Counsel of New York Sidney A. Schatkin made an analysis of the topic, which he published in the *New York Law Journal* in 1945.¹⁹¹ Schatkin's article endorsed the decision of the Canadian judge in *Orford* that artificial insemination of a married woman without her husband's consent was adultery and the position of the *JAMA* editorial that even consent could not legitimate the resulting child.¹⁹² Medical practice and legal opinion appeared to be on a collision course.

B. Professional Crosstalk

1. The Debate in *Human Fertility*

The endorsement of the *JAMA* position by a lawyer who was also a public official must have caused some consternation among doctors, particularly those who practiced in New York City. Schatkin's article stimulated the beginning of a public conversation between doctors and lawyers on the topic. The journal of the Planned Parenthood Association, *Human Fertility*, obtained permission to reprint Schatkin's article for its readers,¹⁹³ and then asked Guttmacher, a member of its editorial board,¹⁹⁴ to respond, which he did in an article entitled "The Legitimacy of Artificial Insemination."¹⁹⁵ Describing donor insemination as having become a "common tool" in the last three decades, Guttmacher rejected the reliance of the *Orford* court on what it called "Mosaic law" in order to discern the "essence of adultery." Calling the legal analysis "balderdash," he explained his perspective that "[a]dultery and artificial insemination are absolutely the antithesis of each other. One is done clandestinely to deceive and to enjoy carnal pleasure; the other decently and frankly to beget offspring without the emotional and physical enjoyment of coitus."¹⁹⁶ Guttmacher did not attempt to argue

190. Comments of Dr. George W. Kosmak in Weisman, *Studies, supra* note 67, at 130.

191. Sidney B. Schatkin, *Artificial Insemination and Illegitimacy*, 113 N. Y. L. J. 2432 (1945).

192. Sidney B. Schatkin, *Artificial Insemination and Illegitimacy*, 11 HUMAN FERTILITY 14, 15-16 (1946).

193. *Id.* at 14-16.

194. Guttmacher later became president of Planned Parenthood. Frederick S. Jaffe, *Alan F. Guttmacher, 1898-1974*, 6 FAMILY PLANNING PERSPECTIVES 1, 2 (1974).

195. Guttmacher, *Legitimacy, supra* note 151, at 16-17.

196. *Id.* at 17.

for a different interpretation of existing law, but, making his appeal based on the intent of the procedure and the full consent of the husband, predicted that some day the law would change to legitimate the procedure.¹⁹⁷

By using Guttmacher to author a public response to Schatkin, *Human Fertility* was calling upon a prominent advocate of artificial insemination who had previously published on the subject and was a member of the American Society for the Study of Sterility. By the time Guttmacher directly attacked the legal reasoning of *Orford*, the *JAMA* editors, and Schatkin as “balderdash,” he could claim three decades of common use of the practice. The legal profession inserted itself into what had been a purely medical discussion because by the 1940s, for every public advocate like Guttmacher, there were uncounted numbers of doctors across the country, some fertility specialists, others family doctors or obstetrician-gynecologists, who were performing artificial insemination with husband sperm and donor sperm, without any fanfare.

2. Chicago Symposium

The Chicago symposium, organized by local legal and medical organizations, revealed this world of silent practitioners.¹⁹⁸ To consider artificial insemination as a medicolegal problem, the symposium included presentations by a doctor on the medical aspects and by a lawyer on the legal aspects, and then a moderated discussion among the participants, who included both lawyers and doctors. The moderator was Dr. Morris Fishbein, the long-time editor of *JAMA* who had been involved in publishing the discouraging editorial in 1939.¹⁹⁹ The presenting doctor, J.P. Greenhill, was a local luminary, a senior member of the obstetrical community, a professor and a co-author of a textbook on obstetrics.²⁰⁰ In his remarks, he revealed that he was also a silent practitioner of artificial insemination, including donor insemination, having performed his first successful artificial insemination in 1923. Pointing to recent articles in popular magazines like *Reader's Digest* as

197. *Id.*

198. The symposium was co-sponsored by the Chicago Bar Association and the Institute of Medicine of Chicago. Although Morris Fishbein, editor of the *Journal of the American Medical Association*, was asked to chair the session on artificial insemination, the American Medical Association was not a sponsor. SYMPOSIUM, *supra* note 1, at title page, xi, xv, xviii.

199. *Discussion and Question Period*, in SYMPOSIUM, *supra* note 1, at 70.

200. R.M. Wynn, *J.P. Greenhill: 1895-1975*, 186 ANATOMICAL RECORD 241 (1976). Greenhill's textbook was THE PRINCIPLES AND PRACTICE OF OBSTETRICS, co-authored with Joseph DeLee, and published in its eighth edition in 1944.

the cause, Greenhill claimed that the demand from patients was ever-increasing and that he turned down many couples as unsuitable candidates. Reviewing the medical discussions of the legality of the procedure, Greenhill concluded that doctors were “gambling.”²⁰¹ For the present, however, Greenhill was willing to continue to gamble as he had been doing for twenty years. In fact, he challenged the lawyers present: “Regardless of what you lawyers believe unless you take some action artificial insemination will continue.”²⁰²

Another unnamed doctor in the audience told the doctors and lawyers present that he, too, was a long-time practitioner of the technique, and that one of his earliest artificial insemination babies had married two years previously. After discussions with lawyers, he had decided to forget legal worries “and just take a chance,” and he had continued to do so for many years, although without publishing any case reports. If that newly-married test tube baby had difficulty conceiving, he would be willing to inseminate her, just as he had inseminated her mother.²⁰³

Despite these untold numbers of silent practitioners, the medical profession was not unified on this issue. Greenhill made his challenge knowing that for every doctor like himself, quietly using the practice, there existed at least one other doctor who found the practice abhorrent and would not engage in it. He admitted that his textbook co-author “censored [him] severely” when he learned that Greenhill was practicing donor insemination.²⁰⁴ Another doctor in the audience declared that he had not engaged in the practice and “would personally rather not do it.”²⁰⁵

The presenting lawyer, James Wright, had also never written or spoken on artificial insemination. Confessing his ignorance of the topic until asked to present, Wright described his astonishment as he began to learn of the extent of the practice. Once word of his impending role in the symposium was announced, he was amazed to find himself stopped in the halls of the courthouse by other lawyers anxious to discuss the topic.²⁰⁶ The extent of the practice, the popular discussions

201. Greenhill, *Medical Aspects*, *supra* note 6, at 56. *Discussion and Question Period*, in SYMPOSIUM, *supra* note 1, at 86–87.

202. *Discussion and Question Period*, in SYMPOSIUM, *supra* note 1, at 86.

203. *Id.* at 77.

204. *Id.* at 87.

205. *Id.* at 68.

206. James F. Wright, *Legal Aspects of Artificial Insemination*, in SYMPOSIUM, *supra* note 1, at 57, 65.

about the issue, and the interest of the bar had convinced him that there was a need for legislation—this medicolegal problem needed a legal solution. Wright recommended that the state legislature set up a committee to study the matter.

While he did not specify the nature of the legislation he would like to see, Wright was generally hostile to the technique, admitting only that there “may be some exceptional cases where artificial insemination is proper.”²⁰⁷ Reviewing the law of legitimacy, and the *Orford* decision, Wright agreed with previous legal commentators that a donor child would be a legal bastard, and that donor insemination was legally adultery.²⁰⁸ His distaste for the procedure was clear when he argued that if the courts had not yet concluded that donor insemination was adultery, they should, on the grounds of public policy.²⁰⁹ Wright linked his position to that of the law of abortion: “If it is wrong to artificially stop a life by abortion when no real medical need exists, then why is it not likewise wrong to start a life artificially? Certainly a human life is not a toy to be started or stopped through some whim or caprice.”²¹⁰ He called for those present to consider the issue according to moral laws and holy scripture.

Wright thus set the controversy in a broader context. The question for him was not simply whether a feasible medical practice to relieve involuntary childlessness produced a legitimate or an illegitimate child, the narrow question defined by *JAMA* and the discussions in the medical literature. Wright argued beyond the technicalities of family law, focusing, as had the Catholic Church for decades, on the unnatural aspect of the practice. One lawyer in the audience sided with Wright, adding that as well as considering morality, policy makers needed to consider overpopulation as a social problem. He considered the desire of parents to go to such lengths to have child to be “an outgrowth of selfishness” that need not be supported by the law.²¹¹ By the end of World War II, eugenics had faded in elite and popular discourse after it became associated with the policies of Nazi Germany, and this speaker reflected a general shift from discussions of race suicide to concerns

207. *Id.* at 57.

208. *Id.* at 60, 63.

209. *Id.* at 64.

210. *Id.*

211. *Discussion and Question Period*, in SYMPOSIUM, *supra* note 1, at 69–70 (comments of Royal W. Irwin).

about overpopulation.²¹² The overpopulation discourse was not very powerful in 1945, however, with Europeans concerned with repopulating a war-ravaged continent, and Americans worried about the bomb and in the throes of the baby boom.²¹³ Unlike earlier popular and medical commentators in the 1930s, no one at the symposium raised the possibility of improving the human race through artificial insemination, nor did the suggestion that childless couples seeking fertility treatment were “selfish” garner much support.

The discussion following the formal papers revealed a gulf primarily between those with direct experience with infertile couples (some of the doctors present) and those without such experience (most of the lawyers and other doctors). Koerner had traveled from New York to attend the symposium and was the only identified participant, besides Fishbein, who had previously published on the subject. He spoke to remind the audience that one in ten couples were involuntarily childless, and that their distress needed to be considered in weighing the morality of the practice. “We who are doing this work [artificial insemination] . . . like to consider that at least one of the parties who comes to us is on the verge of despair, many on the verge of divorce.”²¹⁴ Those who both faced the distress of the infertile and knew themselves to have the means of relieving that distress were much more sympathetic to the technique than those who considered the question in the abstract. Countering Koerner’s plea to consider the plight of such couples, one lawyer responded that “the mere fact that a woman wants a child, that she longs for a child, is no reason she should be gratified.”²¹⁵

While Greenhill argued, as had other practitioners previously, that the happiness the technique brought to the involuntarily childless was all the justification doctors needed to continue the practice, the lukewarm reception of this attitude by lawyers reflected a social reality which the medical professionals had been ignoring. Most Americans

212. MAY, *supra* note 30, at 200; ANDREA TONE, *DEVICES AND DESIRES: A HISTORY OF CONTRACEPTIVES IN AMERICA 207–08* (2001).

213. Seymour had suggested using artificial insemination to help repopulate postwar England. Martin Richards, *Artificial Insemination and Eugenics: Celibate Motherhood, Euteleogenesis, and Germinal Choice*, 39 *STUD. HISTORY PHIL. BIOLOGY & BIOMEDICAL SCI.* 211, 217 (2008); MARSH & RONNER, *THE EMPTY CRADLE*, *supra* note 15, at 167. The connection between fear of the bomb and artificial insemination was made explicit in the popular novel, *Mr. Adam*, published in the United States in 1946, which involved a plan to use the sole remaining fertile male after a nuclear accident to produce the next generation of Americans. PAT FRANK, *MR. ADAM* (1946).

214. *Discussion and Question Period*, in *SYMPOSIUM*, *supra* note 1, at 72.

215. *Id.* at 79.

were like the Chicago lawyers. They had no direct experience of infertility. Further, most Americans lacked even second-hand knowledge of artificial insemination as a treatment for infertility. Because of the injunction of secrecy on patients, Americans must seldom have known friends, neighbors or relatives who had used donor insemination. Greenhill claimed that among his patients, families kept the secret of their children's origins even from the grandparents.²¹⁶ While women shared information about their abortions through informal information networks in order to help each other find abortion practitioners even when the procedure was largely criminalized,²¹⁷ discussions of donor insemination were taboo. Although such secrets must occasionally have been shared, the risk of a whispered discussion was exposure and harm to a much-wanted child. Due to the intense secrecy surrounding the practice, most Americans must never have knowingly encountered an artificially conceived child. While to Koerner and Greenhill donor insemination was common and familiar in 1945, most Americans, like the Chicago lawyers, found it startling and strange.

The medical community had been assuming that not only should it be the gatekeeper of this technique, but that it had the most authoritative perspective on the medicolegal and social questions surrounding it. One of the lawyers present flatly rejected the doctors' claim: "The doctors say they are ahead of the lawyers, . . . [B]eing ahead of the lawyers, they are being apart from the human race. I think the lawyers are much closer to the people and to everyday life than the doctor or the scientist."²¹⁸ Test tube babies in 1945 were still not part of "everyday life." As artificial insemination became broadly perceived not just as a futuristic or fringe medical technique, but as a feasible and common means of family formation, its social and legal aspects began to dominate the discussion. Its use was no longer a matter to be determined solely based on medical expertise. When the medical profession had been unable to achieve an internal consensus on the issue, it was no wonder that artificial insemination as a sociolegal problem appeared unresolvable.

216. *Id.* at 85.

217. REAGAN, *supra* note 2, at 21, 23–32 (abortion as an "open secret").

218. *Discussion and Question Period*, in SYMPOSIUM, *supra* note 1, at 78.

CONCLUSION: ARTIFICIAL INSEMINATION AS A SOCIOLEGAL PROBLEM

By their persistence and success in performing artificial insemination, and especially, donor insemination, doctors drew the attention of the legal profession to the problems that doctors themselves had been unable to resolve. As the technique became more widely known in the 1940s, it became clear that legal uncertainty had been no bar to developing a new medical technique that many doctors used to respond successfully to pressing patient demand. Babies were being born as a result of this practice, and litigation would surely follow. There was a medicolegal problem in need of a solution. As legal certainty became more desirable, the uncertain social acceptance of the practice presented an obstacle. Practitioners of artificial insemination understood it as a medical treatment that reinforced traditional notions of femininity, motherhood, and families. It was, to doctors who performed it, socially supportive rather than subversive. Men and women achieved happiness and marriages were saved when doctors made it possible for barren wives to bear children. In the first tentative conversations across professional boundaries in the mid-1940s, however, fertility specialists learned that what they had come to accept as an established practice and a social good appeared to many others as new, threatening, and a social ill.

When doctors worried about the legal status of assisted conception, they focused on the relatively narrow medicolegal problem of the legitimacy of the child resulting from donor insemination. After 1945, as artificial insemination became more widely discussed, first in court cases and newspapers, and then in state legislatures, artificial insemination became recognized as a broader sociolegal problem which was not solely within the boundaries of medical expertise. To determine whether family law needed to be adjusted to recognize the legitimacy of such children, Americans first needed to find consensus on whether they wanted to live in a society that accepted assisted conception and recognized a separation of biological and social paternity in ways that felt uncomfortably different from traditional adoption. The question "who decides?" which reemerged in abortion politics in the 1950s, would also become a question for assisted reproduction. As the social and legal questions surrounding artificial insemination were debated and resolved, the medical practice would also change as the medical assumptions of secrecy and control were reexamined and challenged.