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‘A Tragedy as Old as History’: Medical Responses to Infertility and Artificial Insemination by Donor in 1950s Britain

Gayle Davis

Introduction

The history of sexuality in late modern Britain has, in recent decades, become an intellectually and methodologically vibrant field, with the concept of sexuality deployed as a prism through which a rich range of social, cultural, and political issues have been explored.[1] Much of this scholarship has centred upon England, and in particular upon the metropolitan attitudes and behaviours of London, which are unlikely to have been representative of England as a whole, let alone Britain. Historiographical progress was slightly later in advancing north of the Border,[2] where scholars have recognized the need to take into account Scotland’s separate traditions in law and local government, as well as an arguably distinctive civic and sexual culture where religion appears to have continued to exercise considerable social significance.[3]

In both countries, much illuminating historical work has been conducted specifically into reproductive health. The increasing availability of safe and effective means of fertility control – birth control and abortion – and the social politics surrounding it have comprised an important focus.[4] The history of infertility in

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late modern Britain has, by comparison, been underexplored. Naomi Pfeffer's 1993 monograph *The Stork and the Syringe* remains the most comprehensive work on the subject, and provides an important introduction to medical responses to infertility, set within their wider social and political context.[5] However, assisted reproduction – the use of techniques such as artificial insemination and in vitro fertilization to enhance fertility – has elicited heated debate from a range of other scholars, including social anthropologists and sociologists, and more recently from historians. Interesting themes include the extent to which such 'unnatural' interventions subvert the legal and moral integrity of the family unit,[6] and their application as a strategy for positive eugenic improvement.[7]

Such was the concern that infertility and, more specifically, its treatment by artificial insemination engendered by the mid-twentieth century that a Departmental Committee was appointed to investigate the issue. The terms of reference of the 1958 Departmental Committee on Human Artificial Insemination, otherwise known as the Feversham Committee since it was chaired by Lord Feversham, were:

> To enquire into the existing practice of human artificial insemination and its legal consequences; and to consider whether, taking account of the interests of individuals involved and of society as a whole, any change in the law is necessary or desirable.[8]

The immediate impetus for the establishment of this Committee was a Scottish divorce action in the Court of Session, *MacLennan v. MacLennan*, which considered whether a woman who had had artificial insemination by donor (AID) without her husband's consent could be said to have committed adultery (media responses to this legal case are discussed in depth in Hayley Andrew's contribution to this volume).[9] The rich vein of information embedded within the proceedings of the Feversham Committee has not hitherto been adequately explored by historians seeking to chart the history of infertility. The wide range of medical, legal, and religious witnesses approached to give evidence, and the voluminous written and oral testimony received, offer rich insights into medical thinking and practice in 1950s Britain, and into the complex social politics and ethical anxieties surrounding infertility and its treatment by artificial insemination at this time.

This chapter will focus in particular upon the testimony supplied to the Feversham Committee by medical witnesses in order to explore how doctors perceived, characterized, and treated the infertile couple in 1950s Britain. It will confine itself to their discussions of AID, the issue with which the Committee was 'mainly' concerned 'since A.I.H. appear[ed] to raise very few problems'.[10] Thus, artificial insemination using the husband's semen (AIH) elicited significantly less testimony from witnesses. It will be considered to what extent, and in what ways, women seeking treatment for their infertility were pathologized, in terms of their bodies, personalities, and even agency in proactively seeking motherhood. It will also reflect upon whether the men involved – their husbands, the semen donors, and the doctors themselves – escaped these pathologizing tendencies.

Reluctance to Practise

Since the Feversham Committee was established to investigate the treatment of infertility through artificial insemination, witnesses were asked to focus upon this therapy, rather than providing broader discussion of the possible therapeutic options available to the infertile patient at this time. The method facilitated conception where it was not possible by normal sexual intercourse, either because of sterility in the husband or because of some other physical or mental disability in the husband or wife. Treatment could be performed using AIH or anonymous donor (AID), depending on the couple's specific circumstances. By 1958, it was estimated that there had been 2,000 births by artificial insemination in Britain,[11] just over half of which could be attributed specifically to AID.[12] It was also generally acknowledged, however, that such figures could only ever be a rough estimate in view of the ignorance, shame, and secrecy that surrounded the procedure.

A range of medical witnesses submitted written and oral evidence to the Departmental Committee on Human Artificial Insemination, including individual gynaecologists and psychiatrists, representatives from university faculties of medicine, the royal medical colleges, and major medical organizations. Strikingly, the Committee's survey of those offering artificial insemination using donor semen revealed that only six doctors in Britain were regularly providing such a service at the time of giving evidence, all of whom were based in England. These doctors were Bernard Sandler (1907–97), who established his infertility clinic in Manchester Jewish Hospital in 1947 and practised AID from 1948; the Exeter-based physician Margaret Jackson, who had practised AID since 1940; and Mary Barton (since 1940), Philip Bloom (since 1948), Reynold Boyd (since 1942), and Eleanor Mears (since 1943), all based in London.[13] An attempt was made to attribute an approximate number of AID births to each of these doctors, which varied considerably, from Sandler (16), Mears (20) and Bloom (26) to Jackson (82), Barton (433), and Boyd (500), a total of approximately 1,077 live births.

Two further medical witnesses claimed to have practised AID on a smaller scale in previous years, but to have since given up. Albert Sharman, a consultant gynaecologist, had started a clinic in the 1930s at Glasgow's Royal Samaritan Hospital for Women which was devoted exclusively to the investigation and treatment of infertile marriages, a clinic which he claimed to have been the first of its kind in the United Kingdom.[14] By 1939 it was no longer in operation, and no estimate was provided of the number of births resulting from treatment there. Eustace Chesser was an analytical psychologist based in Harley Street, London, the British hub of private medicine. Five births were attributed to his AID practice in the period prior to 1948. AID was also noted to have been 'practised sporadically' by a range of gynaecologists and general practitioners 'in isolated exceptional cases', both in England and Scotland, including Helena Wright (1887–1982), a London-based specialist who worked closely with the Family Planning Association to provide a variety of services in reproductive

health and sex therapy.[15] However, witnesses representing the Royal College of Obstetricians and Gynaecologists suggested that, 'with the exception of London and two provincial cities [Manchester and Exeter], there ha[d] probably not been much more than 10 children conceived as a result of AID in any one of the large cities of Great Britain during the whole period of the last 20 years'.[16]

Reluctance to practise AID appears to have stemmed from a complex blend of legal, practical, and moral factors. Several of the doctors questioned by the Committee indicated confusion as to the legal status of the practice. As one surgeon asked the Committee: 'The medical profession do not at present have the right of carrying out artificial insemination by donor? Am I wrong there?'[17] Indeed, Albert Sharman claimed to have made enquiries to the Medical Defence Union, only to be told that the organization 'would not guarantee that somebody who had had artificial insemination with donated semen could not bring a legal action' against that doctor.[18] In its submission to the Feversham Committee, the Department of Health for Scotland claimed that there was 'some uncertainty' as to the legality of the procedure, since the National Health Service had failed to issue guidelines on it, and recommended that the doctor 'seek to safeguard himself by securing the written consent of all parties to the transaction'.[19]

Indeed, such uncertainty was also a feature of the legal evidence submitted. Most legal bodies considered artificial insemination a legal medical therapy, but acknowledged that the practice was 'of such recent origin that the courts ha[d] had little occasion as yet to consider its legal implications and that it [was] impossible to forecast with any certainty the answers which they would give to some of the problems which [would] inevitably arise' if the practice continued.[20] However, more critical voices made their presence felt, most notably T.B. Smith, Professor of Civil Law at the University of Edinburgh, who argued vigorously that AID was illegal, given the 'element of deception involved' and 'the production of a bastard', and that it constituted the common law crime of fraud in Scotland and the crime of conspiracy in England.[21]

Medical witnesses also offered various practical reasons for their resistance to offering artificial insemination to patients. Although Albert Sharman continued to undertake insemination using the husband's semen, he discontinued the practice of donor insemination at his clinic after five years because 'success was rare' and donated semen 'very difficult to obtain'. Lack of success featured, similarly, in the oral evidence submitted by Hector Maclennan (1905–78), a senior gynaecology consultant in Glasgow and future President of the Royal College of Obstetricians and Gynaecologists (1963–66), who complained that patients held the 'prevalent' but mistaken idea that those 'prepared to submit to AID' would find success.[22] Inflated patient optimism was a most unwelcome feature as far as many doctors were concerned, particularly given the fact that there was 'an upsurge of requests for AID when anything appeared in the Press'.[23] Eleanor Mears, a London-based doctor who had given up general practice to specialize in subfertility and psychosexual problems, complained

similarly that the 'recent publicity arising out of the Maclennan [divorce] case in Scotland' had increased her referrals 'tremendously'. She added that this influx of patients included those who had previously 'been told nothing could be done' for their infertility, but for whom the press discussion of AID gave new hope.[24] The difficulties of attracting suitable and sufficient donations were discussed extensively by medical witnesses, and will be explored in greater depth below.

In addition to such legal and practical impediments were objections of a more moral nature. Written evidence from the British Medical Association noted that, while AID 'would not appear to contravene any of the accepted principles of scientific medicine', there was 'a substantial body of opinion in the profession which regard[ed] this practice as an undesirable one and many doctors [were] absolutely opposed to it on [...] religious grounds'.[25] Professor Andrew Claye (1896–1977), President of the Royal College of Obstetricians and Gynaecologists (1957–60), argued that the great majority of the College's Council viewed AID as unethical, and that the 'main reason why gynaecologists did not practise AID was that they considered it morally wrong'.[26] Similarly, a Medical Advisory Committee of doctors representing the United Birmingham Hospitals explained that the Committee 'deplored the practice' of AID, finding it 'objectionable on moral, religious, and ethical grounds, especially having regard to the marriage vows'.[27]

Such collective statements were supported by numerous individual witness statements. Doctors representing the Royal College of Surgeons of Edinburgh referred to finding 'much that is repugnant in the practice of AID',[28] and G.W.B. Jones, a London-based psychiatrist, found himself 'bound to admit that I find AID revolting and ethically offensive'.[29] John McDonald, a psychiatrist based in Perth, chose to characterize AID not as a medical treatment but as adultery; [30] similarly Eustace Chesser in Harley Street argued that, in involving 'an extra-marital relationship', AID 'cut right across the decree of the Christian faith'.[31] Audrey Freeth, who had practised gynaecology in both Birmingham and Glasgow, declared to the Committee her disapproval of AID 'on moral, religious and ethical grounds', and tried to dissuade patients from seeking treatment by focusing upon 'all the difficulties and snags' in her patient consultations.[32] Although she claimed that she would refer 'persistent couples' to a more sympathetic practitioner in England, she admitted upon further questioning that she had 'never in fact done so'. Similarly, Hector Maclennan noted that a 'simple statement' calling into question the suitability and motivation of the semen donor was 'sufficient in most cases to discourage further enquiry'.[33]

However, if the patient still insisted on treatment by this method, Maclennan declared himself 'quite prepared to refer her to a recognized practitioner' based in London. One of these was Reynold Boyd, a New Zealander who had specialized in genitourinary surgery but now did 'nothing else but infertility'.[34] Boyd's evidence noted that he had received artificial insemination referrals from Maclennan and other senior gynaecologists 'all

over England and Scotland [. . .] and other countries as well, especially South Africa'. He added that Mary Barton and Margaret Jackson received a related range of referrals. As Sandler remarked, 'Margaret Jackson's name got into the newspapers and she told me as a result of that she has had a lot of enquiries and usually anything further away [from Exeter] than Birmingham she refers to me'.[35] Helena Wright noted a similarly 'wide geographical field – from Scotland to Rome' from which she received applications for AID.[36] Even in the case of those doctors who were receptive to patients seeking AID and referred them accordingly, it could be suggested that making the patient travel a significant distance to consult them, at some personal expense, was just one of several 'obstructive' methods employed by doctors throughout Britain. Indeed, even patients for whom travel was an option might take some considerable time to track down an appropriate and sympathetic practitioner. Some of Bernard Sandler's patients 'told him they had been trying to contact an A.I.D. practitioner for up to 10 years'.[37]

The group of doctors representing the Royal College of Surgeons of Edinburgh suggested a further strategy to dissuade eager patients: the creation of an 'independent' panel in each region to consider applications, consisting of 'a gynaecologist, psychiatrist, minister of religion, welfare worker with experience in marriage-guidance problems, and the applicant's own doctor'. This group would collectively interview both husband and wife in order principally to 'satisfy themselves that the consent of the former was both willing and sincere'.[38] By subjecting the couple to this intimidating panel of professionals, they concluded, 'it is our intention to make the whole thing rather difficult. We have not made suggestions to make it easier, quite the contrary'.[39]

Such strategies have resonances with the 'abortion games' played by British doctors a decade later, strategies adopted in order to minimize their own personal responsibility for decisions made in relation to termination of pregnancy in the years immediately following the passage of the 1967 Abortion Act.[40] Doctors arguably were not trained or qualified to make decisions in these areas, and thus embraced alternative strategies in order either to simplify or displace the decision-making process surrounding the provision of abortion and infertility services. Indeed, as one psychiatrist told the Feversham Committee, the judgement of psychiatrists in this matter was 'in no way enhanced because of their status as Psychiatrists. I feel that it should be stressed that psychiatrists have no peculiar right to make judgement in what is largely a moral field'.[41] Similarly, representatives of the Royal College of Obstetricians and Gynaecologists argued that it was 'outside the province of a medical man to choose who shall impregnate any woman, or intervene in the fundamentals of a marital partnership'.[42]

A final, related explanation for medical reluctance to offer AID is the extent to which it could be considered a medical procedure. With its 'turkey baster' connotations, insemination was described by some witnesses as a 'very simple procedure' which did not appear to necessitate skilled medical involvement.[43] Indeed, in 1950s Britain, figures like the English birth control pioneer Marie

Stopes (1880–1958) were promoting AID as a 'home' remedy for infertility, outlining the technique so couples could 'do it themselves'.[44] Yet, none of the medical witnesses questioned by the Committee discussed the possibility of couples practising the technique themselves, independently of medical involvement. Perhaps they believed, as the London-based psychiatrist and AID practitioner Philip Bloom noted, that artificial insemination took 'so much time and trouble' that there was 'practically no chance of its being carried out in back streets by unqualified people' in the way that abortion was at this time.[45]

The widespread use of AID in the agricultural sector can have done little to persuade doctors to offer this therapy, although few witnesses reflected explicitly on this subject. Religious witnesses were the most likely to speak disparagingly of the conflation of farm and clinic, such as the United Free Church of Scotland, which argued that AID 'reduced human beings to the level of breeding animals' and should be 'confined to the farm-yard, where it belongs'.[46] Dr Hector Maclennan was more subtle in his remarks, but reflected at length on his farming friends' 'extremely difficult work [. . .] to get a good donor and their disappointments [. . .] in breeding'. He asked the Committee: 'How much more complicated is the human being than the Aberdeen Angus bull?', explaining that it was not just a question of physique but also IQ and emotional state, the latter factor being 'extraordinarily hard to assess'.[47] Employing language more suited to the farm, the final line of his written memorandum advised women 'to breed from the best possible stock', and concluded 'I cannot imagine that a donor is the best possible stock'.[48]

Disparaging the Donor

The difficulties inherent in obtaining semen samples of sufficient quality and quantity were discussed widely in medical testimony submitted to the Feversham Committee. As Audrey Freeth noted, 'the donor situation' was 'distinctly tricky' because women had to be supplied 'with a satisfactory specimen'.[49] Evidence suggests that semen donors were required to be 'satisfactory' in two key respects: physical and psychological.

Physical fitness was one aspect of the 'eugenic considerations' which lay at the heart of donor selection. Donors were to be of good general health and intelligence, with no history of transmissible disease or 'adverse genetical characteristics such as alcoholism, criminality, or tuberculosis'. Naturally, they must be fertile. Albert Sharman specified that their semen 'must have a volume of at least one c.c.; must liquefy and rapidly become homogenous; the sperm count must exceed 60 millions per c.c.; and there must be no spontaneous agglutination'.[50] He continued:

> The spermatozoa must show little variation of head-lengths and include less than 15 per cent abnormal forms. Indifferent or intermediate and pathological cell-forms [. . .] must be rare. Bacteriological cultures from the fresh semen must be sterile or show but a light growth of harmless contaminants.

It was also deemed crucial to ensure that the semen donor was not related to the mother, which could 'lead to an exaggeration of all characteristics of the genetic line, including the bad ones'.[51] Although this belief led numerous medical witnesses to urge the creation of a donor register, 'which should record the full medical history of the donors, the number and frequency of donations, and the births resulting', these doctors also tended to stress that such records should be 'kept centrally' with 'carefully restricted' access, restricted even from the infertile couple in order to preserve the donor's anonymity.[52] If the donor's identity was revealed, this would almost certainly discourage would-be donors, who were already in short supply.

To complicate matters further, some medical witnesses discussed the need for infertile couples to be matched to semen donors who could help them to produce children resembling the husband. Thus, the semen donor's hair colour, eye colour and height were all to be considered in relation to the husband's. Some patients also requested religious or racial compatibility. Audrey Freeth, among others, expressed her worries over the accidental use of the semen of 'coloured gentlemen' in white couples.[53] Indeed, Bernard Sandler noted his refusal to practise AID on a white woman when he found that the husband

> was a negro and I was being asked to do AID for a mixed marriage. I thought about this for a great deal of time and I decided that it was too great a responsibility for me to bring a child of mixed parentage into the world. Perhaps I was cowardly but I said there are very many mixed children wanting adoption and I think you ought to adopt one.[54]

In cases of racial compatibility, Sandler 'tried to match donors with recipients as regards' not only 'physical characteristics' but also 'intelligence and background'.[55] Mary Barton did the same, but cautioned of the potential dangers of 'introducing a highly intelligent child into a less intelligent home', though she qualified that 'such problems also arose with natural conceptions'.[56] Indeed, such was the pressure placed on doctors to exactly 'reproduce' the husband that, as Albert Sharman stressed, couples must be warned explicitly that 'no likeness, physical or otherwise, can be guaranteed'.[57]

Added to this were the potential psychological barriers to semen donation. Some doctors offered a lengthy list of ideal attributes for semen donors, including the fact that they should be married men with at least two legitimate children of their own, not only to illustrate the quality of their 'stock' but so that their 'parental drive' would already have 'an available object'.[58] However, for other practitioners, the very fact that a man was willing to donate his semen made him unsuitable for the task. Dr Gerrard, representing the British Medical Association, stated: 'It is the motive that worries me. [. . .] One cannot help worrying just a little bit about the type of man who will be a party to it'.[59] Hector Maclennan went so far as to explain to his patients that a donor

> prepared to give semen to a woman, whose mental and physical background is unknown to him, and who is prepared to father children who will be born into a completely unknown environment, so far as he is concerned, is a man whose ethical standards are so unusual as to be of doubtful value from a eugenic point of view.[60]

David Stafford-Clark, a psychiatrist at Guy's Hospital, pointed out that donation involved masturbation, and that a person who took this 'in his stride' should be regarded with suspicion.[61] He divided donors into three classes: the 'unreflective', 'those who found in it a vicarious enjoyment', and 'the psychopaths', the latter of whom doctors practising AID would find it 'extremely difficult to recognise'.[62]

Feversham witnesses who represented religious bodies employed similar medical terminology, possibly in a conscious effort to strengthen their argument, as was the case in slightly later abortion debates, where non-medical groups recognized the power of medical language in fighting for their cause, whether it be to liberalize or restrict access to abortion.[63] Thus, the Free Presbyterian Church of Scotland suggested that a willing semen donor could only be regarded as 'psycho-physically or psychologically abnormal' since 'few normal men, if any, would debase themselves to donate semen'.[64] Similarly, the United Free Church of Scotland highlighted donors motivated by 'a perverted sense of power' to perform an act that 'might appeal to many men with undesirable mental abnormalities', and the resulting 'grave danger of large numbers of children inheriting such undesirable traits'.[65] Such medico-moral statements reveal a distinct pathologization of those men willing to act as semen donors.

A further attempt to denigrate the semen donors, expressed by numerous medical witnesses, related to their alleged financial motivation for involvement in the process. A committee of doctors representing the Royal College of Surgeons of Edinburgh declared themselves 'at a loss to assess the motives of men who act as donors, but believed that in most cases these must include financial gain', and stressed their 'abhorrence' at 'the possibility that a man might make his living, or even a substantial income, out of such "donations"'.[66] Indeed, this group argued that 'there should be no direct remuneration of the gynaecologist concerned', let alone the semen donor, given the technical simplicity of the procedure and the 'obvious abuse' which could arise from financial incentives on anyone's part. In subsequent oral evidence to the Feversham Committee, the Chairman asked them to account for their belief 'that most cases involved financial gain', since the evidence of those actually engaged in the practice of AID suggested that donors were 'often husbands of the wives who had been successfully treated' for infertility, who were thus acting 'out of gratitude, in the spirit of service to others' rather than for financial gain.[67] The surgeons responded: 'I do not think we have any factual knowledge. We were judging what we believed to be the state of affairs in the United States [. . .] in regard to [Britain], one has heard some mention of the

fees paid to donors, but we have no factual evidence whatsoever'.[68] With only marginally more 'factual evidence' was Dr Jones, St Mary's Hospital, who had 'known one would-be donor personally', and stated that donor's motive to be 'money [. . .] he asked for 25 guineas per case, with first class travel and a daily subsistence allowance'.[69]

Medical witnesses who offered AID treatment at the time of giving evidence, or had in the past, were in fact asked to account for the origins of the semen donations which they had obtained. Most began by stressing the difficulty of finding donors. As Albert Sharman complained, 'the provision of semen' was 'entirely in the physician's hands'.[70] This was a somewhat ironic statement as it turned out, since his personal solution was to approach fellow doctors, as well as personal friends.[71] Similarly, Philip Bloom 'had to rely on acquaintances he knew well and this accounted for a large proportion of his donors being in the medical profession'.[72] While Barton did not acknowledge it in her testimony to Feversham, it subsequently transpired that her husband – the Austrian physiologist Bertold Paul Wiesner (1901–72), with whom she jointly managed her private fertility clinic in London – had anonymously donated sperm that his wife used to perform AID, resulting in an estimated 600 successful births.[73]

Nor, it seems, were these doctors alone in this practice, since the National Marriage Guidance Council felt compelled to urge that 'doctors (or husbands of women doctors) should not be donors in AID they perform'.[74] On a possibly related note, Thomas Norman Arthur Jeffcoate (1907–92), Professor of Obstetrics and Gynaecology at the University of Liverpool, spoke of 'unmarried students being used as donors in Liverpool, at an age when they were easily persuaded on emotional grounds of the rightness of the cause'.[75] It was not, however, stated whether these were specifically medical students.

Otherwise, evidence presented to Feversham found little mention of medical donors. Most of the donors used by Bernard Sandler and Margaret Shotton were husbands of patients 'treated successfully for infertility' who 'acted out of gratitude', with no payment made to them.[76] Half of Eleanor Mears's donors were, similarly, the husbands of patients she had treated for subfertility; the other half were 'friends with families'.[77] Mary Barton explained that, when she began practising AID, she had sometimes used the semen of the husband's brother, 'but this was universally fatal to the marriage', so she had since 'found it necessary to make payment' to attract some donors.[78] Similarly, Albert Sharman cautioned that:

> Certain facile assumptions suggested by purely biological considerations must be refuted. Thus, the husband's brother might be regarded as the first choice because of genotypical resemblance, but experience shows that this choice is usually incompatible with secrecy, and that it is conducive to emotional disturbances involving both husband and wife.[79]

As one of many, Sharman emphasized that 'prospective parents should never be aware of the identity of the donor', since a 'responsible donor' and

'maternal women' would be 'emotionally too deeply involved in procreation to regard their relationship with detachment'. Atypically, Bernard Sandler also discussed the very general practicalities involved in semen donation: 'I have to have a man who works reasonably near to my place, he can slip out during his lunch hour, produce a specimen, go back to work. He also has to be on the telephone because I give them very short notice and I do not pay them in any way'.[80]

Suitability for Parenthood

Such pronounced medical reluctance to offer AID as a treatment for infertility leads us to consider how the women consulting these doctors were characterized and treated. As evidenced by their testimony to the Feversham Committee, some doctors further justified their lack of involvement in AID, or denial of treatment in specific cases, by stressing the female patient's lack of suitability. These problems tended to be of a more emotional or psychological nature, rather than physical. Representatives from the Royal College of Surgeons of Edinburgh noted: 'One finds most of the women who are infertile suffer from various forms of neurosis'.[81] While such characterization of all infertile women as psychologically damaged appears to have been a particularly extreme viewpoint, within the context of the testimony received, even those practising AID on a regular basis, such as Bernard Sandler, mentioned their need to refuse treatment to some women 'on psychological grounds'.[82] He described 'a certain type of woman who can become quite obsessional about her childlessness', and considered infertility 'one symptom, if you like, of a general disturbance of the whole personality'.[83]

In addition, several gynaecologists chose to characterize those women who sought AID in a similarly dysfunctional way. Thus, Hector Maclennan described most of the patients who approached him for this form of treatment as being 'of a highly nervous disposition', 'frustrated and introverted', and 'a bit emotionally disturbed'.[84] Similarly, Audrey Freeth criticized the wife who 'must have a child at any price', indicating 'a lack of understanding and an emotional immaturity' that did 'not augur well for the future of that marriage'.[85] While it was natural that a married woman would wish for a family, she could want this too much and thus get 'carried away emotionally'.[86] Some of the psychiatrists who submitted evidence to Feversham were similarly minded. Eustace Chesser automatically regarded a woman seeking AID as 'unstable', and suggested that her motives 'must be largely neurotic', since 'normal people would prefer adoption'.[87] London-based psychiatrist G.W.B. Jones had 'always been struck by the obsessional attitude of women' he had met 'who had requested (or demanded) AI'. He added: 'Most seemed to be in need of psychiatric treatment rather than semen'.[88]

Even noted advocates of the therapy, such as Bernard Sandler, might make damning remarks about the type of woman seeking AID, and those who failed to conceive thereby. In his oral evidence to the Committee,

Sandler suggested that 'emotionally immature women often failed to conceive', and that even where treatment succeeded in such cases, it was 'not always [. . .] with very happy results'.[89] Rather more curiously, he discussed a woman's ability to conceive only when she had made a 'conscious decision' to do so: 'She has to decide whether she is having a baby or new curtains or a new car or giving up a profession and therefore this is a conscious decision'. Eleanor Mears noted that perhaps half of the couples who she rejected for AID were rejected on the grounds of their psychological instability.[90]

More common still was acknowledgement of the inevitably damaging nature of the AID treatment itself. This featured particularly prominently in the evidence presented by the two witnesses who had practised AID on a smaller scale but since discontinued the practice. Albert Sharman discussed the 'danger of psychological damage to the patients, both husband and wife', 'either through the inevitable interference with their sexual relations or through the consciousness of reproductive inferiority'.[91] Eustace Chesser no longer offered AID 'because of the psychological significance'.[92] He was disturbed by one patient 'who treated him as the father', and noted the 'tremendous blow' to the male partner's pride, 'confirmed by their reluctance even to have sperm counts undertaken'. He warned that 'couples could not forget that their child was an AID child', particularly the husband, for whom AID 'reflected his own inadequacy and broke the marriage bond'.

The potentially damaging impact of AID upon marriage was a focus of attention in the witness statements of numerous other doctors, but particularly psychiatrists. It was expressed unanimously that single women were not and should not be treated with AID, so the relationship at the heart of these patient consultations was commonly reflected upon. David Stafford-Clark argued that a woman 'pregnant by semen which her husband had not contributed' had 'received something intrinsically sexual from outside the marriage', 'the final seal on the husband's incapacity'. He flagged up the related 'danger that the child would be made to suffer at a later stage', summing up that 'human beings were not as rational as AID presupposed them to be'.[93] Similarly, John McDonald suggested that AID was problematic for any less than perfect marriage, for the birth of a child by this procedure would constitute 'a standing reminder' of 'already disturbed family relationships'.[94] Echoing Chesser's experience, McDonald added that the female patient 'may even feel that she is committing adultery with the doctor'. An unnamed forensic medicine lecturer at the University of Edinburgh expressed the related view that 'denigration of the family concept [. . .] was the most extensive and serious cause of mental disturbance and human maladjustment', the implication being that AID would compromise the integrity of the 'natural' family unit.[95] This mixture of concerns on the psychological impact of infertility and its treatment has strong resonances with Jacky Boivin and Sofia Gameiro's contribution to this volume.

Adding further complexity to the issues raised was the treatment option of 'AIHD', the practice of inseminating a woman with a mixture of semen from

her husband and an anonymous donor. The technique appears to have been adopted predominantly in the hope that the couple would believe that they had conceived naturally, though Reynold Boyd was atypical in employing AIHD because it was 'virtually impossible to guarantee sterility', thus the husband had 'a chance of fatherhood in almost every case'.[96] Most who supported the practice noted that the procedure of mixing sperm might mitigate some of the psychological dangers inherent in donor insemination, including damage inflicted upon the self-esteem of infertile husbands and the 'stigma of "test-tube" origins' suffered by resulting children who became aware of their status.[97] The procedure might make the husband 'feel that he had a chance of being the father',[98] or, as Mary Barton put it, 'let the couple have their little bit of pleasant doubt'.[99]

Expressed in fuller detail, Albert Sharman's technique involved not telling the husband when he was totally sterile, but having a 'heart to heart talk' with his wife and asking her to keep that information to herself.[100] As he put it, 'I told the wife she was not to go home and blurt out the whole truth of the matter [...] I saw marriages going on the rocks, ruin and divorce, through telling the husband'. The husband was instead told that he was 'impaired' but that there was 'hope with treatment or in time things might remedy themselves', thus any resulting pregnancy using AIHD might be passed off as resulting from marital intercourse. Going further still, Eleanor Mears 'did not believe in telling a man he was sterile',[101] so asked him to provide a specimen for the purposes of artificial insemination, but tended then not to use it, using only donor semen. Several doctors also noted that, whether or not AIHD was used, the couple was encouraged to 'lead a normal married life' (i.e. to have marital intercourse) during artificial insemination treatment.[102]

However, most medical witnesses who expressed serious reservations about AID extended their deep concerns to AIHD. Summing up these concerns, a group from the University of Edinburgh's faculty of medicine argued that this mixture of semen led to 'unnecessary confusion and ambiguity', made the 'accurate' keeping of records 'impossible', and that it was fundamentally dishonest to place the couple in a position where they did not know whether or not the husband was the father of their child.[103] Hector Maclennan similarly stressed the dishonesty of the procedure, adding that since he objected in principle to AID, 'mixing it up with the husband's semen does not strike me as making it any more right. It is just putting a cloak over it'.[104] For perhaps more practical reasons, the Royal College of Obstetricians and Gynaecologists argued that in no case was AIHD warranted: if the husband was not sterile, donated semen should not be used at all, and if he was sterile, the use of his semen was 'pointless'.[105]

Given the inherently dishonest nature of AIHD, medical hypocrisy in characterizing the infertile woman herself as somehow 'duplicitous' is striking. Doctors from the Royal College of Surgeons of Edinburgh, for example, noted that steps must be taken to ensure that such women were 'genuine

and honest' in their desire for such treatment.[106] Meanwhile, in cases of AIH and AIHD, Albert Sharman cautioned that female patients being asked 'to bring along a specimen of the husband's semen' must also be requested to supply proof that this was indeed her husband's semen *and* that he had consented to the procedure.[107] After all, as Sharman complained, 'the woman could bring along a substitute semen if she so felt [. . .]. We have no proof: we are injecting it in good faith'. When a member of the Feversham Committee retorted that this point was surely 'only a theoretical one' since any woman who would 'go to the trouble of bringing the semen of a man other than her husband' would 'surely try ordinary methods of adultery', Sharman responded defensively that he had 'no doubt [. . .] from the way an occasional woman talked to him, that she did indulge in adultery'.[108]

In a bid to counter such allegations, Bernard Sandler wrote to the Feversham Committee, subsequent to appearing before them, with a case that had just been referred to him.[109] It involved a couple married for seven years, who had adopted a child after two years of marriage upon the discovery that the husband had incurable sterility. Having found that adoption 'did not satisfy either of them', and seemingly with no other options available, 'after very much thought and consideration' the wife arranged 'to have intercourse with another man, with her husband's full knowledge and consent'. The intended outcome of this adulterous encounter, a natural birth, was successfully achieved. The couple then wished for a further child, but 'neither [. . .] felt able because of the emotional strains' of this adulterous method. Some years later, 'only when the publicity of last year in the press revealed to them that there was such a practice as AID did they feel that this was the method of choice for them'. Sandler stressed the importance of this case in illustrating that, 'contrary to what the critics think, AID is a highly moral and ethical procedure which in the rare cases such as this one will actually avoid immorality'.[110] As another of AID's strongest advocates and most enthusiastic practitioners, Margaret Jackson wrote similarly: 'Many of the couples asking for AID seem to regard it as a special form of adoption [. . .]. They are deeply hurt if they are told that AID is tantamount to adultery – that is precisely what they wish to avoid'.[111]

Nonetheless, for those doctors who appear to have conflated AID with adultery and moral taint, this story is likely to have done little to dissuade them of their belief. While most witnesses were sympathetic to the woman's plight, in her unsuccessful quest for motherhood, Hector Maclennan was not alone when he stated that barren women had 'been there since the old days, in the Old Testament', 'a tragedy as old as history', and that modern medicine was providing false hope to such women. 'It would be far better', Maclennan argued, for such patients to 'face the fact [. . .] and be told to adopt than that she should go from clinic to clinic' with such a small chance of successful treatment.[112] Such medico-moral discussion of infertile women seeking treatment bears a striking resemblance to the religious testimony received. Thus, the Church of Scotland asked the infertile to accept 'the mysterious workings

of Providence [. . .] without resentment and in quiet trust',[113] while the Free Church urged the childless 'to recognise the Divine will' and to 'pray for submission', which would 'maintain the sanctities of the marriage bond and the joys of the marriage relationship in a way that was impossible by the [adulterous] methods of artificial insemination'.[114]

Conclusion

Over 100 organizations and individuals were approached to give evidence to the Feversham Committee. The resulting oral and written testimony provides significant insights for the historian of infertility and its treatment in twentieth-century Britain, who often has to work hard to uncover suitable sources in this sensitive field. This chapter has exploited those archival riches, which provide a valuable snapshot of medical thinking and practice. One must naturally bear in mind the context within which the Committee was operating – in this case, the aftermath of a divorce case which had divided legal opinion and caused 'public outrage', according to some newspapers of the time – which may have influenced both the questions asked of witnesses and the responses given. One might also lament the difficulties of capturing a 'patient' perspective through such sources, whether that be the voice of the woman, husband, or married couple collectively seeking treatment, or even the semen donor, all of whom are effectively silenced. Thus, oral history-based investigations such as Angela Davis's contribution to this volume, which explores women's perceived loss of autonomy in medical encounters from their own perspective, can provide a valuable counterbalance to such 'official' testimony.

The proceedings of the Feversham Committee nonetheless shed a valuable light on the history of infertility and its treatment through artificial insemination in mid-twentieth-century Britain, particularly from the medical perspective. We can note a lack of extensive or sustained experience in the practice of AID in many of those giving evidence (for a range of legal, practical, and moral reasons), which nonetheless did not prevent most witnesses from expressing strong views on the subject. Such ill-informed yet confidently voiced beliefs arguably betray the sense that moral objections played a significant part in the formation of medical views on AID. Doctors appear to have refused to offer this form of treatment where it conflicted with their own moral sensibilities, and used various strategies to repel eager patients, including robustly questioning the health and motives of willing semen donors and in some cases subjecting patients to an intimidating degree of scrutiny.

Medical testimony reveals a pronounced tendency to pathologize the infertile woman, whom they appeared to consider diseased not simply by virtue of her imperfectly functioning reproductive system, or even because of a perceived association with psychological impairment, but because it was psychologically and morally questionable to seek out AID as a form of treatment. Even for those (presumably) fertile women married to an infertile man, there was an explicit questioning of what motivated them to seek insemination treatment,

with perceived risks of dishonesty due to the level of desperation that many felt to be pregnant. A wish to engage with this form of therapy was taken as the very proof that you were not a healthy and appropriate candidate for parenthood. As feminist historians have stressed, maternity has long been considered the 'female norm',[115] but some women could want this too much, such that they became frustrated, obsessional, and precisely the wrong sort of person to 'function well as a parent'.[116] Thus, the infertile woman seeking treatment by artificial insemination was arguably considered to be as reproductively 'deviant' as the woman seeking a termination of pregnancy in mid-twentieth-century Britain.

Yet, the fundamentally dishonest nature of AIHD treatment throws into sharp relief the hypocrisy of the medical profession in characterizing the female patient as somehow untrustworthy or duplicitous. Indeed, Feversham testimony indicates that the woman was by no means the only pathological character in this story. One could say that every other element of AID was equally pathologized by mid-twentieth-century doctors. Thus, we find much enthusiastic characterization of the greedy, eugenically compromised or psychopathic semen donor. A rather more paternalistic, or simply patronizing, attitude was displayed towards the (infertile) husband, with concerns that he had not consented to such a treatment and might thus be deceived by an adulterous wife, or that his self-esteem simply could not cope with the knowledge of his reproductive inadequacy. Discussion of the husband nonetheless betrays a tendency to pathologize him, too, not merely in terms of his imperfectly functioning reproductive system, but of his fragile psychological state. Moreover, 'adulterous' doctors do not escape this tendency to pathologize, their motives questioned for involvement in a sphere of activity with agricultural associations which did nothing to boost their skills or reputation. Finally, the very treatment itself was pathologized. Little wonder, then, that some of the most critical Feversham witnesses did not single out one of the parties for criticism, warning instead that everyone involved must be punished for practising 'this unnatural form of immorality' – the couple themselves, the donor who supplied the semen, and the doctor who facilitated the therapy.[117]

Notes

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3. Callum Brown, *The People in the Pews: Religion and Society in Scotland since 1780* (Glasgow, 1993).

4. See, for example, Barbara Brookes, *Abortion in England, 1900–1967* (London, 1988); Lesley Hoggart, *Feminist Campaigns for Birth Control and Abortion Rights in Britain* (Lewiston, NY, 2003); Davidson and Davis, *The Sexual State*, part 2.
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6. Rita Snowden, *The Artificial Family: A Consideration of Artificial Insemination by Donor* (London and Boston, MA, 1981); Fenella Cannell, 'Concepts of Parenthood: The Warnock Report, The Gillick Debate, and Modern Myths', *American Ethnologist*, 17:4 (1990); Sarah Franklin and Helena Ragone (eds), *Reproducing Reproduction: Kinship, Power, and Technological Innovation* (Philadelphia, PA, 1998).
7. John McMillan, 'The Return of the Inseminator: Eutelegenesis in Past and Contemporary Reproductive Ethics', *Studies in History and Philosophy of Biological and Biomedical Sciences*, 38:2 (2007); Martin Richards, 'Artificial Insemination and Eugenics: Celibate Motherhood, Eutelegenesis and Germinal Choice', *Studies in History and Philosophy of Biological and Biomedical Sciences*, 39:2 (2008); Angus McLaren, *Reproduction by Design: Sex, Robots, Trees and Test-Tube Babies in Interwar Britain* (Chicago, IL, 2012).
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9. See also Gayle Davis, 'Sexual Snapshots: Departmental Committees and their Value to the Historian of Sexuality', *Scottish Archives*, 18 (2012).
10. NRS, HH 41/1450, 'Notes for Representatives of Government Departments appearing before the Committee on 7 December, 1958', November 1959.
11. NRS, GRO 5/1838, 'Notes for Representatives of Government Departments appearing before the Committee on 7 December 1959'.
12. NRS, HH 41/1459, 'Extent of AID in this Country', undated appendix to AI (59) 5.
13. NRS, HH 41/1459, 'Extent of AID in this Country', undated appendix to AI (59) 5.
14. NRS, HH 41/1453, Memorandum of Evidence by Dr Albert Sharman, 6 November 1958. Sharman also co-authored the textbook *Sterility and Impaired Fertility: Pathogenesis, Investigation and Treatment*, 2nd edn (London, 1948) in conjunction with fellow authorities in the field including Mary Barton.
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17. NRS, HH 41/1455, Verbatim Report of Oral Evidence by the Royal College of Surgeons of Edinburgh, 13 October 1959.
18. NRS, HH 41/1458, Verbatim Report of Oral Evidence by Dr Albert Sharman, 11 February 1959.
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