

Turkey-baster Babies: The Demedicalization of Artificial Insemination

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I do not know, but one day what you have discovered may be applied in the human species to ends we little think of and with no light consequences [letter by a colleague congratulating Spellanzani on his success in 1780 in artificially inseminating a spaniel (Poynter 1968)].

The technique is really very simple. It's just a matter of getting the sperm and inserting it into your vagina. Contrary to what most people think, you don't have to be extra careful about light or air or heat or anything. . . . I heard about a group of lesbian women on the West Coast who were inseminating themselves using a turkey baster. That's right, the kind you keep in your kitchen. I know it sounds a little strange but I thought it was a wonderful idea. . . . So I used a turkey baster and there was nothing to it. . . . (Fabe and Wikler 1979)

THE ADVENT OF NEW REPRODUCTIVE METHODS SUCH as in vitro fertilization, embryo freezing, and surrogate motherhood has fired the imagination of the American public. Although the high-tech aura surrounding some of these events has fed the public's fascination with scientific methods of creating human beings, the new practices have also generated an unsettling sense of risk to traditional mores governing reproductive behavior and family life.

The reports both of laboratory breakthroughs and of emotionally charged court disputes between people claiming to be parents have spurred a broad debate over the development and control of these new reproductive methods.

In the midst of these highly publicized advances, without fanfare or much notice, a novel reproductive practice of comparable social significance has arisen: self-insemination, practiced in the main by single women. Although the number of women who have performed self-insemination can only be estimated, it is surely greater than those involved in surrogacy, in vitro fertilization, and surrogate embryo transfer combined. More significant than the statistics, however, is the social consequence of the act: reproduction under circumstances entirely of the single woman's own choosing. Unlike reproduction through sexual intercourse, the prospective mothers need not have the cooperation of a man, and unlike artificial insemination as traditionally practiced, they do not need to be accepted as "patients" by a physician.

This practice presents two important challenges to the conventional classification of artificial insemination as a medical procedure. First, self-insemination, by its very success, questions the need for a doctor's technical skills. Since its inception, physicians have learned, performed, and taught the technique. They have also billed for it, and they have controlled the circumstances of its use, including the selection of women to be inseminated. The success of lay women in performing artificial insemination on their own raises the question of why the technique should be performed by doctors at all.

The second challenge addresses the traditional understanding of the purpose of artificial insemination. In keeping with its status as a medical procedure, the technique has until now been regarded as therapy for couples suffering from the medical problem of infertility. However, the single woman who successfully uses the technique to have a child on her own is not infertile, nor is the technique used to compensate for the infertility of any particular male. Short of cloning, the insemination of the single woman is as close as our species can come to parthenogenesis, and the practice forces us to confront a cluster of key social and moral issues concerning parenthood and reproductive freedom that either do not arise or are obscured when artificial insemination is used within the context of a conventional nuclear family.

Together, these challenges require a thorough rethinking of the practice of artificial insemination. They require prospective mothers,

clinical specialists, governmental regulatory bodies, the courts, and society at large to reconsider the role assigned to the technique both in medical practice and mores and in laws regulating family relationships. Indeed, the challenge to the medical status of artificial insemination is not restricted to the case of the single woman; more broadly, it leads us to question whether artificial insemination need be performed by a physician even in the case of infertile couples. In this article, we examine the rise and partial decline of artificial insemination as an exclusively medical practice. We briefly review the historical development of insemination, focusing in particular on physicians' understanding of their role. We then chronicle the challenge posed to the existing medical monopoly by the steadily growing number of women who, finding physicians' services unavailable, unwelcoming, or too expensive, have discovered that they could easily learn the technique themselves. The implications of their successes for a series of policy questions concerning the status of artificial insemination as a medical procedure are discussed in the final section.

The issue of medicalization of artificial insemination is closely linked to an important question about family structure: what social policy should be adopted on the deliberate creation by single women of fatherless families. The link derives from the fact that most women who have chosen to self-inseminate have been single women; indeed, until recently, self-insemination was the only way in which most single women could be inseminated. Objections have been raised to this practice on the premise that the offspring suffer; it has also been opposed as contributing to society's welfare burden and to a weakening of the family unit. Insemination of the single woman also poses a serious question about the status of the sperm donor, whose role as "father" is not supplanted by a husband, as in the traditional use.

These questions bear on the issue of demedicalization of artificial insemination, to which this article is devoted, as one consequence of demedicalization is easier access to insemination by single women. However, the ethical and social issues involved in the insemination of single women deserve an essay in their own right, which we must leave to another occasion.

The consideration given here to the medicalization of artificial insemination, however, does shed light on some wider questions. The exotic and impressive science involved in the new ways of making babies has led some observers to believe that technological progress has actu-

ally created the key moral and social dilemmas by itself and stands to determine their resolution as well. Self-insemination practiced by single women counters this impression. For self-insemination is determinedly low-tech, nearly no-tech, available to any woman with access to ordinary kitchen utensils and the address of a cooperative sperm bank. Yet self-insemination raises the same profound questions about family mores and the control of reproduction as those prompted by the more advanced technologies. By removing the illusion of technical necessity for medical control over artificial insemination, we can make plain the social issues involved and thus transfer the debate to the public domain from that of the experts.

Artificial Insemination as a Medical Procedure

Although some of the fertility-enhancing measures used in artificial insemination by husband (AIH) require the medical scientist's technical skills, artificial insemination by donor (AID) can be performed safely and effectively by lay people without special equipment. Turkey basters, a common kitchen utensil, are adequate instruments, and, in any case, the physician's syringe is readily available. Insertion of the syringe or turkey baster is quite uncomplicated. For females with no reproductive problems, vaginal deposit is as effective as any other technique (Behrman and Kistner 1975; Mazer and Israel 1961; Potter 1958; Stone 1980). Sterile technique is not required to avoid infection (and of course is also not present with sexual intercourse). Physicians' skills are not required to make use of semen obtained from sperm banks; in any case, fresh semen can be used, although, as with sexual intercourse, the possibility of AIDS infection or other sexually transmitted disease must be taken into account. Thus the status of artificial insemination as a medical technique, as opposed to, say, appendectomy or radiotherapy, is a phenomenon that needs explanation.

What accounts for the continuing classification of artificial insemination as a medical procedure? We suggest six complementary explanations for the physician's role.

1. Physicians investigating reproductive physiology and seeking to alleviate infertility were the first to develop the technique of insemination.

2. Physicians and patients have believed that physicians' skills were helpful or essential in performing insemination.

3. Insemination was until recently sought only as a remedy for a married couple's infertility, a (presumably) medical problem that brought the couple to seek the help of specialists.

4. These couples valued important benefits, such as confidentiality, which physicians could offer because of their professional status.

5. Financial incentives have been sufficient to induce physicians to offer the service.

6. The physician's role has been buttressed by the legal framework regulating artificial insemination, delegating authority to physicians practicing insemination to act as *de facto* agents of social control.

Our explanation for the traditional classification of artificial insemination as a medical procedure is that it began that way, by dint of its development by physicians, and that it remained medical because this arrangement met the perceived needs of clients, physicians, and society. Although some physicians have adamantly insisted that only physicians ought to perform insemination, there has not been any organized effort by physician groups to retain their hegemony. Indeed, inertia, in the form of unquestioning adherence to conventional thinking, may be cited as an additional factor, as may the social mores that all but precluded the insemination of unmarried women who wished to have children on their own. The recent turn to self-insemination by some single women counters both of these factors, and thus provides the occasion for a reconsideration of the status of insemination as a medical procedure. In this section, we explore the reasons for the physicians' original and continuing role in insemination, all of which must be taken into account in any policy decision on the desirability of demedicalizing the technique.

Insemination as Experimental Medicine

Although the key concepts were in currency long ago—the possibility of conception due to the presence of semen in bath water is raised in the Talmud (Finegold 1964), and Arab horse breeders were said to have practiced artificial insemination on mares in medieval times (Rubin 1965)—there is no record of artificial insemination having been

practiced on humans until the late eighteenth century (Home 1799). The performance of that insemination was directed by a leading experimental surgeon, John Hunter, and all contributors to the early literature on insemination in humans were physicians and medical scientists (Poynter 1968).

The leadership of physicians in developing artificial insemination stemmed from their roles as scientists interested in the body's functions and as healers consulted by infertile couples. Although such landmarks as the discovery of the spermatozoa in 1677 (Poynter 1968) were only marginally relevant to insemination technique, other information on the reproductive cycle, particularly regarding its timing, was essential.

The physicians who first experimented with artificial insemination were sometimes ill informed on this point. Dr. Marion Sims, a nineteenth-century pioneer, believed that ovulation occurred during menstruation, which might explain his 4 percent success rate (Gregoire and Mayer 1965; Sims 1871). Some authorities insisted that conception required the female to attain orgasm (Ellis 1910). Physicians were mistaken on technique as well. Some held erroneously (and dangerously, given the risk of infection) that insemination could succeed only if the semen were placed within the cervix (Stone 1980). As late as 1905, physicians in Cologne assured a court that artificial insemination was a medical impossibility (Rohleder 1934).

Nevertheless, physicians experimenting with artificial insemination, particularly in France but also in the United States and England, succeeded often enough to establish insemination as a topic fit for leading medical journals and, not far into the twentieth century, as an accepted mode of treatment for infertility (Poynter 1968).

Perceived Medical Benefits

Medical hegemony over artificial insemination was sustained in part because both physicians and patients continued to believe that medical skills were essential for the technique's success. Through the middle of this century, physicians devoted much attention in their treatises on the subject to specifying the precise manner in which the semen was to be transported to the cervix (Schellen 1957). The physicians were mistaken in believing that only they could insert the semen properly. However, as they developed the knowledge base needed for screening donors for

genetic problems and for semen-transmitted disease, their technical skills did offer a significant benefit to their clients.

Doctors as Infertility Experts

Insemination has traditionally been used as a remedy for infertility within the context of marriage. Because lay people are not ordinarily able to determine on their own the cause of their inability to conceive a child, their problem leads them to establish a therapeutic relationship with a physician. The physician consulted may also be engaged after conception to oversee the management of the desired pregnancy. Donor insemination performed in this context is thus but one of the "medical" services offered by the physician, although it is applied to the reproductively healthy marital partner rather than to the one with the medical problem.

Benefits for Patients due to the Physician's Professional Status

An important factor supporting the doctors' role in artificial insemination stems from their status as medical professionals. One benefit that the doctor can bestow is a sharing of the medical ethos. With artificial insemination by donor, medical control converts sin into therapy. This conversion is necessitated by the ambiguities of the relationship of the donor to the inseminated woman. The brute fact is that the inseminated woman, if married, carries a fetus genetically unrelated to her husband—which some interpreted as being pregnant with another man's child. If artificial insemination is to be accepted by those loyal to conventional morality, it must be authoritatively cleared of any association with adultery (*Lancet* 1960).

Early critics of artificial insemination insisted that the practice *was* a sin, even if performed by physicians. A French judge stated in 1883: "It is important for the dignity of marriage that such procedures should not be transferred from the realm of science to that of practice and that the law could not sanction obligations based on their use" (Poynter 1968). Over time, however, the public came to accept the notion that the involvement of doctors, particularly doctors specializing in the treatment of infertility, changed the character of the act. "I have to

overcome this feeling about another man," said one husband in a recent study. "Carly won't be cheating on me. She will be lying in a doctor's office, getting a medical treatment" (Baran and Pannor 1989).

The doctor's professional status also confers concrete advantages, which, as sociologists Snowdon and Mitchell show in their study, *The Artificial Family* (1981), would otherwise be difficult for many couples to secure. If the couple wishes, the entire intervention can be kept a secret. No one need know that the husband was not the father. Use of the physician also resolves the otherwise difficult problem of obtaining semen, and promises the mutual anonymity of the semen donor and the inseminated woman. Management of the relationship (or ensuring the lack of relationship) between donor, mother, child, and husband, if any, is a key factor in assuring that the transaction will be satisfactory to all parties involved—indeed, of making the procedure an attractive prospect. Physicians who take on this task thus provide what is for many women an essential service. The physician is also present to deal with the special emotional needs of women following this path to pregnancy. For many "patients," these benefits of medical management of artificial insemination more than outweigh the financial costs and partial loss of control and privacy that may also be entailed. The physician's ability to offer these benefits, in turn, entrenched the profession's dominant position in the practice of artificial insemination.

Source of Income

As with most medical services, the prospect of adequate compensation may induce some physicians to offer artificial insemination. The busiest (those with at least 100 patients per year) practices surveyed by the Office of Technology Assessment (OTA) of the U.S. Congress reported per patient costs of \$133 per insemination, along with \$521 for initial consultations, examinations, and testing. The average patient receives seven inseminations, making the total charges at these practices \$1,718 (U.S. Congress, Office of Technology Assessment 1988a). Doctors who do fewer inseminations charge less, perhaps because they are more likely to use frozen semen, to screen donors, and to be hospital based (Alta Charo, personal communication, March 1988), but the average reported from all doctors surveyed whose practices were primarily AID (75 percent or more) was \$1,105.

Social Control Function

Finally, physicians performing artificial insemination have received support in both law and custom by acting, if unwittingly, as agents of social control. Physicians have used their decision-making authority to screen donors according to social as well as medical criteria. One function has been protection of public health and safety, which was cited by the California Court of Appeal in upholding the legislative requirement for physician involvement in insemination.¹ Beyond this medical role, however, physicians have guarded the public's purse, its common morality, and its social structure by acting as gatekeepers, refusing to inseminate candidates whom they have felt unfit to the task. "Artificial insemination is one phase of medicine in which the physician may honorably refuse to attend a sick patient," counseled a text published over 25 years ago (Finegold 1964). This phrase is unintentionally revealing, for the "patient" in artificial insemination is not at all "sick." The physician's judgment in refusing to inseminate the woman is essentially a eugenic judgment, in the sense that it is a decision on who should bear children, ostensibly made on society's behalf.

Some of these gatekeeping functions are mandated by law. Statutes in several states require that the physician obtain the written "request and consent" of the husband, if any, before insemination is performed (Donovan 1982-83).² In 1981 the Wisconsin legislature passed a bill (vetoed by the governor) amending the definition of professional conduct to bar "the provision by a physician of artificial insemination to any woman who the physician knows, or has reason to believe, is receiving Aid to Families with Dependent Children . . . or medical assistance . . . or would be eligible to receive aid . . . as a direct result of the birth of a child conceived by means of artificial insemination."³

In the main, however, the restrictions placed by physicians on the exercise of artificial insemination are determined by their own personal sense of professional responsibility. Despite the difficulty of assessing the mothering ability of a nulliparous woman, nearly every comprehen-

¹*Jhordan C. v. Mary K.*, 179 Calif. App. 3d. 386 (1986).

²*Conn. Gen. Stat. Ann.* sect. 45-69g(b) (1981); similarly *Kans. Stat. Ann.* sect. 23-128 (1981) and *Okla. Stat. Tit.10* sect. 553 (1981).

³Budget Adjustment Bill SB 783, 1982, sect. 85m.

sive medical treatise on artificial insemination over the years has cautioned their physician readers to take this responsibility seriously.

This literature provides little extended discussion of criteria for acceptance of women as "patients" (Kerr and Rogers 1975), but if the published accounts are representative, selection seems to have been idiosyncratic. One authority insisted that the woman to be inseminated have an IQ of 120 or more (Schellen 1957). Another authority provided a catch-22, stating that "all stereologists agree that applicants for artificial insemination should be honest and should stand in good repute morally," but holding also that these honest parents must be counted on to lie: "Another important trait for which we must search is the ability for the pair to keep confidences. One of the great values of A.I. is its secrecy. Couples who will expose to friends and relatives the fact that their child is not the biological issue of the husband must not be invited to partake of the procedure" (Finegold 1964). Physicians were advised to ensure that "the wife must not be using a demand for donor insemination as revenge for her husband's failure to give her a child" (Kerr and Rogers 1975). Others called on the physician to ascertain whether the couple would be financially capable of paying for the child's education. One physician made a point of requiring the prospective parents to hand over an insurance policy for this purpose before she would inseminate the wife (Schellen 1957). At least two well-known practitioners required both husband and wife to provide fingerprints so that their marital status could be checked (Finegold 1964). Couples "overly concerned about donor selection" ought to be excluded, according to one review essay, along with women over the age of 37 (Kerr and Rogers 1975). Other practitioners have insisted on evidence of the parents having a reasonable life expectancy (Snowden and Mitchell 1981).

Indeed, couples requesting artificial insemination had to jump through all kinds of hoops. For example:

A young couple, whose name indicated an Italian background, was referred to us. . . . Apparently they were forewarned that we do not perform A.I. on members of the Catholic faith. . . . During the interviews, the husband claimed that both he and his wife were Unitarians.

Detecting that we were suspicious, the wife blurted, "Oh doctor, you know we are Catholic. Why should that make a difference?" Af-

ter prolonged debate, we were able to convince the couple that adoption was the best solution for their problem. . . . (Finegold 1964)

Although most physicians do not seem to have taken it upon themselves to decide whether their clients' religious faith made artificial insemination advisable, most of the guidance found in the literature urged stringent gatekeeping. Even the pioneering Dr. Alan Guttmacher (1960) advised: "Only a small percentage of patients applying qualify for so radical a social procedure. When a doctor consents to do an artificial insemination from an unrelated donor, it is really the couple's insignia of good character." The judge was presumably to be the individual physician.

A key social-control function performed by these physicians in their gatekeeping role was denial of insemination to single women. These women's quest was premised not on the need for help with infertility, but rather on the desire for a child in a nonstandard family context. In the view of physicians writing for fellow physicians, however, the woman's personal reasons for wishing to become pregnant through artificial insemination were irrelevant; what counted were the medical "indications" of "treatment." A 1975 treatise, for example, states without qualification: "The only true indication for artificial insemination is the psychologically and physically normal female married to a psychologically healthy male who has, for whatever reason, total azoospermia" (Behrman and Kistner 1975). The other "indication" mentioned in the medical literature is a family history of genetic disease in the husband (Behrman and Kistner 1975).

Physicians who have written on "indications" and selection criteria for artificial insemination have provided no acknowledgment of serving as society's agents. Nor is there any explicit recognition of an informal contract providing for medical monopoly in exchange for exerting social control of reproductive choice. This literature suggests that physicians understood these social judgments to be medical ones, although one discussion pointed out that they were "clearly ill defined and subjective" (Kerr and Rogers 1975).

This social agency has been a latent function of medical control. It is a product of the physician's sense of professional responsibility in making decisions regarding their patients' reproductive plans. Over the

years, physicians' sense of what this responsibility entails has changed. The American Fertility Society (AFS), which regularly updates its guidelines for the use of semen donor insemination, has recently substituted "male partner" for "husband" throughout the document (Moghissi 1990). What has not changed, however, is the physicians' assumption of responsibility and control. The "indications" for insemination in the AFS guidelines all refer to medical problems of the male partner rather than to the wishes of the prospective mother. So long as the doctors' domination of insemination remained unchallenged, however, the social character of these "medical" guidelines remained invisible.

The Challenge to Medical Hegemony

As a clearer understanding of the mechanisms of artificial insemination emerged, it became obvious to physicians that lay people could perform the technique on their own. One standard text found this troubling:

The technique of artificial insemination is simple. In fact one of the hazards of the procedure is the ease of its performance. Since very little medical training is necessary and no elaborate instruments are required, artificial insemination can fall into the hands of charlatans and quacks. (Finegold 1964)

Nevertheless, there have long been dissenters to the orthodox view that artificial insemination must be performed by physicians within the medical community itself. The first recorded insemination of a human being was performed at home by the "patients" themselves, following their physician's advice (Home 1799). Much later, the English physician Mary Barton, for example, insisted in 1945 that "any intelligent woman, once fully instructed, is capable of recognizing the ovulatory phase [of the menstrual cycle] by the low level and/or the peculiar preluteal drop in the waking temperature. [Accordingly,] the wife is instructed how to record her rectal temperature throughout the menstrual cycle on waking"—"the wife is taught to carry out self-insemination within the fecund phase of the cycle" (Barton, Walker, and Wiesner 1945). Another physician, F.G. Lane (1954), published an article forthrightly entitled "Artificial Insemination at Home," recommending this

venue because it “makes artificial insemination more acceptable to some couples.” Until recently, however, these seem to have been minority views.

The current challenge to the status of artificial insemination as a medical procedure comes not from physicians but from single women who, like the woman quoted at the beginning of this essay, sought to achieve insemination without the cooperation of physicians. Their success in achieving pregnancy through insemination without medical help was initially known only to a limited number of feminist activists, but is now familiar to a wider public.

Sources of the Current Movement

The roots of these changes in artificial-insemination practice date from the unparalleled social experimentation of the 1960s, and from the concomitant rise of the women’s movement. The most direct causes of these changes were cultural and political. The 1960s distrust of elites and insistence on accountability and greater democratization led to challenges to all sorts of professionals, with medicine being a special target. This was an era in which patients asserted their rights, challenging the assumptions of earlier generations that physicians should be entrusted to fashion answers for patients even to the mortal questions of life, death, and reproduction. The rise of medical ethics as a discipline and as a subject of public debate was premised on the denial that physicians had, by dint of their professional status, any special claim to superior knowledge or insight into matters of values. The physician’s monopoly over the performance of insemination was contested: the self-help movement, abetted by some physicians, attempted to distinguish between procedures and responsibilities that necessarily called for the physician’s specialized education and those that the patients could be educated to take on themselves.

The second important phenomenon of the 1960s was the women’s movement, which revived feminism in a much more assertive form. The threat to medical hegemony over artificial insemination arose when feminism begat the women’s health movement, which aimed at autonomy, empowerment, and self-help. Women’s health clinics, often run by lay women and organizations, taught many thousands of women techniques for self-care (Ruzek 1978). A huge audience was alerted to these possibilities by the success of *Our Bodies, Ourselves*, published

by one such group (Boston Women's Health Book Collective Staff 1976). Before there was any thought of self-insemination, these clinics were teaching women to time ovulation through the use of basal body temperature (BBT), to maintain records of BBT and of changes in cervical mucus (the distinctive mucus secreted from the cervical os prior to ovulation), and to use the speculum and mirror to see and feel the widening of the cervical os as ovulation approaches.

Although this was done to enable the women to practice safe contraception, Mary Barton had taught the same techniques to her patients many decades earlier to help them to self-inseminate. Thus the stage was set for self-insemination when a number of women became interested in becoming single mothers; just as contraception permitted sex without procreation, insemination led to procreation without sex. Medical help was not always welcoming or welcome. Many physicians flatly refused to provide the service to single women. Thus the prospect of becoming pregnant through insemination without the help of doctors was an attractive one.

The first attempts by women to appropriate artificial insemination are difficult to date with precision. The existence of a group of California women experimenting with self-insemination was discovered in the late 1970s by one of the authors (NW) in the course of research on childbearing decisions by career women. One woman's experience was documented in that book (Fabe and Wikler 1979). In 1978, staff physicians at the Feminist Women's Health Center in Los Angeles began to provide semen ordered from a commercial sperm bank (which required a physician's order) to women requesting insemination (Hornstein 1984).

About the same time, a group of women met in a London pub to discuss an article on artificial insemination published in the *Evening News*, which had emphasized the need for medical supervision (Klein 1984). That group conscientiously researched the issue, conducting library searches and asking medical authorities whether the procedure carried risk. After their research turned up no compelling reasons for relying on doctors, members of the group made their own arrangements. One was told that "you could buy an inseminator from John Bell and Croydon in Wigmore Street" for seven pounds. Semen was donated by male friends. After a time of experimentation with methods and venues—the initial transfer point for the semen was a subway station (Feminist Self-Insemination Group 1980)—the women arranged

to use a room in the house of a member of the men's support group. Several pregnancies resulted.

A key to success with self-insemination, indeed, has been locating a supply of semen. In the era before AIDS, the donors were often male friends or sympathizers. Because many women did not want a future relationship with the donor for themselves or for the child, go-betweens were sometimes used. These friends agreed to find a donor with the desired characteristics. Even this arrangement presented risks, however, because the go-betweens carried with them a hugely important secret and usually lacked the privilege and duty of confidentiality that a physician ostensibly possessed. As a result, some women used go-betweens to contact a second party, who in turn contacted a semen donor (Kern and Ridolfi 1981-82).

A further development in the United States has been the establishment of sperm banks controlled by women. As far back as 1975, the Vermont Women's Health Center had added artificial insemination by donor to its services, but semen had to be obtained from private donors or from existing sperm banks with the assistance of sympathetic doctors. In 1980, the Northern California Sperm Bank was opened in Oakland, California, with the express purpose of providing semen to unmarried as well as married women; it also serves women regardless of sexual preference or physical disability (Hornstein 1984). Seventy-one percent of its clients are single, and the bank ships frozen semen directly to women throughout the country (Gore and Raboy 1986). The advent of overnight parcel delivery services has even made it possible for women in rural areas to be supplied by distant sperm banks using semen frozen in dry ice. The organization was established to enhance women's control over their bodies, to provide a greater choice of donor characteristics, and to furnish a personalized, "homey" atmosphere for on-site inseminations. The organization provides the means for the child to identify the donor if both child and donor so desire (Vermont Women's Health Center, personal communication, December 14, 1983). The sperm bank does, however, screen the recipients. Women who are emotionally disturbed or addicted to drugs or alcohol are referred for counseling, although they may be accepted after completing therapy. Of the fifteen sperm banks surveyed by OTA, most agreed that marital status was not a reason to deny a patient's request for insemination, and a third reported that they sell semen to both doctors and patients (U.S. Congress, Office of Technology Assessment 1988a).

The AIDS epidemic, which introduced an element of risk to any insemination using fresh semen, has greatly increased the importance of sperm banks in nonmedical insemination. Although not even the most stringent precautions of these banks can totally eliminate the risk of contracting AIDS through insemination, self-inseminators with access to the sperm banks take no greater chance than those inseminated by physicians.

The simultaneous occurrence of self-insemination in England and the West Coast of the United States indicates that the idea had become widespread. The phenomenon is no longer a secret. Hundreds of women in the San Francisco area have participated in six-week groups for single women considering parenthood (Pies 1985). A conference on the subject attracted several hundred interested women, and hundreds more had to be turned away. A kit for self-insemination has been displayed on the BBC (Snowdon and Mitchell 1981). Network television shows in the United States, including the popular "Donahue" and "Today" shows, have featured single women considering self-insemination, and the topic has turned up in a Broadway comedy revue. Manuals and books (including *Having a Baby Without a Man* [Robinson and Pfizer 1986], a lucid guide coauthored by a physician) have begun to appear. A book on parenting for lesbians assumes throughout that the method of conception will be artificial insemination done at home (Pies 1985).

So free of medical context has insemination become in these circles that it is invariably mentioned in connection with the turkey baster. Pies reports in her book (1985): "This has been an unfortunate association and has been the source of a great deal of anger . . . among mothers, their friends, and support networks." However, the same author quotes another view more in keeping with the quotation at the beginning of this article: "Some women have especially loved using the turkey baster as a means of redefining a female cooking tool, changing it from a tool of 'keep her in the kitchen and pregnant,' to one of woman-controlled conception" (Pies 1985).

Legal Support for the Medicalization of Artificial Insemination

The advent of self-insemination has begun a process of de facto demedicalization. This process is hindered, however, by continued medical-

ization de jure. Any social-policy decision supportive of lay insemination will have to include a reconsideration of the laws that have supported a leading role for physicians.

For the most part, the role the statutes give to doctors was incidental to the purpose of providing clear legal designation of the (social) parentage of the offspring. Compelling women to use the services of physicians was not the motive for the legislation; indeed, the laws were framed to apply to married women, who are more likely than single women to use doctors' services in any case. Once enacted, however, the laws applied to single women and others who have reasons to avoid the medical system. It is a historical coincidence (and irony) that new legislation was providing legal recognition of the doctor's role at the same time that the women experimenting with self-insemination were not only rejecting medical control, but, in effect, demonstrating the lack of any inherent rationale for it.

The artificial-insemination statutes recognize the doctor's role principally in the course of defining the role of donor. Many of the statutes hold that the donor will have none of the rights or responsibilities of fatherhood, so long as the insemination is carried out by or under the supervision of a licensed physician. The donor's role in inseminations done without medical help is left unspecified. Unless care is taken to ensure that the donor is kept ignorant of the identity of mother and child, therefore, women practicing self-insemination may face the possibility that a court would award a donor parental rights. In a recent California case, a donor was awarded visitation by a court because the insemination had been arranged nonmedically; the decision was upheld on appeal.⁴ Absent the medical auspices, the insemination was treated no differently from sexual intercourse, an act that creates rights and responsibilities for the father regardless of the initial intent of either parent.

Some state regulations are more explicit in their intent to provide an exclusive role for physicians. One section of New York City's 1947 health code forbade anyone but a doctor to collect, offer for sale, sell, or give away semen for artificial insemination (Sergeant 1970). Twenty-one states have laws explicitly requiring that artificial insemination be performed by physicians (U.S. Congress, Office of Technology Assessment 1988b). Oklahoma's statute, for example, specifies, "No person shall perform the technique of heterologous artificial insemination un-

⁴*Jhordan C. v. Mary K.*, *supra* footnote 1.

less currently licensed to practice medicine in this State;”⁵ other statutes are similar. Oregon requires that physicians select the semen donors.⁶ A bill introduced in the California Assembly would have required anyone receiving semen from a sperm bank to be inseminated by a licensed physician; the clause that specifies this was added at the behest of the California Medical Society.⁷

Most of these laws do not specify any penalties for persons other than physicians who perform artificial insemination. Three states, however, do. Georgia makes nonmedical artificial insemination a felony; in Idaho and Oregon it is a misdemeanor. The American Fertility Society’s board of directors once proposed model legislation that would provide fines and jail sentences to anyone other than a physician or person under a physician’s supervision who performed artificial insemination, but no state enacted it.

Some legal analysts read the existing statutes as implying penalties for nonphysician artificial insemination even when none is specifically stipulated. Because they require physicians to perform the procedure, artificial insemination done by others would constitute the practice of medicine without a license. Even in states lacking such statutes—indeed, even in states having no statutes on artificial insemination—it is still possible that nondoctors who perform artificial insemination could be held to have practiced without a license because artificial insemination is usually regarded as a medical procedure (Kritchevsky 1981; Shaman 1980). In the United Kingdom, the offense is not performing medical acts but falsely holding oneself out as a doctor (Somerville 1982). The actual impact of these statutes is difficult to assess because self-insemination is an inherently private activity, and detection of those who violate laws requiring medical supervision would be difficult.

Ironically, the artificial-insemination statutes that do not expressly proscribe self-insemination may have as great a medicalizing effect as those that do. By denying the women and their offspring the legal protections they offer those who use doctors, the statutes leave the women open to problems over parental rights; the donors, for example, can

⁵ *Okla. Stat. Ann.* (1982), Artificial Insemination, 10 553.

⁶ *Oreg. Rev. Stat.* #677.365 (1977).

⁷ Assembly Bill 1011 (1983), an Act to end chapter 4.5 to Division 2 of the Health and Safety Code Relating to Sperm Banks.

sue (and have sued⁸) for visitation and even custody. Statutes specifically addressing married couples, in contrast, strip the donor of rights and responsibilities and bestow these upon the husband. These statutes do not automatically exempt the donor of sperm to single women from the usual responsibilities and rights of fatherhood. The Ohio statute specifies that the donor's rights and responsibilities are null even if the recipient is unmarried, but other state statutes are less clear on this point (U.S. Congress, Office of Technology Assessment 1988b, 246).

This prospect, in fact, presents the unmarried woman with two concerns. First, she may have chosen to become pregnant through artificial insemination rather than through sexual intercourse with the donor precisely because she did not want the man involved in her or her children's lives. Second, she may be especially vulnerable to custody challenges because of the very factors that led her to self-inseminate—her status as a single mother or, particularly, as a lesbian. Thus the women most likely to be interested in self-insemination would be most deterred from doing so by these statutes if they believed that the laws would be enforced to the letter (Donovan 1982–83). The safer alternative would be to use a doctor's services, if the woman could prevail on a physician to make these available, or failing that to remain childless. The effect of the laws, to the extent that they are enforced, is to create a legal role for the physician in artificial insemination where no medical rationale exists. Indeed, passage of this legislation portends a legal trend toward medicalization even as more people, including many physicians, understand and accept the lack of any medical necessity for a doctor's role.

Should Artificial Insemination Remain Medicalized?

Medicalization, as portrayed in the works of sociologists such as Irving Zola and Eliot Freidson, is a process by which medical concepts such as "healthy" and "ill" attach to an ever-increasing part of daily life, thereby bringing these phenomena under the jurisdiction and control of medical professionals (mainly physicians) and medical institutions

⁸ *C.M. vs. C.C.*, 152 N.J. Super. 160, 377 A.2nd A21 (1977); see also *Jordan C. v. Mary K.*, cited in footnote 1 *supra*.

(clinics, hospitals, and research centers) (Freidson 1970). In consequence, circumstances of the doctor's work dictate that services are provided in clinics and medical suites, and are segmented into billable episodes. Most important, medicalization brings about a subtle, even invisible, alteration of decision-making authority. Physicians take over what Zola (1981) described as "priestly functions." Although the physician operates in the zone of societal taboos, the medical ethos is one of value neutrality. Morals are discussed in clinical terms, and ethical decisions are characterized as medical judgments, with physicians viewed, by themselves as well as by others, as neutral arbiters of moral values. Ethical choices that are recognized as such are viewed as governed by a code of medical ethics, a sense of duty and responsibility internal to the profession, whose social character is left obscure.

The intimate nature of artificial insemination, stemming from its connection to childbearing, sexuality, and private body parts, has made the practice congenial to the medicalization process. This has had certain inherent advantages, both for parents and for society, but it has not been an unmixed blessing. It needs to be debated on its merits. Unfortunately, medicalization tends to preclude this necessary questioning. The process bestows decision-making authority on a powerful "priestly" class, the physicians, who have interests of their own at stake and who may be loath to contemplate demedicalizing the technique. More subtly, medicalization creates the illusion of necessity, engendering the belief that medical hegemony is part of the natural order of things and perhaps even founded on science. It effectively removes from the political agenda matters that should be democratically decided.

Artificial insemination is a particularly transparent case of medicalization. Decision-making authority has been vested almost entirely in doctors although the medical expertise actually required is nearly nil. Its medicalization has also been remarkably effective. Discussions of the desirability of medical control are almost entirely lacking in the literature on artificial insemination. To this end, we survey the benefits and drawbacks of medical hegemony for this technique.

The Individual's Interests

Social and Legal Advantages. Viewing artificial insemination by donor as a medical procedure has offered numerous social benefits to some prospective parents. In maintaining secrecy, in obtaining donated

semen, and in vesting the procedure with their aura of objectivity and moral neutrality, physicians have protected their "patients" from the chilling effect of traditional social mores. Indeed, doctors stayed one step ahead of the public in introducing, first, artificial insemination by husband and then artificial insemination by donor. Doctors, rather than infertile couples, could "take the heat"; insemination may not have been accepted if it had first been tried outside the medical domain.

Although still condemned by Catholic doctrine, artificial insemination is now accepted in all but the most conservative quarters. In this respect, the physicians have done their job well, and patients no longer need to draw on their moral authority. Married and single women alike can draw on sperm banks and keep their dignity intact. Some women may prefer physician involvement because of the confidentiality physicians can offer, but they may be able to devise their own ways of keeping the insemination a secret. The prospect of these advantages, in any case, does not argue for making a physician's role compulsory; women can decide for themselves whether being inseminated under a doctor's direction is worth the various costs.

Many of the social advantages of medical insemination, in any case, do not accrue to single women. Unlike married women, they need not concern themselves with the kinship of donor insemination and adultery, nor can the doctor help keep secret the fact that the child is born out of wedlock. Although single women could benefit from an orderly and lawful assignment of parental rights and responsibilities, such as has attended artificial insemination practiced by physicians for couples, lawyers could be of more help in this matter than physicians.

Health and Safety. Because physicians offer no important advantages in safety or efficacy in the insemination itself, the only medical justification for the doctors' role must rest on the screening they perform on donors and their semen, particularly with regards to AIDS. It must be kept in mind that the risk of contracting AIDS from informally obtained fresh semen is not necessarily greater than the risk posed by sexual intercourse, which thus far has remained unmedicalized, because donors can be informally screened just as lovers can. Still, protection from AIDS may be a reasonable motive for many women to seek medical assistance.

The threat of AIDS, however, is not sufficient grounds to *require* that artificial insemination be performed by physicians. Prescreened se-

men may be made available to individuals directly from sperm banks. Moreover, questions have been raised about the quality of the screening done by many physicians.

Doctors' screening activity in the United States has been surveyed twice in the past decade. A survey published a decade ago found that "the donors . . . were subjected to very little genetic screening. Family histories were usually superficial, and biochemical tests were rarely performed" (Curie-Cohen, Luttrell, and Shapiro 1979). The survey also found important gaps in the knowledge of even those practitioners who did screen: "71.4 [percent] would reject a donor who had hemophilia in his family, even though it would be impossible to transmit this X-linked gene unless the donor were affected . . . the severity and genetic risk of the conditions were not reflected in the frequency of use for donor rejection" (Curie-Cohen, Luttrell, and Shapiro 1979). The 1988 OTA survey (1988a) also found that physicians barred some donors for genetic diseases that the donors could not transmit and failed to screen out donors whose family histories indicated a high risk of carrying cystic fibrosis, the most common genetic disorder among American Caucasian children. Physicians generally did far less testing than did sperm banks (U.S. Congress, Office of Technology Assessment 1988a).

Indeed, the need to test for AIDS contamination provides a reason to obtain semen from sperm banks rather than from physicians who provide semen directly from donors who may not have been adequately screened. Serologic tests of sperm donors for AIDS require a lag time of three months or longer (Mascola and Guinan 1987), leading some physicians to rely exclusively on frozen semen (Sherman 1987). Other physicians, acting on the belief that success rates with fresh semen are much higher, continue to offer this service in conjunction with thorough history taking as well as serologic testing of the donors (Schlaff 1986). Women inseminated in medical practices have been exposed to AIDS-contaminated semen, even in university programs using rigorous screening procedures (Anonymous personal communication from the chief of a fertility clinic, June 5, 1986). The OTA survey found, however, that some physicians were not testing for HIV in the donors they used, whereas all sperm banks did (U.S. Congress, Office of Technology Assessment 1988a). The decision to trust a physician's screening over that of a sperm bank is not without risk, especially when the physician is less familiar with the details of the screening procedures. Indeed,

physicians commonly use sperm banks themselves. The OTA survey (1988a) showed that six of ten physicians used frozen semen during the survey year; about three quarters obtained the semen from a commercial sperm bank.

Of course, one might draw from these findings the conclusion that physician performance in screening donors should be improved, rather than that physicians may just as well be avoided. Physician involvement offers other benefits as well. For example, the interaction with the client may establish a doctor-patient relationship that extends to the care needed during pregnancy. Moreover, the doctor may be able to help the woman in her emotional accommodation to becoming pregnant through this unorthodox method. Once again, however, these benefits offer more support to a policy of making medical insemination available than for making it compulsory.

Cost. Counting against any medical and nonmedical benefits of medicalization is the need to pay the doctor. Half of the women receiving insemination through doctors have no insurance that covers the procedure, according to OTA data, and those with insurance still must pay 52 percent of the costs out of pocket (U.S. Congress, Office of Technology Assessment 1988a). The average cost of \$953 must be a deterrent to lower-income women, many of whom have no insurance (endnote 1). Indeed, as the nation struggles to contain the cost of health care, medicalized artificial insemination may come to seem an expensive luxury, one with an aggregate price tag of \$87 million for doctors' services (U.S. Congress, Office of Technology Assessment 1988a). Furthermore, the cost of artificial insemination by donor and by husband totals \$164 million for the 172,000 women receiving the medical services.

Although self-insemination would be cheaper, expenses could be incurred in obtaining semen (particularly if semen banks are used). Some of these women may seek medical advice on conception and pregnancy, just as when contemplating becoming pregnant through sexual intercourse.

Intrusion and Loss of Control

Artificial insemination has not always been a pleasant experience for the "patients." Medicalization, while offering a measure of confidentiality, also involves intrusion and the possibility of some loss of control.

The first recorded instance of artificial insemination by donor, performed in Philadelphia a century ago, provides an extreme example:

At that time the procedure was so novel, so peculiar in its human ethics, that the six young men of the senior class who witnessed the operation were pledged to secrecy. . . . A wealthy merchant of Philadelphia consulted Professor Pancoast to learn why his home was childless. The man was forty-one years of age, of sound body as far as he knew. . . . His wife was ten years his junior, a perfect picture of health. . . . the spermatic fluid was shown by the microscopic examination to be absolutely void of spermatozoons. . . . A joking remark by one of the class, "the only solution of this problem is to call in the hired man", was probably the incentive to the plan of action which followed. The woman was chloroformed, and with a hard rubber syringe some fresh semen from the best-looking member of the class was deposited in the uterus, and the cervix slightly plugged with gauze. Neither the man nor the woman knew the nature of what had been done at the time, but subsequently the Professor repented of his action, and explained the whole matter to the husband. Strange as it may seem, the man was delighted with the idea, and conspired with the Professor in keeping from the lady the actual way in which her impregnation was brought about. In due course of time the lady gave birth to a son. . . . That boy is now a business man of the city of New York. (Hard 1909a)

Although this travesty (if it was such; the eyewitness account was later disputed [Hard 1909b]) may have remained unequaled, physician control remained a reality. The guidelines of the American Fertility Society (1986) caution doctors to discourage couples who wish to mix the husband's semen with the donor's, holding that this practice "confuses the issue" and that such "psychologic uncertainty . . . be dealt with before proceeding with insemination; this poorly supported claim has since been deleted from the Guidelines" (Moghissi 1990). The majority of doctors (91.8 percent) surveyed in one study of artificial-insemination practice do not allow recipients to select their own donors, and the rest have done so only rarely (Curie-Cohen, Luttrell, and Shapiro 1979; endnote 2). Yet, one practitioner recently reported using semen from the brother of the husband, keeping this a secret from the wives of each brother (Schoysman 1975).

Women patients, moreover, remain at the mercy of whatever procedures the physicians deem appropriate. In the past, this literally has taken the physician into the bedroom because orgasm was thought by

some to be a necessary concomitant; although the procedure occurs in the doctors' suites today, it remains an intimate undertaking in which the potential for emotional distress is real. This kind of discomfort is a recurring theme in feminist writing on their experience with artificial insemination. A woman in the London group wrote:

I felt like a spy as I handed over twelve pound notes and got in exchange a large brown envelope containing a needleless syringe and a plastic bottle with about a teaspoonful of sperm in it. . . . The doctor's role was insignificant—all he did was find the donors and do some medical checks on them. But in other ways it was alienating. He had not been prepared to discuss anything and I wanted to talk with him more about the practicalities of getting pregnant. Even if I'd wanted, he wouldn't have discussed feelings. (Feminist Self-Insemination Group 1980)

Physicians offering artificial insemination to their clients can do much better than this, and many do. The Oakland feminist sperm bank, however, does one better, encouraging their clients to perform the inseminations at home in company of their choosing. Given the lack of any technical need for medical supervision, there seems to be little reason for its performance in any clinic, however welcoming.

Lack of Access. The most significant problem with medicalization for many women is the lack of access to the service. Physicians reject one in five women seeking insemination for nonmedical reasons; 61 percent refuse to inseminate single women who have no (male) partners, and even more refuse to inseminate lesbians (U.S. Congress, Office of Technology Assessment 1988a). These difficulties in access present an obstacle to becoming pregnant for women in these groups; but other women as well are affected by the indignity of having to convince the physician that she conforms to the physician's idea of what a fit mother is.

As in the past, women applying to sperm banks may have to submit to judgment of their mothering potential. The OTA study of current practices found a long list of reasons given by sperm banks for refusing a woman applicant, including criminal record, drug and alcohol abuse, psychological immaturity, and evidence of child abuse, and even for lack of a high school degree and "less than average intelligence" (U.S. Congress, Office of Technology Assessment 1988a).

However, the OTA data reveal notable differences in the degree of

rigor of screening. Most important, the sperm banks were much more likely to consider an unmarried woman, with or without a partner. Thirty-two percent of physicians reported unwillingness to inseminate women of less than average intelligence, whereas only one in six sperm banks has such a policy. Most physicians still reject lesbians; none of the sperm banks in the study does. Thus while demedicalization would not provide certain access to safe sperm for women with such problems as child abuse and drug dependency, direct use of sperm banks would permit many women to avoid having to conform to the tendency of many doctors of using personal moral values as "contraindications" to insemination.

Ought we to shun even the minimal social control applied by sperm banks' recipient criteria? Other biological products, most notably blood, are carefully screened for public-health reasons. Insemination differs from blood transfusion in that the transfer of the material can be accomplished without any medical intervention, leaving even those women rejected by sperm banks at liberty to seek sperm through informal networks. One could argue that because the selection criteria currently used by most sperm banks are not based on intrusive prejudices or moralism, the public-health protection they provide justifies a policy favoring (or even requiring, when feasible) their use by women seeking donor insemination over the use of informal networks. Such a policy, however, would impose protective controls in the case of insemination that are wholly lacking for ordinary sexual intercourse.

Society's Interests

The concerns of individual women, however, are not the only consideration; medicalization has been thought to protect public interests as well (Wadlington 1970). The social-control function of physician hegemony over artificial insemination, we have argued, has been largely unwitting. Nevertheless, some may fear that demedicalizing the technique will permit wrongful and indiscriminate use, to the detriment of important values and social interests. Physicians' insistence on strict ethical standards in the practice of artificial insemination, in this view, is a benefit to society that must not be taken lightly.

The key question, to which the tradition of medicalization of artificial insemination is but one answer, is what degree of liberty of reproductive choice women should have. Deputizing physicians to decide

which women should become mothers through insemination curtails women's liberty to make this choice on their own. Those who would place these restrictions on choice would point to the putative need to shore up traditional mores binding the nuclear family. This in turn would be justified by the potential threat that demedicalized insemination, used principally by unmarried women, would pose to the offspring. These very difficult issues must be left to a future article. In any case, there are grounds for faulting medicalization even as a means to these ends.

One is that physicians are not particularly qualified for the job. Physicians have no special education or insight into what makes a good parent. Although the medical literature on insemination uses scientific-sounding terms like "indications for treatment," the fact that single status is the most common reason for refusing insemination indicates that the standards physicians applied are often subjective, moral ones. The problem is compounded by its invisibility to the practitioners themselves. The guidelines of the American Fertility Society (Moghissi 1990), for example, currently list as "indications" for insemination (of women) a variety of reproductive problems of males (male partners or husbands). The desire of the woman to become pregnant by this means, which could perhaps serve as the sole "indication," is nowhere mentioned.

A second drawback to this strategy for social control is that physicians are increasingly reluctant to act in this role, and no longer present a united front. Physicians who continue to reject prospective mothers, whether for eugenic or other reasons, will have no power to stop them from seeking the services of more compliant colleagues. Even more to the point, the perception that one must secure a physician's cooperation to be inseminated is fading. With so many gates open, gatekeeping is likely to become a pointless exercise.

None of these considerations argues that social policy should encourage physicians to inseminate women who would be (or are married to those who would be) obviously unfit parents. The point is rather that a social policy that attempts to enforce the status of artificial insemination as a medical procedure so that physicians can sort out the unsuitable would-be parents is on balance unwise, due to its futility and to the inconsistency, indignity, and caprice that have attended "patient screening" to date.

Attempts to enforce medicalization face more general objections as

well. The medical status of insemination has thus far traded on illusions: the mistaken belief that special skills are necessary for safety and effectiveness and the unthinking assumption that artificial insemination by donor is therapy for a health problem. Perhaps certain basic myths are necessary for society to function, but generally honesty is the best policy.

Social control without medicalization might be effected by giving the gatekeeping decision to some sort of expert committee. One practitioner proposed, apparently with tongue in cheek, that to a committee consisting of "a social worker, psychiatrist, gynecologist, urologist, clergyman, lawyer, and educator, one must add a banker to this board" (Finegold 1964; see also Kerr and Rogers 1975). Mary Warnock (1985) has argued that by giving the decision to licensed centers, "at least no doctor in general practice would be obliged to establish his own criteria for accepting or rejecting people for the service . . . [and] then the terms on which the licences will be granted, the inspection of the centres, and the changing of the conditions of licence from time to time will all be ultimately the responsibility of the Cabinet Minister in whose province such things fall. And the legislation that gives him such powers will have stemmed, not from medical opinion alone, but from Parliament. There is no other authority that we have any business to recognize." This suggestion may be more plausible in the United Kingdom than in the United States, where giving an elected official direct responsibility over reproductive-matters practices is a recipe for policy paralysis. In any case, Professor Warnock admits that "this is of course to pass the buck only a very little way down;" many of the objections to medical control noted here would apply also to such licensed "centers."

Whether medicalized or not, efforts to maintain social control in insemination compound another conceptual failing of medicalizing the technique in presuming to draw a sharp distinction between insemination and sexual intercourse. The basic difference between these two phenomena, considered as routes to procreation, is simply the vessel introducing the semen. Although they have very different social and emotional meanings and vastly different social import, for many women either technique might be an acceptable route to motherhood. Does it make sense to apply controls to procreation by syringe in the midst of millions of instances of wholly unregulated baby making in the traditional mode?

The advocate of imposing controls on insemination might adopt any of three distinct positions. First, they may be overimpressed with the difference between intercourse and insemination, and therefore unreflectively assume that permitting insemination presents a different and much graver dilemma in balancing the interests of prospective parent and potential offspring than would intercourse. We hope that our discussion will undermine this view.

Second, they might hold that reproduction is not entirely a private decision when the medical profession or the state becomes involved. The justification for gatekeeping in insemination, then, is precisely that physicians and the state must exercise this function to protect their own integrity. This argument, however, reinforces the case for demedicalization. Nor will all physicians want to insist on imposing their own moral views on women whom they inseminate, if most of these women could make their own private choices by self-inseminating.

Finally, the advocates of control could simply argue that insemination should be regulated, even when intercourse is not, because this control is socially acceptable. The idea is to prevent the evil of unfit parenthood where it is feasible to do so. This argument, too, is unconvincing. Aside from the questionable assumption that the women thus prevented from becoming mothers would in fact be notably unfit, it simply ignores the widely accepted view that the decision to have a child is an individual's to make. Limitations on reproductive choice in insemination, we have argued, have been premised on a medicalized view of the technique, one that is based on a series of illusions. To the extent that demedicalization tends to blur the distinction between insemination and intercourse as alternative means for becoming pregnant, the former will increasingly be placed in the zone of privacy that has come to protect conventional reproduction.

Conclusion: A Policy of Demedicalization

Although the practice of artificial insemination has long been considered a medical technique, the rationale for this tradition has been surprisingly obscure. The reasons for having a doctor perform insemination are almost entirely nonmedical. Many of those who have been inseminated by physicians could have inseminated themselves just as

effectively and safely, and at less cost and loss of control. A growing number of women have done exactly that.

If our arguments have been convincing, it is time to begin to consider what a policy of demedicalization of artificial insemination would entail. "Demedicalization" is a process that has in certain respects been underway for nearly two decades. Thus far, however, the change has occurred largely as a result of the initiatives of the women who have performed or encouraged self-insemination, rather than any social consensus on the lack of a rationale for medical involvement. Demedicalization by design, that is, as a policy decision, would involve changes in law, custom, and public attitudes that would continue this trend. Its result could be either a modest further opening of the present system, a radical break with the past, or something in between.

A modest policy of demedicalization would be aimed at ending the vestiges of medical monopoly of the practice of insemination. At a minimum, laws, such as Georgia's, that make insemination a crime when performed by a person other than a physician would be repealed, and performing insemination would not be classified as practicing medicine without a license. Laws that deny the responsibilities and rights of donors only when the insemination is performed by a physician would be changed to omit this restriction, although demedicalization per se would not preclude other legal conditions on semen donation.

For the medical community to act in concert with this demedicalization policy, professional societies concerned with insemination would avoid any suggestion in their codes of ethics or guidelines for practice that insemination is a procedure that should be performed by physicians. Physicians could continue to offer their services, and confidentiality and other social advantages of medical performance of insemination would continue to be protected by both law and custom. Similarly, sperm banks would be encouraged to deal directly with women seeking to inseminate themselves.

Taken to the extreme, this incremental opening to nonmedical insemination could completely sever the link between artificial insemination by donor (although not by husband) and medical care, except for those women with reproductive maladies of their own. In this event, insemination would routinely follow an autonomous decision by a woman desiring to become pregnant, necessitating only a transaction with a sperm bank and an act of self-insemination. Even for married

couples, the involvement of physicians in AID would cease once the cause of infertility was traced to the husband (unless, following unsuccessful self-insemination or other indication, the wife had reason to question her own fertility).

This radical change of view regarding the relation of artificial insemination by donor to medical care is, we believe, consonant with the arguments we have advanced, but for some readers it may seem to be a *reductio ad absurdum*. This picture of radical demedicalization may conjure up images of reproductive decision making free of all social regulation and family structure; of mail-order sperm banks pitching their advertising to impulsive women of dubious fitness as parents; and, in the end, of legions of unhappy children suffering from absent fathers and genealogical bewilderment.

In actuality, however, no such conclusion follows from demedicalization itself. The controls imposed by physicians are part of a web of conditions placed by society on women seeking to reproduce through insemination, conditions imposing by statute and tradition the legal titles of "mother," "father," and "donor" on the parties involved. In important respects, current law pushes insemination toward medicalization when it relies on physician involvement to determine on whom and at what point these labels are to be applied. Such relationships, however, would need to be defined and clarified even if the practice of artificial insemination were wholly wrested from physicians.

These fears, however, are themselves revealing, for they are evidence that a chief function of medicalization is this very promise of control over reproductive behavior. So long as doctors are in charge, our society need not decide whether women should be at liberty to make their own decisions about using insemination to become pregnant. Perhaps we are thus spared a troubling examination of our own values regarding reproductive freedom, the meaning of parenthood, and the interests of children; but medicalization has been policy making by default. These are issues affecting the public at large in ways both subtle and profound, and deserve a public debate.

Endnotes

1. Judging from responses from large insurers queried by the authors, insurance-company policies on artificial insemination are not consis-

tent across the industry. One insurer never covers insemination unless it is mandated by law, or the woman has infertility problems of her own (in which case artificial insemination would rarely be effective). In such cases no distinction would be made between married and single women. Another covers AID for married women but never for single women on the ground that in the latter case AID is not being used in response to infertility.

These intricacies are testimony to the effect of medicalization on the way insemination is viewed. Women choosing insemination do so for a variety of reasons. Unmarried women may do so for lack of a suitable male partner or because of sexual preference, whereas married women may do so because their husbands are infertile. None of these reasons speaks to the woman's own medical condition. The insurance companies covering insemination for married women, however, apply the criterion of medical necessity only to the women who have one particular reason for being inseminated: having an infertile husband. Although the husband's problem is indeed a medical one (he is not reproductively healthy), the designation of this motive for seeking insemination represents a purely social judgment, cloaked as a medical one. Because the insurer incurs costs by covering insemination as "medically necessary" in these instances, we can assume that it has no stake of its own in supporting the medicalizing assumption and is merely following (or bowing to) conventional thinking on the medical status of insemination.

2. Inseminees have a variety of reasons for wishing to choose donors. Lesbian couples have inseminated one partner with semen from the other partner's brother. "Dear Abby" published a letter from a woman whose husband lost his testes to cancer when he was 19 years old: "At that time, his parents told him that should he ever marry and want children, his father would gladly donate semen. They live 2,000 miles away, but we have a sperm bank to store it, and a doctor to handle the insemination. . . . It is much better to 'know your donor.' . . . It was a two-year search to find a doctor and a clinic to handle our case because no one had ever heard of doing it this way before" (Van Buren 1988). This couple's experience underscores the burdensomeness of medical control, the insinuation of doctors' morality into the couple's reproductive decision—and the apparent unthinkability of simply inseminating without the doctor's help, thus freeing themselves of these burdens.

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