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Medico-legal aspects of artificial insemination

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THE MEDICO-LEGAL ASPECTS OF ARTIFICIAL INSEMINATION

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INTRODUCTION

A present day cliché states that scientific advances far exceed the standards of civilization in which man lives. Often cited as an example is atomic energy. Plans are underway only now for its use in a peaceful nation, yet it was used over a decade ago to kill and maim thousands, thereby bringing halt to an already vanquished warring nation.

Another example, which in contrast is of little importance to the general public, but which is of atomic blast proportion within the medico-legal fields, is the practice of artificial insemination. The practice has increased widely over the last twenty-five years, but to date there is no legislation concerning the procedure. Tucker[1] defends this fact by stating that "the lag between medicine and law is not only inevitable but desirable. Too often scientific theories and practices fail to fulfill their promise. Were medical discoveries immediately reflected in the law, we would have not progress but chaos. Science with impunity may reverse itself repeatedly, the law hardly ever." This, in a sense is true. But this paper will point out how legal opinions have vacillated regarding artificial insemination, and how the physicians may attempt to avoid legal entanglements.

HISTORY

A review of the literature points out that artificial insemination is one of the few medical techniques that cannot be

traced back to Hippocrates. Furthermore, there are no references to artificial insemination among preliterate people.[2] In fact its first human application appears only one hundred and sixty years ago.[3]

According to historical legend the procedure was first used by the Arabs in the breeding of horses in the fourteenth century. However, an overlooked Talmudic document has been uncovered which antedates the Arab tale by some 1,100 years. This article discusses in a philosophical manner the application of artificial insemination in the human, but no mention is made of its application.[4]

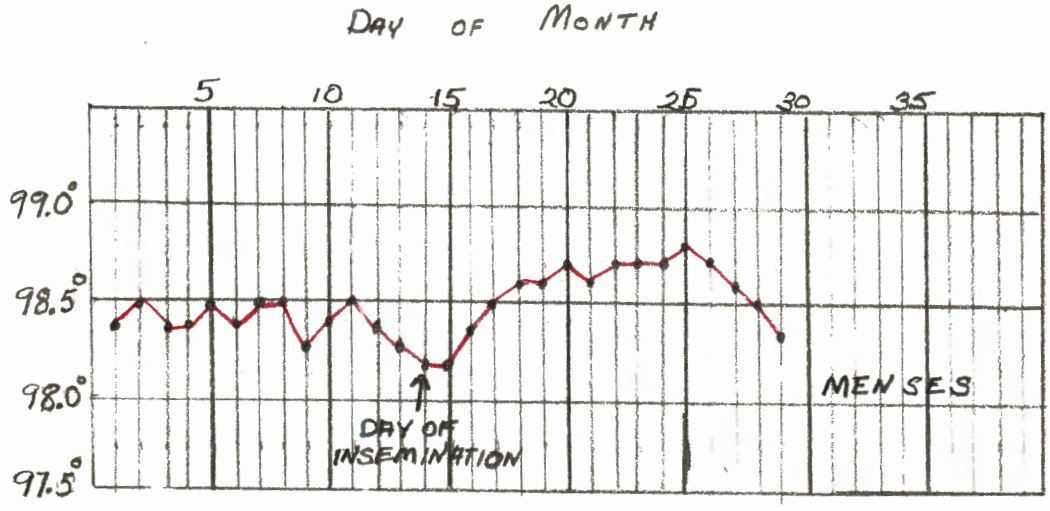
Credit for the first human application of this method is given to John Hunter in 1690. This illustrious physician impregnated the wife of a linen draper whose sterility resulted from hyposadias. The husband's semen was injected by Hunter into the wife's vagina with a normal pregnancy resulting.

Since 1907, the year the Russian physiologist, Ivanoff, published his famous monograph, artificial insemination has played an increasingly important role in animal husbandry. In this manner the services of valuable sires have been spread over many cows, ewes and mares. In 1936 alone as many as six million cattle and sheep were artificially inseminated.

TECHNIQUE

The technique used by the physician in carrying out artificial insemination is basically the same in each instance with each physician employing minor vatiations. The factors which vary are the methods of dating the period of ovulation, the method of insemination, the site of insemination and the number of inseminations per cycle.

In the most instances the day of ovulation is determined by plotting the woman's basal temperature. At ovulation the normal temperature curve takes a characteristic drop and then rises to remain elevated until just before the next period.[5] Such a graph is shown below.



Guttmacher[3] selects the date for insemination on the basis of the menstrual data. If the cycle is twenty-eight days, the procedure in the first month is to select days eleven and fifteen, considering the day of the onset of menses as day number one. If conception does not take place, these days are changed during the next menstrual cycle to days twelve and sixteen or ten and fourteen until conception takes place. If the cycle is longer than twenty-eight days the difference in days is added to the usual day for the first trial. Thus if a woman's cycle were every thirty-two days, the first inseminations would be performed on days fifteen and nineteen. Cary[2] also employs this technique, feeling that the daily

examination of vaginal smears is cumbersome and difficult of interpretation.

During the period in which the woman is charting her basal temperature, the physician should evaluate the womans[4] fertility. The Basal Metabolic Rate to determine the thyroid activity, the Rubin test to determine patency of the tubes, and vaginal smears to evaluate ovarian function may all be employed to rule out the wife as a cause of sterility. The serology and the Rh factor should also be determined.

The means of introducing the sperm into the location where they will contact the ovum are multiple. Shields[5] aspirates the semen into a sterile dry glass syringe with an intravenous cannula. Then, with the patient in the lithotomy position and the hips elevated, the cervix is vizualized with an unlubricted, sterile speculum, and the semen is merely spurted at the external os. The patient is kept in this position for twenty minutes before she is removed from the examining table.

Guttmacher[3] uses this technique except that he inserts the cannual 0.5 to 1.0 cm. within the external os. The semen is spurted into the canal with four to five thrusts of the plunger of the syringe. As the speculum is withdrawn the blade is wiped back and forth across the external os to bathes it in the seminal pool which has formed by the semen running out of the cervix. This procedure is also used by Kleegman.[6]

Cary[2] places the patient in the Sims position because she is better relaxed and the speculum can be better removed without spilling the bulk of the semen. Weisman[7] inserts a diaphragm into the vagina one half hour after the patient has been inseminated to retain seminal contact with the cervix in the ambulatory state.

Schultz,[3] a German physician, introduces the semen into the uterine cavity. A catheter, with syringe attached, is inserted into the fundus. He then clamps the cervix to prevent reflux of the semen and slowly injects the ejaculate under little pressure. The catheter is then washed out with 1 to 2 c.c. of warm sterile dextrose. Both Cary[2] and Kleegman[6] employ intrauterine insemination when the husband's semen is used.

The possibility of infection is far greater when intrauterine insemination is performed. Endometritis and salpingitis are complications and a case of fatal sepsis has been reported. Guttmacher[3] states that uterine cramps also are more likely to occur for the semen with its pungent hyperalkalinity acts distinctly as a foreign body in the human uterus.

Whitelaw[8] introduced the cervical cap as an adjunct to artificial insemination. The caps are plastic and vary in size from 28 to 36mm. They are filled with semen, slipped along the vaginal wall and inserted on the cervix with slight pressure. The cup is is held on the cervix by suction. As it is difficult to prevent sperm spillage while attempting to place the cup on the cervix,

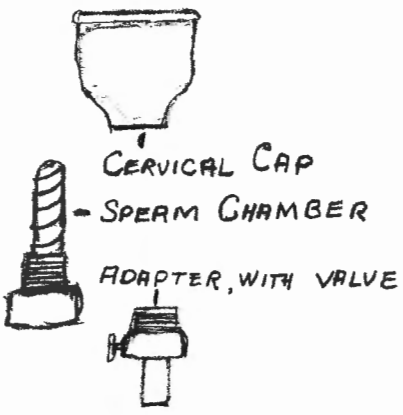
other procedures have been devised. The empty cup may be dislodged from the cervix and then filled with semen by means of a long curved glass syringe. When filled, the cap is flipped back onto the cervix. A third procedure entails drilling a small hole in the cup. With the cup on the cervix, the semen is instilled into the cup through the small hole by means of a small flexible syringe.

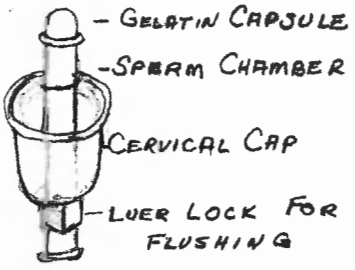
Haman[9] reports a 27% increase in his results with the cup as against the cannula technique. Moreover, he reports no complications using the cervical cup, where he had five cases of pelvic inflammatory disease or 10% complication using the cannula. However, both Payne[10] and Kleegman[6] reports no appreciable difference in results as compared to paracervical insemination.

Lane[11] employs the cervical cup at home to enhance the possibility of conception when the husband's sperm is defective in number or quality. The patient is fitted with a cup that has a polyethylene tubing connected to the center of the cup. At the time of ovulation, the patient's husband collects a semen specimen, either by masturbation or coitus interruptus, and injects it into the cervical cup through the tubing by means of a syringe.

Greenberg[12] has devised a more complex cervical cap, which he feels will conserve sperm and facilitate their passage through the cervix. The cap has a threaded sperm chamber which is inserted into the cervix. An adapter is attached to the chamber to permit

flushing with a physiologically amicable solution. This not only prevents loss of sperm by muscular contraction or by gravity, but also permits the flushing of any seminal fluid out of the cap system. This improved cervical cap can also be used for injecting gas or radioopaque media, for dilatory treatment of dysmenorrhea, for collection of samples used in exfoliative cytology and for holding radium.





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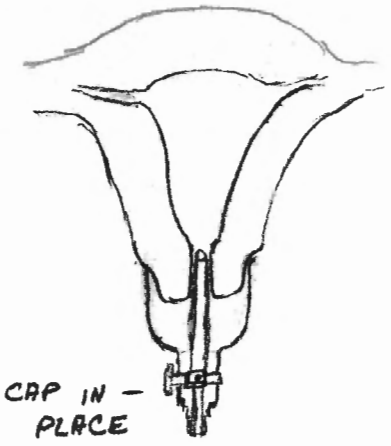
CAP ASSEMBLED



CAP IN PLACE

Theories as to the number of inseminations per menstrual cycle vary with the physician. As stated before both Guttmacher[3] and Cary[2] inseminate the patient twice during a cycle at intervals of four days. Haman[4] inseminates the patient several times near the midcycle until the basal temperature graph has been compiled. Then the insemination is performed at the day of the temperature drop and at the day of the first rise. Kleegman[6] usually limits inseminations to three per cycle, but Warner[13]

reports from one to nine inseminations per month between the fifth and twenty-third day of the cycle. Grody[14] used two inseminations per cycle at thirty-six hour intergals, stating the second is only an insurance measure.

The enzyme, hyaluronidase, was given a role as a factor in sterility following studies by Bergenstal.[15] He stated the sperm count was roughly proportional to the hyaluronidase level. When sperm were present some degree of hyaluronidase activity was found, but there was no activity if the semen was azoospermic. With this evidence, Barondes[16] suggested adding hyaluronidase in Ringer's solution to the husband's semen, if it contained some motile, apparently normal sperm, yet sterility existed. This has not gained wide practice, however, for Chang[17] later stated that the role of hyaluronidase in the dispersal of the cumulus cell mass surrounding the eggs in vitro is not as important a process in fertility in vivo as investigators once thought. Experimental data has not proven that the addition of the enzyme to a sperm suspension will increase the fertilizing capacity of the spermatozoa.

RESULTS

To determine the effectiveness of artificial insemination, a vast number of statistics have been compiled. The following chart gives the results with the cases divided into insemination with the husband's or donor's semen, when the information was given as such.

Results of Artificial Insemination as Reported Since 1866[4]

Name	Year	No. of Cases		No. of Preg.		% of Preg.	
		Donor	Husband	Donor	Husband	Donor	Husband
Sims	1866		55		1		1%
Prochownik	1915	3		0		0%	
Dickinson	1920	3		2		66%	
Rohleder	1924	127		52		40%	
Seguy	1925	24		0		0%	
Schorohowa	1927	206		86		47.2%	
Engleman	1927	185		65		35%	
Wilson	1929		1		1	100%	
Mason	1929	5		2		40%	
Abbett		37		11		29%	
Pierra	1931	9		1		11%	
Turpault		6		1		16%	
Cohen	1934	2		2		100%	
Douay	1934	2	1	2	0	100%	0%
Seguy	1935	16		7		44%	
Jeanneney	1936	6		1		16%	
Fulconis	1937	50		2		1%	
Goldberg	1938	1		1		100%	
Seashore	1938	1		1		100%	
Lane-Roberts	1939		23		6		26%
Cary	1940	17	18	8	4	47%	22%
Seymour-Koerner	1941			3649	5840		
Isreal	1941	6		5		83%	

Name	Year	No. of Cases			No. of Preg.			% of Preg.		
		Donor		Husband	Donor		Husband	Donor		Husband
Schultz	1941		131			36			27%	
Schultz	1941	3		99	2		13	66%		13%
Copeland	1943			11			6			54%
Halbrecht	1944	52		28	23		2	44%		7%
Warner	1944		9			6			66%	
McKenzie	1944		12			4			33%	
Siegler	1944	42		6	22		2	52%		33%
Guttmacher	1944	49		8	21		0	42%		0%
Kornblith	1944	1		3	1		3	100%		100%
Barton	1945	15		30	10		9	66%		30%
Weisman	1946	87			74			85%		
18 Halbrecht	1946		86			43			51%	
19 Vimeaux	1947	33		13	19		8	57%		61%
20 Cary	1948		83			66			79%	
21 Haman	1948	47		35	30		10	66%		28%
4 Haman	1948	36		30	19		5	52%		16%
13 Warner	1948		78			59			75%	
23 Murphy	1948		32			10			31%	
5 Shields	1950		63			47			73%	
14 Grody	1952			15			10			67%
9 Haman	1954		177			134			69%	
6 Kleegman	1954		116			74			63%	
10 Payne	1954	67	___	159	38	___	56	57%	___	35%
TOTAL		457	1436	535	274	712	136	62%	49%	25%

It is to be noted that the use of the husband's semen results in far poorer statistics than when a donor's semen is used. This is explained by the fact that the Husband's semen was usually defective in regard to motility, number and/or structure.

The number of inseminations required to effect a pregnancy varied with the technique and the physician. Haman[4] reported an average of 6.34 inseminations for sixty-six patients. Although thirteen patients were inseminated in only one cycle and became pregnant. In a larger series of 177 patients, Haman[9] reports twenty-four pregnancies after only one insemination and twenty-three pregnancies after inseminations in the course of one menstrual cycle. On the other hand, one patient received thirty-four inseminations and twenty-three patients received ten or more inseminations. Warner[13] states that the total number of inseminations for her fifty-nine successful cases varied from one to fifty-four. Approximately two-thirds of the successful cases required ten or less inseminations, and only one-tenth of the group required twenty-two to fifty-four inseminations. It is felt by some that the number of inseminations should be limited for both economic and psychological reasons.

The successful day of insemination varies according to the day of ovulation. Haman[9] states that the insemination resulting in pregnancy occurred from day nine to fourty-five of the cycle, but 81% of the successful inseminations occurred between the eleventh and the sixteenth day. Shields[5] found that the average successful day was between the thirteenth and fifteenth day of

the cycle. The majority of Warner's[13] patients were conceived between the eighth and sixteenth day of the menstrual cycle.

A survey[24] with reports from over seven thousand physicians establishes that more than 97% of all pregnancies resulting from artificial insemination terminated in living, normal babies. The remainder included 217 miscarriages and abortions, this incidence being only one-fifth or less than that among the so-called normal women in whom pregnancies resulted without aid. There are twenty-two extrauterine pregnancies in the series, which is only one-sixth that of the number which would be expected in an average series of pregnancies. In every case the living children were normal in every respect and by every standard.

LEGAL PROBLEMS

Physicians to the human race in comparison to physicians of animals are considerable behind in both scientific investigation and the successful practice of artificial insemination. To be sure, the physician is restricted by conventions, moral codes and human frailty, from which the legal problems arise. In nearly every case the legal questions result from divorce cases in which the wife wishes to keep their child begotten of artificial insemination. Such an instance occurred in Chicago in 1954.

Mrs. Mary B. Doornbos of Riverside, Illinois, filed suit for divorce against her husband, George. She contended that her five year old son, David, was conceived as result of artificial insemination, and that her husband had no rights to the child. Further-

more, Mrs. Doornbos filed a petition asking a declaratory judgment that artificial insemination is not contrary to public opinion; nor is it adultery; that a child born of the procedure is the child of the mother, and that the child is legitimate.

Countering in a manner characteristic of an indignant husband, Mr. Doornbos filed a petition just to the contrary. He stated that he was the father of the child, but if his wife had been artificially inseminated, he contended that his wife was guilty of adultery and should be punshied. Furthermore, and this is important to the medical profession, Mr. Doornbos felt that the physician and those who had any part in the "conspiracy", presumable the donor and hospital personnel, should be prosecuted.[25]

Here in a single law suit, a couple have brought to light the most important controversial questions arising from the practice of artificial insemination. These questions will be considered separately, reviewing the law suits that have arisen in association with the charges.

First a distinction must be made between heterologous and homologous artificial insemination. Homologous insemination entails the use of the husband's semen, where he cannot impregnate his wife because of such conditions as hypospadias, impotence, or excessive obesity. In other cases the wife may be the cause of the infertility. In such instances the fault usually is attributable to an abnormal position of the uterus, cervical stenosis, vaginismus, dyspareunia, or tumors. Where the husband's semen is used, no legal problems

arise. The child will unquestionably be legitimate, and, of the physician exercises due diligence, uses ordinary knowledge and skill and his best judgment and respects the confidence of his patient, he will not be liable for damages, even though the resulting child be defective.

The legal quandary has resulted from heterologous artificial insemination. This entails the insemination of the wife with semen from a person other than the husband. The indications for donor insemination exist when the sterility of the husband is established and the wife is apparently fertile.

The decision as to whether or not this procedure constituted adultery first appeared in the Canadian courts in 1921. A couple by the name of Orford were married in Canada, but shortly after the marriage the wife sailed to England. During her stay she submitted to artificial insemination without her husband's knowledge or consent, the semen specimen being provided by another man. She then returned to Canada with the child and sued her husband for divorce and alimony charging that his neglect and cruelty drove her to the act described.

In the ensueing case the court held that the wife's submission to artificial insemination was adultery, the essence of which was not necessarily in the "Moral turpitude of the act of sexual intercourse, but in the voluntary surrender to another person of the reproductive powers" of the wife to another man. The judge further developed his point by stating that "sexual intercourse is adulterous because in the case of the women it involves the possibility

of introducing into the family of the husband a false strain of blood".[26]

The fallacy of this argument was pointed out by Guttmacher,[27] the renowned Baltimore physician. He contends that a "hysterectomy would be 100% protection against the possibility of committing adultery. Certainly if the women without a uterus has extramarital coitus, she could not contaminate her husband's blood line."

Judging this case under present conditions certain aspects must be taken into consideration which support the judge's assertions, but which do not constitute an argument against artificial insemination at this time. It must be remembered that this women submitted to the procedure without her husband's knowledge or consent. As conditions are presently, no physician would perform heterologous artificial insemination without first securing both the husband's and wife's consent. Furthermore, during the trial, evidence was presented that Mrs. Orford had "carnal relations in the ordinary manner."[28] With this in mind, it is obvious that the judge had reason for his adjudication.

A more recent ruling in Chicago in 1945 held that the procedure was not adultery. The conclusion was based on the fact that no definition of adultery includes artificial insemination.[29] In support of this view, it is pointed out that statutes concerning adultery use phrases such as "if any man and women should live together in an open state of adultery" of the words "open", "notorious", "Cohabit" or the like. The American and English Encyclopedia of Law (Vol. 1: 747) defines adultery as a "criminal

conversation with another man's wife", while the ecclistical law defines it as a sexual conversation between a man and a women, one of whom is married to a third person. In heterologous artificial insemination there is no cohabitation, and there is no ppeness or notoriety associated with it. The procedure lacks the elements of lust, passion or force. There is an absence of physical, sexual relationship between man and women. It is also pointed out that statutes relating to adultery apply to natural and physcial acts, where this procedure, as its name acknowledges, is artificial.[30]

Despite these facts, in the most recent decision Judge Gibson E. Gordon[31] ruled in the aforementioned Doornbos suit that "heterologous artificial insemination, with or without the consent of the husband..... constitutes adultery on the part of the mother." It must be mentioned, however, that Judge ~~Gibson~~ Gorman is Roman Catholic, and his church, in a decree of the Holy Office, labeled use of donor insemination as "immoral and illicit". Judge Gorman, who states that the decree had no bearing on his decision, expressed hope his ruling would be appealed to a higher court "as basis for establighing a beginning for all legal unentaglement to follow".[32] Presently the question, as to whether or not heterologous artificial insemination constitutes adultery, stands in this state of flux.

The question of legitimacy of the child, likewise, is in a state of controversy. There are two important, but contradictory opinions. Both decisions seemed to be based on considerations beyond the domain of the ruling party - the legal question being based on the practical aspect of the case, and the medical decision being based on a legal consideration.

The medical profession was first to voice its opinion in an editorial in the Journal of the American Medical Association in 1939.[33] Generally it is presumed that a child born in lawful wedlock is legitimate. But the reasoning of the editorial is that this presumption "is not absolute and conclusive under all circumstances." Even at early common law the presumption was overcome by proof of the husband's sterility. Today the presumption as to the legitimacy is more easily controverted than it was in earlier times. Now it is generally recognized by the courts that a child is illegitimate though born or begotten during marriage, when it is impossible for the mother's husband to have been the father." It follows that in heterologous artificial insemination, when the "semen of some other male is utilized, the resulting child would be illegitimate."

Despite this legal opinion handed down by the editorial staff of the American Medical Association, Judge Henry Clay Greenberg,[34] of the New York State Supreme Court, ruled that a child begotten of artificial insemination is not illegitimate. Indeed, logically and realistically, is no different than that pertaining in the case of a child born out of wedlock who by law is made legitimate upon the marriage of the interested parties."

The ruling of Judge Greenberg's again resulted from divorce proceedings. Mrs. Strnad, the plaintiff, hoped to deny to her husband the right to visit their child on grounds that Mr. Strnad was not the father of the child. But Judge Greenberg stated that during the course of the trial that if Mrs. Strnad "was successful in her suit, the child would be established as illegitimate.

How will that help the child? The court will not lend itself to making any child illegitimate. It would be inhuman and contrary to the highest precepts of society."

It is pointed out that consent by both the husband and wife to the procedure is a valid exercise of a right incident to the marriage relationship to accomplish one of the ends of marriage. It is reasoned that because their is no express prohibition by law against this procedure, the resulting child would be legitimate.

To ascertain the most recent opinion as to legitimacy the Doornbos case must be referred to again. It was in this case that the Judge ruled that heterologous artificial insemination constituted adultery. He also felt that "a child so conceived is not a child born in wedlock and therefore illegitimate." However at the request of the trial judge, the office of the state's attorney has filed request for permission to intervene and appeal the portion of the decision declaring the child illegitimate.[31]
Thus, in the state of Illinois, as throughout the United States, the question of legitimacy remains unsettled.

The reasoning that contends the child is illegitimate states that the problem can be solved by adoption. But this only raises more problems. In most cases the husband does not wish to proclaim his sterility by starting adoption proceedings. Moreover the husband cannot be compelled by law to adopt the child. If forced to do so further disagreement might arise between the husband and wife.[35]

If the child is not leggally adopted the question of inheritance

is raised. Although the point has never been subject to legal scrutiney it is felt that if a child conceived of this procedure were to have his inheritance contested, it would not be granted to him. A will would circumvent this problem, but this again entails the publication of the husband's sterility.

A means of avoiding the legitimacy problem is to refer the artificially inseminated woman to another physician to be cared for during her pregnancy and delivery. Supposedly the second doctor would instinctively name the husband as father in filling out the birth certificate. A more drastic means of accomplishing the same end was suggested by Guttmacher[36] in a paper given before the Interstate Postgraduate Assembly of North America. His rather startling recommendation was that hospital records and birth certificates be falsified in the event that the physician delivered the child begotten of heterologous artificial insemination. No one will question either the sincerity of purpose or the illegality of the recommendation.

The question of legality of heterologous artificial insemination is the most important aspect of the problem from the physician's standpoint. The opinions on the subject are as numerous as those writing on the subject.

The Canadian Courts were the first to broach the subject. Basing the opinion on the Mosaic laws, the Ontario Supreme Court thought that "had such a thing as 'artificial insemination' entered the mind of the law giver, it would have been regarded

with the utmost horror and detestation as an invasion of the most sacred of marital rights."[26] Reading this decision, Allan F. Guttmacher[37] felt compelled to chide the court's adjudication. He thought it "truly remarkable to judge a twentieth century medico-sociologic procedure through the eyes of an Israelite, now dead for at least 3,000 years." Moreover Guttmacher wonders "how Moses would have regarded the transfusion of 500 cc of Philistine blood into the veins of his brother, Aaron, the high priest; or the injection of an extract of bull's urine into the gluteal region of his sister, Miriam. I imagine with the utmost horror and detestation, yet Judges would have us use Moses's reactions as the yardstick of propriety in the treatment of a case of sterility in 1946."

The Bureau of Legal Medicine and Legislation for the American Medical Association has made the following comment in an unpublished communication regarding artificial insemination as a whole.[27] "It has been argued that morals are necessarily injured by attempted assignment of sex rights and perogatives and production of a bastard issue; that every child of strange or questionable paternity is a reproach to morality; that the procedure nullified the legislative intent concerning sexual monopoly between husbands and wives, and that the procedure itself tends to the degradation of the resulting child. For these reasons it is argued that all participants in the procedure might be guilty of violating a statute common in most states making it a criminal offense for two or more persons to conspire to do any illegal act injurious to public morals."

Having set up a number of arguments by which heterologous artificial insemination might be judged, the bureau then attempted to refute them. It is pointed out that this procedure is not an assignment of sex right. There is no consent to intercourse by a third party, nor to any other rights the husband has in his wife. And because society has not had time to evolve any moral opinion of the procedure, it can hardly be called immoral.

Just this year, 1955, the American Medical Association appraised the question following the Doornbos case. No definite ruling was made regarding the legality of the procedure by Judge Gorman, but he did feel that it was "contrary to public policy and good morals". If this were the case, it would automatically become a criminal offense for it violates a statute common to most states. The American Medical Association feels that better legal thinking supports the view that the procedure is not, in the absence of specific statute forbidding it, a crime. Consequently a criminal proceeding will not lie against the doctor for performing the procedure.[38]

The questions of legality, legitimacy and adultery are but a few of the legal problems arising from heterologous artificial insemination. These three problems have been considered by the courts. The number of problems which might arise, that the court have not adjudged is almost beyond conjecture. The limit to such questions depends only on the imagination, knowledge and intellectual curiosity of the inquirer. Among other legal questions are the following:

"Is fraud perpetrated or an illegal act committed by executing a birth certificate without divulging that the mother's husband is not the natural father of the child? Does the donor have any obligation to the child? Does the donor have rights of inheritance from ~~obligation to the child? Does the donor have rights of inheritance from~~ the child? Is the child begotten of this procedure an heir of his mother's husband's ancestors? Does the procedure contravene the "spurious heir" statute that have been enacted in some states? What is the relation between a child born of this procedure and a naturally conceived child of the same mother and husband? What are their respective rights? Does the procedure defeat carefully drawn adoption statutes? Might a husband and wife resort to the procedure, even in the absence of sterility, for strictly eugenic reasons? Must the procedure be limited to married women? If the woman is inseminated without her consent, is the husband or physician or others guilty of rape?"[31] It is clear from the list that these problems have a wide scope, and require due consideration."

INCIDENCE

One might question whether the practice of artificial insemination is great enough to warrant all of this medico-legal conjecture. To evaluate the degree to which the procedure was being practiced, the National Research Foundation for Eugenic Alleviation of Sterility sent 30,000 questionaires to physicians throughout the country in 1941. One quarter of those questioned replied bearing witness to the fact that nearly 10,000 women had achieved at least

one pregnancy by this method. However two-thirds of all successful pregnancies were effected through the use of the husband's semen alone. Only 3,649 children were conceived with the use of a donor's semen.[24] But this figure was established fourteen years ago. It is now estimated that nearly 15,000 children have been born as result of heterologous artificial insemination.[4] This is a small number in a country with four and a half million people, but it takes on greater proportions if these children are considered as bastards and their mother as adulteress.[5]

RESPONSIBILITIES OF PHYSICIAN

It is evident that the physician assumes many responsibilities when he practices heterologous artificial insemination. However there are several measures he may take to reduce their ponderosity. In selecting a donor the physician assumes responsibilities, the nature and limit of which have not been determined by law or defined by the courts. How far the courts will recognize a right on the part of the woman, who is to be inseminated and of her husband, to assume by express contract the risks of unsatisfactory results due to the unfitness of the donor, it is impossible to say. A patient by express agreement may relieve the physician of some of the obligations. The reason for not absolving the physician of all obligations is that the law realizes that this is a potent factor in insuring proper medical care.[21]

With the increasing use of the procedure, the courts may expect to find from the testimony of competent medical witnesses, what degree

of skill and care is possessed and exercised by physicians who engage in the practice. From this information a standard may be established on which evaluation of the physicians responsibility may be made. A review of medical literature reflects that the procedure is no longer experimental. Scientifically, it is an established procedure.

The first decision the physician has to make is whether the couple, assuming the male is sterile and the wife is normal, that requested artificial insemination, are fully capable of the necessary adjustments. He must be certain that both the husband and wife are equally serious and sincere in their decision, and that they grasp the psychological and emotional dangers which they face. If either partner shows only half-hearted interest the subject should be dropped immediately.

An important prerequisite is a probationary period during which the physician will see both the husband and wife and familiarize himself with the mental and psychological make-up of the couple. This period gives the couple an opportunity to review the picture dispassionately and permits the husband to reconsider his decision. He must clearly understand the emotional effect that this procedure may have on his future relationship with his wife and be aware that present sentiments are not always enduring.

It is the physician's duty to refuse heterologous artificial insemination to any couple that do not fit these qualifications. He thereby saves the husband and wife from much unhappiness and himself from any possible legal entanglements.[3]

The second decision that the physician is obliged to make is the selection of the donor. There are certain prerequisites that he faces here, too. Naturally the donor must resemble the husband, not only racially and physically but emotionally and temperamentally. To meet such specifications Russell[39] advises that the donor be required to fill out a questionaire. The donor would list his physical characteristics concerning his complexion, heighth, build and color of hair and eyes. Information regarding his schooling and family would be required. The history of any familial diseases and allergies, with special reference to venereal diseases would complete the questionaire.

To determine the donor's health, Russell feels the donor should have a complete physical examination. This includes a urinalysis, blood count, RH typing, and semen analysis. Moreover the donor should be examined four times a year to make certain that he has not contacted any venereal diseases, and that his semen is adequate. The donor should at all times remain anonymous and should make no inquiries as to the recipient of his semen. This prevents the possibility of blackmail and the transference of affections from the recipient to the donor.[22]

Having made the decision to inseminate the woman, the physician should obtain a written consent from both the husband and wife. This should set forth in detail the act to be performed, and its possible consequences, both legal and medical.

Artificial Insemination Form of Consent

Whereas, We, the undersigned _____ and _____ are husband and wife, having been married in the City of _____ County of _____, State of _____ and

Whereas, this marriage has to the present time been childless, and

Whereas, we are desirous of having a child and have been informed that _____ is capable of procreation;

Now, Therefore, we and each of us do hereby request and authorized Dr. _____ to select a donor, who in his sole discretion and judgment will meet the following qualifications;

We and each of us further request and authorized the said Dr. _____ to obtain from said donor sperm necessary to inseminate the said _____ and to thereupon artificially inseminate her with said sperm in the usual and customary manner, and to do such acts in furtherance thereof as may seem necessary and advisable in the sole discretion of Dr. _____.

We and each of us understand that said Dr. _____ does not warrant or guarantee the qualifications of said donor, and that in determining whether said donor meets the aforesaid quailifications the said Dr. _____ shall be required to make only such investigation of and concerning such donor as shall in the sole discretion of said Dr. _____ seem reasonable necessary.

We and each of us further agree that we shall not now, nor at any future time require nor expect said Dr. _____ to obtain or divulge to us the name of said donor, nor any other information concerning said donor's race, nationality, characteristics, qualities, or any other information whatsoever concerning said donor.

We further agree that following the said insemination the said Dr. _____ shall destroy all information and records which he may have as to the identity of said donor, it being the intention of all parties that the identity of said donor shall be and forever remain anonymous.

We and each of us further covenant and agree to forever refrain from instituting, pressing or in any way aiding any claim, demand, action or cause of action for damages, costs, loss of services, expense or compensation for or on account of or hereafter arising out of the premises hereinabove set forth.

Form of Consent - continued

We and each of us further promise and agree to idemnify and save harmless the said Dr._____from any loss and/or expenses incurred by him in connection with the defense or payment of any claim or action arising out of the aforesaid premises or agreements herein contained.

This agreement shall be binding upon ourselves, and each of us, our assigns, heirs, executors and administrators.

Dated this_____day of_____, 19___.

_____ _____
(Husband) (Wife)

Witnesses:

_____

_____

Relying upon the authorization and agreements above set forth, I hereby agree to obtain a donor and to artificially inseminate the said _____.

Dated this_____day of_____, 19___.

_____

PRESENT LEGAL THOUGHT

Today the legal problem is discussed from the standpoint of what the law is, rather from the standpoint of what the law should be. It is perfectly obvious that all the legal opinions relative to the procedure are struggling to interpret within the legal boundaries of ancient statutes and common law dealing with illegitimacy and adultery. Since artificial insemination was not practiced when these laws were formulated, they were never meant to encompass the procedure. It is not a question of whether or not the procedure is legal or not; it

is a question of whether or not it should be legal. That is the basic problem, and the question of what the law is today is but an incident.

To obtain satutory clarification of the rights of persons in a new field such as this, there must be established customs and practices which are generally considered morally sound. Such a result may be accomplished by careful practice on the part of the physician to avoid the incidents which shed unfavorable results otherwise beneficial, and by a well organized campaign for the dissemination of information as to the benefits of the treatment, for the respectful avoidance of practices repulsive to religious tenets, and for intelligent and dignified counters to sensationalistic discussions of the subject.[21]

No legislation has been enacted in any states regarding artificial insemination, although bills have been introduced in six state legislature. Following the Strnad case in 1948 a bill was introduced into the New York State Legislature to establish the legitimacy of the child born of the procedure. The bill provided that "in cases where the husband and wife are living together when artificial insemination takes place with the husband's consent, expressed or implied, the child shall be deemed the legitimate issue of both the husband and the wife".[34]

A similar bill was introduced into the Virginia State Legislature the same year. In both Wisconsin and Indiana bills were presented which would have declared the child to be legitimate and to have the rights of inheritance. As evidence that the lawmakers

are unwilling to commit themselves either for or against the procedure, the Ohio State Legislature defeated a bill which would have made heterologous artificial insemination illegal.[31]

This is the present status of artificial insemination. It is experiencing and increasing practice throughout the United States, yet the law declines to be precipitated into any hasty decisions regarding its legality. Thus with each day it becomes of greater importance to more and more practicing physicians, infertile couples, and artificially conceived children. From these personages arise the plea that the law set forth a definite ruling, either for or against, so as to remove them from this state of indecision and legal vacuum in which they now exist.

SUMMARY

The technique of insemination varies with the physician. Intravaginal, intracervical, and intrauterine insemination are all done by means of an intravenous cannula. The cervical cap has been introduced as an adjunct to artificial insemination in order to concentrate sperm and to prevent there loss. The number of inseminations per menstrual cycle average between two and three, and are most successful if performed between the eleventh and sixteenth day.

Statistics compiled since 1866 point out that donor insemination is much more successful than when the husband's semen is used. The number of inseminations required to cause a pregnancy varied between one and fifty-four, but averaged ~~out to~~ 6.34 in one writer's series of sixty-six patients. Ninety-seven percent of all pregnancies resulting from this procedure terminated in normal babies.

The questions related to heterologous artificial insemination are presently in a state of flux. Deliberations concerning this subject first appeared in the oft quoted Orford v. Orford case in 1921 in which the woman in question was charged with committing adultery. Then little was published until 1939 when an editorial in The Journal of the American Medical Association expressed the view that a child begotten of heterologous artificial insemination was illegitimate. A contrary opinion was declared in the New York Supreme Court in the Strnad v. Strnad case in 1948. Just this year,

however, the Doornbos case reaffirmed the position held by the American Medical Association. Decisions regarding the legality of the act have also been subject to change. Although there are no specific laws forbidding the procedure, it was considered contrary to public policy and good morals in the Doornbos case, which automatically makes it subject to legal scrutiny.

There are several considerations which the physician must take into account to absolve himself of as many responsibilities as possible. He must carefully evaluate the couple who request the procedure to ascertain whether they are capable of making the necessary psychological and emotional adjustments. He must also select a donor that closely resembles the husband. Moreover he should have them sign a form of consent to release himself from any responsibilities as to the outcome of the procedure.

There have been several bills introduced into the state legislatures for and against the procedure, but none of them have been enacted.

CONCLUSION

There are no specific laws concerning heterologous artificial insemination.

This procedure is being practiced throughout the United States.

The practice will continue until a law is passed making it illegal.

BIBLIOGRAPHY

1. Tucker, B.F.: Legal Problems of Artificial Insemination, Women's Lawyer Jour., (Spring) p. 50, 1947.

2. Cary, W. H.: Experience with Artificial Insemination in Treating Sterility, JAMA, 114:2183 (June 1) 1940.

3. Guttmacher, Alan F.: The Role of Artificial Insemination in the Treatment of Sterility, JAMA, 114:442 (Oct. 10) 1942.

4. Haman, John O.: Artificial Insemination, Calif. Med. 68:5 May 1948.

5. Shields, Francis E.: Artificial Insemination as Related to the Female, Fertil. Steril. 1:3 1950.

6. Kleegman, Sophia J.: Therapeutic Donor Insemination, Fertil. Steril. 5:1 1954.

7. Weisman, A. I.: Studies on Human Artificial Insemination West J. Surg. Ob. Gyn. 55: 348-351 (June) 1947.

8. Whitelaw, James M.: Use of the Cervical Cap to Increase Fertility in Cases of Oligospermia, Fertil. Steril. 1:1, 1950.

9. Haman, John O.: Results in Artificial Insemination, J. Urol. 72.3 (Sept.) 1954.

10. Payne, Sheldon; Skeels, Robert F.: Fertility as Evaluated by Artificial Insemination, Fertil. Steril. 5:1, 1954.

11. Lane Fredrick E.: Artificial Insemination at Home, Fertil. Steril. 5:4, 1954.

12. Greenberg, Emanuel M.: Improved Cervical Cap and Sperm Chamber for Artificial Insemination, West. J. Surg. Ob. Gyn. 60:2 (Feb.) 1952.

13. Warner, Marie Pichel: Artificial Donor Inseminations Fertil. Steril. 13:37-46 (June) 1947.

14. Grody, Marvin H.: Robinson, Donald W.: Masters, William H.: The Cervical Cap. An Adjunct in the Treatment of Male Fertility, JAMA, 149:5, 1952.

15. Bergenstal, D. M.; Scott, W. W.: Studies on Hyaluronidase, JAMA, 137:1507, 1948.

Bibliography - Continued

16. Barondes, R.: Levine, D. I.; Feinstein, M.; Kane, T. J.: Artificial Insemination with Modified Seminal Fluid, Ann. West. Med. & Surg. 3:6 191-194.

17. Chang, M. C.: Fertilization, Male Infertility and Hyaluronidase, Ann. New York Acad. Sc. 52: 1192-1195 (May 31) 1950.

18. Halbrecht, I.: Experience with Artificial Insemination, Human Fertility 11:72-74, 1946.

19. Vimeaux; Foreign Letters, Paris, Artificial Insemination, JAMA, 135:11 (Nov. 11) 1947.

20. Cary, W. H.: Results of Artificial Insemination with Extramarital Specimens, Am. J. of Ob. & Gyn. 56:721-732, 1948.

21. Haman, John O.: Artificial Insemination: Its Position in the Treatment of Sterility, Urologic and Cutaneous Review, 52:10, 1948.

22. Guttmacher, Alan F.; Haman, John O.; McLeod, John: The Use of Donors for Artificial Insemination: A Survey of Constant Practice, Fertil. Steril., 1:3, 1950.

23. Murphy, Douglas P.; Farris, Edward J.: Treatment of Sterility; Insemination Timed by Rat Ovulation Test. JAMA, 138:13, (Sept. 4) 1948.

24. Seymour, Frances I.; Koerner, Alfred: Artificial Insemination, JAMA, 116:2747 (June 21) 1941.

25. Artificial Insemination Act of Adultery, Omaha World Herald, (Oct. 30) 1954.

26. Schatlin, Sidney B.: Artificial Insemination and Illegitimacy, Human Fertility, 11:1, (March) 1946.

27. Guttmacher, Alan F.: The Legitmacy of Artificial Insemination, Human Fertility, 11:1 (March) 1946.

28. A Symposium on Artificial Insemination, Its Medico-Legal Aspects, American Practitioner 1:227, 1947.

29. Schlemer, John H.: Artificial Insemination, Mich. State. Med. Soc. 5:52, 1953.

30. Medicolegal Aspects of Artificial Insemination, JAMA, 147:3 (Sept. 15) 1951.

31. Medicolegal Aspect of Artificial Insemination, A Current Appraisal, JAMA 157:18 (April 30) 1955.

32. Goldenstein, Robert: Legal Rights of Test Tube Babies, Omaha World Herald, 16:6 (Jan. 9) 1955.

33. Artificial Insemination and Illegitimacy, Editorial, JAMA, 112:1832 (May 6) 1939.

34. Legitimacy of a Child From Artificial Insemination, Legislation, Human Fertility 13:1 (March) 1948.

35. Davidson, Henry A.: Let's Talk About Artificial Insemination, Medical Economics 32:13, (Oct.) 1955.

36. Abel, Stuart: The Present Status of Artificial Insemination, Surg., Gyn. & Ob. 85:16 (Dec.) 1947.

37. Schatkin, Sidney B.: The Legal Aspects of Artificial Insemination, Human Fertility 13:2 (June) 1948.

38. Brodney, M. Leopold; Rosen, Daniel: The Urologist and Artificial Insemination, J. Urol. 61:5 (May) 1949.

39. Russell, Murray: Artificial Insemination, A Plea for Standardization of Donors, JAMA, 144:461.