# *'The Reluctant Stork'*
# *Science, Fertility, and the Family in Britain, 1943 – 1960*

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# *Abstract*

This dissertation is a story of ordinary people – the heterosexual married couple, wanting to have a baby – who were willing to seek out and undergo medical treatment in order to start a family. Yet, it is also the story of an extraordinary period of public concern over the state of the 'natural' family, and the power of science to transform society. This dissertation tells two related and parallel histories of the 1940s and 1950s. First, it examines the development and expansion of fertility services, which was influenced by patient demand and the cultural climate in Britain. Secondly, it interrogates debates over artificial insemination, which ultimately led to the first government inquiry into assisted reproductive technologies in Britain. Assisted conception posed a threat to the family, but it also encouraged a more fluid definition of family roles, which by 1960 was beginning to take hold. Thus, the developments and debates from 1943 to 1960 laid the groundwork for those that followed in the 1970s and 1980s, when new technologies once again called into question family law and the ethics of human life.

Although popular narratives of reproductive technologies often begin with the birth of Louise Brown in July 1978 – the first "test tube baby" – the meaning attached to this term and the practice of assisted conception has a longer history. This dissertation argues that the 1940s and 1950s were a formative period in the development of fertility services – including artificial insemination – which sparked a seventeen-year-long debate over the meaning of the 'natural' family, and the role of science in human reproduction. This history has largely been neglected, with the focus tending towards the advances made in reproductive technologies in the 1960s and 1970s. This dissertation therefore sheds light on an important period that defined the relationship between science, fertility, and the family.

This dissertation is dedicated to my parents, Pat and John Andrew,
who cultivated my interest in feminism and medicine,
and who always spoke openly with me about matters of reproductive choice.

# *Acknowledgements*

My interest in fertility, reproductive choice, and medicine stems from a formative experience as a teenager. At the age of fourteen, I shadowed my father – a family physician in Tillsonburg, Ontario – at 'take our kids to work day', when he received an urgent call that a patient was in labour and ready to deliver. At the hospital, I stood nervously in the hallway as pained screams came from the delivery room. Wanting to maximize my learning experience, the delivery room nurse asked the soon-to-be parents if I could observe the birth. For reasons I have yet to understand, they said yes and I was thrust into a chair at the bedside witnessing one of the most intimate moments in a person's life – labour, delivery, and birth. To this couple, who twenty years ago let me share in this most personal experience, and to the many couples whose stories are included in this dissertation, who wanted nothing more than to have a child: thank you for allowing me a glimpse of your private life and deepest emotions.

The York University History Department faculty and staff have been a vital source of support during this project. Thank you to my supervisory committee – Stephen Brooke, Molly Ladd-Taylor, and Kathryn McPherson – who have offered thoughtful feedback, encouragement, and intellectual support that has been essential in seeing this project through. This research would not have been possible without the financial support of the following generous organizations and individuals: the Social Science and Humanities Research Council (SSHRC), the Ontario Graduate Scholarship (OGS), the Faculty of Graduate Studies at York University, Albert Tucker, the History Department at York University, and the St George's Society of Toronto.

I am grateful to the staff at the Wellcome Library and Archives, the Galton Institute, the National Archives, the Royal College of Obstetricians and Gynaecologists, the York University Scott Library, and the Toronto Reference Library for access to archives and research materials that formed the basis of this dissertation. I also benefited greatly from feedback received at the Infertility in History, Science, and Culture conference in Edinburgh in 2013. For organizing this conference, and for guiding me through my first publication process, thank you to Gayle Davis and Tracey Loughran. I am also grateful to the participants at the New Frontiers Graduate History Conference (2012 and 2013) for feedback and comments on early iterations of dissertation chapters.

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## *List of Abbreviations*

| | |
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| AI | Artificial Insemination |
| AID | Artificial Insemination by Donor |
| AIH | Artificial Insemination by Husband |
| AIHD | Artificial Insemination by Husband and Donor |
| ALRA | Abortion Law Reform Association |
| BCIC | Birth Control Investigation Council |
| BMA | British Medical Association |
| BMJ | *British Medical Journal* |
| FINRRAGE | Feminist International Network of Resistance to Reproductive and Genetic Engineering |
| FPA | Family Planning Association |
| HFEA | Human Fertilisation and Embryology Act |
| IUI | Intra-Uterine Insemination |
| IVF | In Vitro Fertilization |
| M-O | Mass Observation |
| MDU | Medical Defense Union |
| MGC | Marriage Guidance Council |
| MGTB | Marriage Guidance Training Board |
| MRC | Medical Research Council |
| MWF | Medical Women's Federation |
| NBCA | National Birth Control Association |
| NBCC | National Birth Control Council |
| RCMD | Royal Commission on Marriage and Divorce |
| RCOG | Royal College of Obstetricians and Gynaecologists |
| RCP | Royal Commission on Population |
| WHO | World Health Organization |

# *List of Illustrations*

## *Introduction*

### *Family Planning in the Scientific Age*

On 22 June 1945, six weeks after the victory in Europe, Mrs. T of Liverpool wrote to the Family Planning Association to request information on sub-fertility services and the possibility of artificial insemination:

> I have been advised to write to you, on behalf of my husband, and myself, we very much wish to have a child, but find my husband cannot give me one, and have recently heard about Test Tube babies. We would be very pleased if you could let us have details of the necessary procedure.[1]

Mrs. T was one of many correspondents writing to the Family Planning Association (FPA) in search of a solution to infertility in the years following the Second World War. The possibility of 'test tube babies' – by way of artificial insemination (AI) – captured the attention of the press, politicians, physicians, and the public. This dissertation is a story of ordinary people – the heterosexual married couple, wanting to have a baby – who were willing to seek out and undergo medical treatment in order to start a family. Yet, it is also the story of an extraordinary period of public concern over the state of the 'natural' family, and the power of science to transform society.

This dissertation tells two related and parallel histories of the 1940s and 1950s. First, it examines the development and expansion of fertility services, which was influenced by patient demand and the cultural climate in Britain. Secondly, it interrogates debates over artificial insemination, which ultimately led to the first government inquiry into assisted reproductive technologies in Britain. Assisted conception posed a threat to the family, but it also encouraged a more fluid definition of family roles, which by 1960

[1] Wellcome Library, London, SA FPA/A3/2 Artificial Insemination correspondence, 1945-64 (22 June 1945)

was beginning to take hold. Thus, the developments and debates from 1943 to 1960 laid the groundwork for those that followed in the 1970s and 1980s, when new technologies once again called into question family law and the ethics of human life.

Although popular narratives of reproductive technologies often begin with the birth of Louise Brown in July 1978 – the first "test tube baby" – the meaning attached to this term and the practice of assisted conception has a longer history.[2] This dissertation argues that the 1940s and 1950s were a formative period in the development of fertility services – including artificial insemination – which sparked a seventeen-year-long debate over the meaning of the 'natural' family, and the role of science in human reproduction. This history has largely been neglected, with the focus tending towards the advances made in reproductive technologies in the 1960s and 1970s. This dissertation therefore sheds light on an important period that defined the relationship between science, fertility, and the family.

Three interlocking arguments frame the focus of this research. First, the dissertation suggests a reconsideration of the definition of 'family planning' in the 1940s and 1950s to include not only birth control and contraception, but also infertility testing and treatment, including artificial insemination. Second, the dissertation reveals how infertility and AI illuminated discussions on the meaning of the family; in particular, AI showed how the idea of the family was influenced by, and influenced discussions of what was considered 'natural' conception and what was considered 'artificial'. In this regard, it demonstrates the ways in which science and technology affected political and popular discussions of reproduction, conceptions of the individual, and conceptions of the

[2] Sarah Franklin, 'Postmodern Procreation: A Cultural Account of Assisted Reproduction', in *Conceiving the New World Order: The Global Politics of Reproduction*, edited by Faye D. Ginsburg and Rayna Rapp, (Berkeley: University of California Press, 1995).

family. Lastly, my thesis contributes in important ways to understanding how gender – concepts of masculinity and femininity – shaped discussions of science, social mores, and political change. Perceptions of gender influenced science fiction cinema, social expectations of marriage, and recommendations for divorce law reform – all of which became concerned with AI in the 1950s. The history of infertility services in this period engages and involves multiple spheres of opinion: the powerful political, legal, and religious elite; the media and popular culture; clinicians and physicians; and, not least, ordinary people. This thesis examines each of these spheres and is attentive to the intersections between them.

**Family Planning and Infertility in Context**

The medical, social, and political landscape around reproductive rights changed dramatically between 1943 and 1960. At the outset of the period, fertility clinics were just beginning to expand with testing methods becoming standardized. Well into the 1940s, many practitioners in the medical community believed that contraceptive use caused infertility and might account for the declining birth rate.[3] Even by 1949, there was no standardization in medical school teaching on 'family planning' issues relating to contraception, infertility, and marital difficulties; some universities dealt with the topics comprehensively, while others treated them as an elective, or ignored them altogether.[4] Yet a wave of change began in the 1940s as greater awareness was drawn to infertility. For example, the Family Planning Association (FPA) expanded their clinic resources from 1943, in part as a response to the growing patient demand for infertility services. In addition, the Royal Commission on Population (1944–49) focused some of its attention

[3] 'Contraception and Infertility' *British Medical Journal*, 23 March 1946.
[4] Wellcome Library, London, SA/MWF/J.24.2, Returns to Medical Women's Federation questionnaire from local authorities in England, Wales, Scotland, and Medical Schools

on the role that involuntary childlessness played in demographic trends. The press paid increasing attention to fertility issues with, for example, the *Daily Mirror*'s 'agony' columnist Sister Clare directing readers to the FPA for help in conceiving.[5] Artificial insemination even became a focus of the Royal Commission on Marriage and Divorce, which declared in 1956 that the practice should be made a new ground for divorce. By the late 1950s there was widespread public awareness of AI as a result of media attention. Although the public was still largely opposed to the practice, this dissertation will demonstrate that there was an undercurrent of permissiveness in popular culture by the late 1950s.[6] The media had an interest in maintaining traditional institutions – including marriage – but it also encouraged tolerance for a new family structure that included the 'test tube baby'. In this way, the popular media challenged the concept of the 'natural' family. However, legislation was slow to catch up. The practice of artificial insemination challenged laws on illegitimacy and divorce, and led to calls for legislation to regulate the practice of assisted reproductive technologies. However, divorce law reform did not arrive until 1969, and it was not until 1987 that both illegitimacy and artificial insemination were addressed in the Family Law Reform Act, to reflect multiple family structures.

The Family Planning Association (FPA) is at the centre of this thesis. The establishment of the FPA in 1939 was the result of the amalgamation of multiple birth control organizations throughout the 1930s.[7] In May 1939, the National Birth Control

[5] Sister Clare, 'A Blessing Denied', *Daily Mirror*, 26 May 1949, p.8.
[6] George H. Gallup (Ed.), *The Gallup International Public Opinion Polls, Great Britain 1937-1975*, Vol.1 1937-64, (New York: Random House, 1976), 189, 449, 454.
[7] The Birth Control Investigation Council (BCIC) and the Workers' Birth Control Group, founded in 1927 and 1924 respectively, joined the National Birth Control Council (NBCC) in 1931. The NBCC had been founded in 1930, but was quickly renamed the National Birth Control Association (NBCA) in July 1931. In

Association (NBCA) became the Family Planning Association (FPA) – the name that the organization continues to function under today.[8] In 1939, the Association's aims were revised to not only advocate contraception and family limitation, but also create Women's Health Centres that would offer contraceptive advice, as well as offer counsel on involuntary sterility, gynaecological disorders, and marital problems.[9] Along with clinical services, the FPA produced didactic materials, such as the publications *How Many Children* (1943) and *For Childless Wives* (1944), which dealt with issues of 'sub-fertility'. As the Association built out its sub-fertility services, a seminological laboratory was also established in London in 1944, dedicated to the testing and treatment of male infertility.[10] From 1943, the FPA began to expand their clinical work in sub-fertility and became a liaison with the press to help couples navigate fertility treatment. Many prominent figures in the FPA were active in both sub-fertility and AI work, including Drs. Margaret Jackson, Joan Malleson, and Helena Wright.[11] Interestingly, many of these medical professionals were also closely involved in the Eugenics Society.

The Eugenics Society is an important but relatively quiet presence in this study. Throughout the 1940s and 1950s, the Eugenics Society provided financial support to the FPA, and for over a decade the headquarters of the two organizations shared an address. This ambiguous relationship between the FPA and Eugenics Society has largely been

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1938, the Society for Provision of Birth Control Clinics (SPBCC) and the Birth Control International Information Centre, founded in 1924 and 1929 respectively, joined the NBCA.

[8] 'Birth Control Investigation Committee'. Social Networks and Archival Context. http://socialarchive.iath.virginia.edu/ark:/99166/w6b42vjk; 'Family Planning Association, SA/FPA'. Wellcome Library Archives and Manuscripts. http://archives.wellcomelibrary.org/DServe/dserve.exe?dsqIni=Dserve.ini&dsqApp=Archive&dsqCmd=Show.tcl&dsqDb=Catalog&dsqPos=0&dsqSearch=%28AltRefNo%3D%27sa%2Ffpa%27%29.

[9] Audrey Leathard, *The Fight for Family Planning, The Development of Family Planning Services in Britain 1921 – 74*, (London: The MacMillan Press Ltd., 1980), 68.

[10] Leathard, *The Fight for Family Planning*, 73.

[11] See Appendix A: Biographies, and Chapter 1 for further details.

ignored in histories of family planning. The shared membership and financial relationship of these two organizations points to an important intersection, with implications for the aims of the FPA in this period. Interests in abortion law reform, birth control, family planning, and eugenics converged, resulting in a high level of membership overlap in representative organizations. These organizations, and the key figures at their centres, will be further explored in the following chapters.

**Language and Meaning**

It is essential to unpack the terminology of infertility and the 'technology' of artificial insemination. The most commonly used terms to describe difficulties conceiving in the 1940s and 1950s were 'sub-fertility' or 'involuntary childlessness'. In the medical community, there was a hesitation to use sterility or infertility. Sub-fertility was considered a more accurate reflection of the potential for a solution and was, therefore, deemed more psychologically hopeful for patients. Moreover, diagnostic testing was not yet advanced enough to confirm sterility with complete accuracy. 'Seminology' – the study of male fertility – was a developing field in this period, and disagreements persisted over medical definitions of male infertility.[12] 'Involuntary childlessness' remained the most common descriptor of infertility for a general audience and in popular culture. The most popularized and controversial technique for treating male infertility in this period was AI. Artificial insemination, or donor insemination, is a form of assisted conception in which semen is injected into the female cervix or uterus during ovulation, with the aim of pregnancy.[13] In the twenty-first century, variations include intra-uterine insemination (IUI), and advancements in reproductive technologies since the 1970s have made both

[12] Post-coital testing was the most common method in this period in establishing normal or 'sub' fertility.
[13] Andrea O'Reilly, *Encyclopedia of Motherhood*, (Thousand Oaks, California: Sage Publications, 2010), 81.

intracytoplasmic sperm injection (ICSI) and in vitro fertilization (IVF) possible to achieve conception.

This dissertation relies on the terminology of the period. In the 1940s and 1950s, there were three different methods of AI: artificial insemination by husband (AIH), by donor (AID), or by husband and donor (AIHD). AIH was employed when the husband's semen was viable but unable to naturally reach the ovum. AID was carried out when the husband was infertile. AIHD involved inserting both the husband and donor's semen (the husband's first, followed shortly by the donor's) offering a chance that the child would be the biological offspring of the father, which some physicians believed could "be of great psychological help to them during the child's upbringing".[14] Some doctors saw a marked ethical distinction between AIH and AID, though the latter was the most-debated form of assisted conception.

The 'technology' of AI must be put in context. Some contemporary commentators framed it within the 'atomic' age of scientific advancement: an example of the failure of the human condition in desiring progress without foresight for the consequences. This was also a period when science fiction film and literature was on the rise, marked by the publication of one of the most famous works of the twentieth century: *Brave New World* (1932). In many ways, referring to AI as a 'reproductive technology' is a misnomer. It was a treatment that assisted conception, but in practice there was nothing 'technological' about it. In the twenty-first century, the treatment is open for patients to undertake the procedure at home; this is not unlike the advice given by Marie Stopes in 1952 when she advised readers to avoid expensive medical fees and undertake the procedure at home

[14] *Report of the Departmental Committee on Human Artificial Insemination*, (London: Her Majesty's Stationary Office, 1960), 9.

with a husband's friend.[15] However, the idea and concept of the practice of artificial insemination in the 1940s and 1950s – generating the colloquial shorthand of making 'test tube babies' – escalated the public response to a level disproportionate to the reality, and divided both elite and popular opinion.

The meaning of the 'test tube baby' has changed over time. It was first associated with the concept of ectogenesis and artificial insemination, popularized in speculative literature in the 1920s and 1930s, and later with surrogacy and IVF, in the 1970s and 1980s.[16] In the 1920s and 1930s, literary references described mechanical reproduction and breeding babies in bottles, and despite the inaccuracy of this concept in the application of artificial insemination, the idea of reproductive technologies creating 'synthetic' life persisted through the 1940s and 1950s.[17] Rather than a literal label, 'test tube baby' became a catch-all phrase used both in the media and by ordinary people to describe assisted reproductive technologies. The term implied that sex and conception were separated, and the child involved came to symbolize 'artificial' life – that was neither 'normal' nor 'natural'. The implication was therefore that the practice of AI was one of scientific experimentation with unknown consequences. This particular label – emphasizing the artificiality of a child conceived by AI – is therefore an important point of reference when analyzing arguments critical of assisted conception. Opposition to reproductive technologies, from the 1940s to present day, has found common ground on two key issues: the 'unnatural' nature of the technology, and the threat to a child's

[15] 'Children: Live Letters', *The Daily Mirror*, 3 March 1952, p.9, and Wellcome Library, London SA/EUG/K.32, Artificial Insemination Letters, 1952.
[16] For example, see *Daedalus* (1924) and *Brave New World* (1932).
[17] See National Archives, London HO 342/58: during the Feversham Committee's interview with Margaret Jackson, Justice Stevenson referred to non-biological fatherhood as "synthetic".

welfare.[18] The first argument draws on fears associated with the potential abuses of such scientific advancement, evoking images of 'Frankenstein' or 'designer babies'. The argument's focus is on the earliest stages of reproduction, not with interventions such as prenatal testing.[19] Arguments over child welfare have focused on the potential psychological damage when a child discovers their origins (ie. donor insemination, or 'test tube' fertilization). Questions have also been raised over the morality of 'creating' more children when many neglected children would benefit from adoption.[20]

The meanings of this language should not go unquestioned. As mentioned, one of the long-standing critiques of those opposed to reproductive technologies is that they are 'unnatural'. Yet the concept of what is 'natural' and what is 'artificial' is culturally constructed.[21] The terminology has changed over time, as 'artificial' reproductive technologies have given way to 'assisted' reproductive technologies. While the term 'artificial insemination' will be used throughout this work, it should not suggest that it is taken at face value, but rather reflects the language and understanding of the practice at the time.

**A Brief History of AI in Medical Practice**

This study is not the beginning of the narrative on infertility treatments or artificial insemination – the former has a documented history stretching back to the early modern period, and the latter to the late eighteenth century – yet it marks a critical stage

[18] Emily Jackson, *Regulating Reproduction: Law, technology and autonomy*, (Portland, Oregon: Hart, 2001), 169.
Since the 1980s, opposition has also focused on the way in which reproductive technologies reinforce gender stereotypes.
[19] Jackson, *Regulating Reproduction*, 170.
[20] Ibid, 174.
[21] See Laura Purdy, *Reproducing Persons: Issues in Feminist Bioethics*, (Ithaca, NY: Cornell University Press, 1996); Laurie Zoloth-Dorfman, 'Our Bodies, Our Cells: Feminist Ethics and the New Reproductive Technologies', University of Wisconsin, http://minds.wisconsin.edu/bitstream/handle/1793/22126/fczoloth.htm?sequence=2

of development.[22] Even the concept of the 'test tube baby' was publicized before the publication of *Brave New World* in 1932.[23] However, the postwar period witnessed a growing public awareness of infertility services, which had become increasingly viable as a result of medical advancements (in endocrinology, ovulation detection, seminology, and post-coital testing) and the realization that both partners required examination, rather than only the woman being seen to have a 'problem'. The FPA played a central role as liaison and service provider throughout the period, and sub-fertility treatment was one aim of the FPA's work at a time of vast organizational expansion.

Documentation of the practice of artificial insemination extends back to the eighteenth century. The earliest reported experience with human artificial insemination was in 1776 when "the Scottish surgeon John Hunter supervised the first successful attempt at human artificial insemination when he instructed a linen draper, afflicted with hypospadias, on how to use a warm syringe to impregnate his wife".[24] For fear of the negative repercussions, the successful insemination was not reported until 1799 in *Philosophical Transactions* of the Royal Society, after Hunter's death.[25] In the nineteenth century, other cases were reported in France, and the United States. In France, Dr. Girault began experimentation in artificial insemination in the 1830s, claiming in his 1860s publications that ten of twelve cases achieved pregnancy.[26] Several French novels took artificial insemination as a theme in the 1880s; it became a subject in French marriage

[22] See Sarah Toulalan, Penny Roberts, Cristina Santos Pinheiro, and Catherine Rider in Tracey Loughran and Gayle Davis (eds.), *A Handbook of Infertility in History: Approaches, Contexts and Perspectives*, (London: Palgrave MacMillan, 2016).[forthcoming]
[23] Angus McLaren, *Reproduction by Design: sex, robots, trees, and test-tube babies in interwar Britain*, (Chicago: University of Chicago Press, 2012), and Duncan Wilson, 'Infertility, In Vitro Fertilization, and 'the Right to Have a Child' in the 1970s', Infertility in History, Science, and Culture Conference, University of Edinburgh, Scotland. 5 July 2013.
[24] Angus McLaren, *Reproduction by Design*, 115.
[25] McLaren, 115.
[26] Ibid.

manuals, and was even satirized by cartoonists.[27] The American gynaecologist, James Marion Sims, published an account of artificial insemination in the 1860s, which "precipitated a lively debate".[28] Yet only one of Sims' six cases achieved conception through insemination, and that pregnancy did not result in a live birth.[29] Mid-nineteenth century commentary illuminates early concerns for the social implications of the practice, including the eugenic implications, as Angus McLaren has described:

> In the 1890s, the conservative social theorist Vacher de Lapouge envisaged using artificial insemination to eugenically perfect humanity 'using a very small number of males of absolute perfection…to inseminate all the female worthy of perpetuating the race'[30]

While there were other documented cases of artificial insemination in Italy, Germany, and the United States in the late nineteenth and early twentieth century, and the Vatican condemned the practice in 1897, discussion of the practice was largely absent in Britain.[31] In the British context, AI was discussed in relation to animals more than humans, as it was not "looked upon as within the sphere of practical medicine".[32] As McLaren rightly points out, the absence of discussion in British journals does not necessarily mean AI was not being discussed or practiced.[33] In the early twentieth century, both Havelock Ellis and Marie Stopes wrote about the potential applications of artificial insemination, in *Studies in the Psychology of Sex* (1900-28) and *Married Love* (1918), respectively.[34] The subject also appeared in literature of the 1920s, including Virginia Woolf's ' A Society' (1921)

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[27] Ibid, 116.
[28] Ibid, 115,
[29] Andrea O'Reilly, *Encyclopedia of Motherhood*, 81.
Dr William Pancoast of Philadelphia is also reported to have conducted artificial insemination in the 1880s.
[30] McLaren, 116.
[31] Ibid, 117.
[32] 'Artificial Fecundation Before the Inquisition', *British Medical Journal*, 1(1940), 5 March 1898, 644; McLaren, *Reproduction by Design*, 117.
[33] McLaren, 118.
[34] Ibid, 118-119.

and *Lady Chatterley's Lover* (1928) by D.H. Lawrence.[35] However, in Britain the clinical practice remained limited to the private practice of a few doctors. Dr. Herbert Williamson (1871-1924) of St Bartholomew's Hospital had, during his career, performed thirty-three artificial insemination procedures, though without any success.[36] Dr. Norman Haire and Dr. S. Jervois were also early practitioners.[37] Although cases of AI had appeared since the late eighteenth century, it was not until the late-1930s that it was practiced on a more considerable scale with a measureable rate of success due to more comprehensive understandings of reproductive function.[38]

Advancements in endocrinology were responsible for increasing the success rate of artificial insemination through the 1940s. Ovulation was not understood until the 1930s, when its relationship to menstruation was determined.[39] Early-nineteenth-century research had linked menstruation with a monthly fertility cycle, and by the mid-nineteenth century there was a theory that monthly ovulation and menstruation were linked.[40] Yet until the 1930s, the purpose of menstruation and its specific relation to ovulation was only speculative.[41] By 1930, it had become possible "to visualize and locate an unfertilized egg", which supported "a consensus that ovulation occurred about fourteen days before menstruation".[42] This understanding of ovulation made it possible to accurately determine a woman's fertile period for insemination, as well as the ideal time

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[35] In *Lady Chatterley's Lover* the character Clifford talks of the possibility to "breed babies in bottles". McLaren, *Reproduction by Design*, 121, and D.H. Lawrence, *Lady Chatterley's Lover*, University of Oxford Text Archive, 151.
[36] Kenneth Walker, 'Diagnosis and Treatment of Sterility in the Male', *British Medical Journal*, 13 October 1928, p.654.
[37] McLaren, *Reproduction by Design*, 120.
[38] *Report of the Departmental Committee on Human Artificial Insemination* (1960), 4.
[39] Lara Freidenfelds, *The Modern Period: Menstruation in Twentieth-Century America*, (Baltimore: Johns Hopkins University Press, 2009), 44.
[40] Freidenfelds, 44.
[41] Ibid, 45.
[42] Ibid, 51.

for conducting post-coital tests and other fertility investigations. Reproductive research on spermatozoa also increased in the 1930s, improving the likelihood of success with AI.[43] It had long been assumed that reproductive problems were due to the female, as male organs were considered to be "less complex and less liable to malfunction".[44] However in 1930 Kenneth Walker, a genito-urinary surgeon at St Bartholomew's in London, wrote in *Male Disorders of Sex* that, "the doctor…no longer starts with the assumption that the wife is to blame" and "for the proper solution of the problem an examination of both is required".[45] It was recognized that sterility in the male was far more common than previously thought, and men were therefore generally tested before unnecessary surgery was performed on the woman.[46] Yet despite these advancements, many doctors remained unaware of protocols for investigating infertility, as indicated in a letter to Marie Stopes in 1931 where 'Mr B' indicated that "only after several operations on his wife did the doctor test his semen, and that the doctor had not even known that this was possible".[47] Even when doctors did test semen, many did not know of, or offer, a solution to low fecundity. This was in part due to the relatively small number of physicians involved in the practice. For example, between 1939 and 1959 there were only twelve known practitioners of AI in Britain.[48] These doctors were all in private practice (some were involved in the FPA), and their cases of AI represented a small part of their overall practice in sub-fertility and family planning.

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[43] 'Ovulation in the Woman', *British Medical Journal*, 16 June 1934, p.1084.
[44] Lesley Hall, *Hidden Anxieties. Male Sexuality, 1900 – 1950*, (Cambridge: Polity Press, 1991), 114.
[45] Hall, *Hidden Anxietes*, 119, 164-5.
[46] 'Sterility in the Male', *British Medical Journal*, 13 October 1928, p.652.
[47] Hall, *Hidden Anxieties*, 165.
[48] National Archives, London HO 342/58, 'Departmental Committee on Human Artificial Insemination: Doctors who have practiced AID'. These 12 doctors were interviewed by the Feversham Committee in 1959.

Medical and technological advancements once again changed the practice of reproductive medicine in the 1970s, with the advent of commercial sperm banks, hormone-based fertility drugs, and the successful birth of a baby conceived by in vitro fertilization in 1978. Work in cryopreservation had shown potential for 'sperm banks' as early as the 1950s, but commercial cryopreservation for semen did not become common until the 1970s, with banks established in the United States.[49] By the late-1960s hormonal treatments for sub-fertility had become increasingly common, and there was growing concern over multiple births as a result of new 'fertility drugs'. In February 1969, Roberts Edwards, Patrick Steptoe, and Barry Bavister published their research on early successes with *in vitro* fertilization in *Nature*.[50] It was not until 25 July 1978 that Louise Brown was born; the baby who would become known as the world's first 'test tube baby' via in vitro fertilization (IVF).

**Artificial Insemination and the Law: Divorce and Illegitimacy**

The legal implications of AI provoked a number of social sensitivities in the 1940s and 1950s. Assisted conception raised important questions concerning family law – in particular, the legal parameters for divorce and the definition of illegitimacy were challenged. First, AI came to question whether a marriage was still valid if a child was conceived 'artificially' and, second, how the legal status of a child conceived by AI should be defined. These questions – generating discussion on already outdated laws of divorce and illegitimacy – occurred within the context of a cultural preoccupation with marriage, divorce, and the state of the 'natural' family.

[49] O'Reilly, *Encyclopedia for Motherhood*, 81-82.
[50] R.G. Edwards, B.D. Bavister, P.C. Steptoe, 'Early Stages of Fertilization *in vitro* of Human Oocytes Matured *in vitro*', *Nature*, 221 (15 February 1969), pp.632-635.

The institution of marriage went through transformative changes in the twentieth century, as demands for divorce climbed and legislation gradually expanded the grounds on which divorce could be sought. Assisted conception gave rise to legal questions concerning divorce and annulment (claimed on grounds of adultery and non-consummation, respectively). I will briefly outline the legal history of divorce to provide context for these later discussions. Until the late-1960s, the grounds for divorce remained highly restrictive, requiring a husband or wife to sue on grounds of adultery, cruelty, desertion, incurable insanity, or presumption of death.[51] The disruption of war sparked a rise in divorce rates, which suggested that the institution of marriage was faltering. After the Second World War, the divorce rate climbed dramatically and AI became framed as a new cause for marital breakdown. In 1946 there were over 40,000 petitions, compared to 4,785 in the early 1930s, and the vast majority were claimed on grounds of adultery, by both men and women.[52] The growing incidence of divorce caused intense social concern for the state of marriage and family life in Britain. This apprehension led to the creation of the Royal Commission on Marriage and Divorce (RCMD), which began its

[51] See Charles Arnold-Baker, *The Companion to British History*, (Tunbridge Well, England: Longcross Press, 1996), 423; Tanya Evans, 'The Other Woman and her Child: extra-marital affairs and illegitimacy in twentieth-century Britain', *Women's History Review*, 20(1), 2011, (pp.47-65), 49; Claire Langhamer, 'Adultery in Post-War England', *History Workshop Journal*, (62) 2006, (pp.87-115), 98-99.
The Matrimonial Causes Act of 1857 gave power to civil courts, which allowed ordinary people to be granted a divorce more easily. Yet there was a high expense attached to divorce which prevented many people from affording it until the introduction of legal aid for divorce in 1950. The cost of a divorce in the early twentieth century was approximately £100. Divorce Law favoured the husband, who could be granted a divorce "on grounds of adultery by the wife", while the wife had to prove adultery in addition to either cruelty or desertion. In 1923, the grounds for divorce were made equal between parties, the wife no longer requiring evidence of cruelty or desertion to obtain a divorce – only proof of adultery. This restriction on the grounds for divorce often led to "fictional" adultery and collusion. The Matrimonial Causes Act that followed in 1937, expanded the grounds for divorce to include "adultery, cruelty, desertion for three years, incurable insanity for at least five years, [and] presumption of death". The 1937 Act further expanded the grounds for the annulment of a marriage to include "willful refusal to consummate, mental deficiency, venereal disease and pregnancy by someone other than the petitioner".
[52] Pat Thane, 'Family Life and Normality in Postwar British Culture' in *Life After Death: Approaches to a Cultural and Social History During the 1940s and 1950s*, (Cambridge: Cambridge University Press, 2003), 198.

proceedings in 1951. The Commission's 1956 Report recommended that new grounds for divorce should include the refusal to consummate the marriage, the institutionalization of a spouse with a mental illness, and artificial insemination by donor without the consent of the husband.[53] There was no immediate legislation on these recommendations, and when the Divorce Law Reform Act did come in 1969 it introduced 'no fault' divorce, at which point the introduction of AID without the consent of the husband as grounds was unnecessary.[54] Yet the fact that such a recommendation was included at all underscores the preoccupation with this 'technology' in the 1950s.

Like divorce, concerns about illegitimacy – a label given to children born outside of legal marriage – were central to the debate over artificial insemination. Children conceived by AID were considered illegitimate under law. Discussions over the legal status of the child, when a donor was involved, also raised questions around inheritance rights and parental responsibility. These anxieties were particularly timely in the 1950s when the 'illegitimacy' rate was seen to be growing.[55] Calls for reform to legitimacy laws were closely linked to calls for divorce reform. It was believed that to maintain the institution of marriage, strict divorce and legitimacy laws had to be upheld, but this necessarily meant that more children would be labeled 'illegitimate' in the eyes of the law. Although slowly over the twentieth century 'illegitimacy' as a label for children was eradicated, it persisted until the late 1980s. There were three waves of reform on the issue of legitimacy through the twentieth century: the first in the 1920s, the second in the late-1950s, and the third in the late-1980s. Before 1926, legitimacy required that a child be

[53] 'The Great Marriage Muddle', *Daily Mirror*, 21 March 1956, p.1.
[54] Arnold-Baker, 423.
[55] In 1949, there were 37,064 illegitimate children in Britain.
Tanya Evans, 'The Other Woman', 54.

born to parents who were married, with the presumption being that a married woman's child was also the biological child of her husband. The Legitimacy Act of 1926 allowed for the legitimation of children whose parents subsequently married (only if those parents had not been previously married) yet those children "conceived within adulterous unions" remained "illegitimate" in the eyes of the law until 1959. However, adoption provided somewhat of a loophole by allowing parents to adopt their own children – making them legally 'legitimate' – after the child was four years old.[56] As Tanya Evans has pointed out, a large proportion of 'illegitimate' children were legitimated through adoption in the 1940s and 1950s.[57] In 1958, John Parker (a Labour MP) introduced a private members' Legitimation Bill, which focused on the "plight of the innocent child", and while it was supported in the House of Commons, the Lords maintained the position that upholding marriage meant upholding the illegitimate status of children outside of wedlock.[58] However, the Lords' decision was not widely supported by the public or most members of Parliament and the bill was ultimately passed.[59] The resulting 1959 Legitimacy Act expanded the potential of legitimation in a limited way:

> [it] allowed men and women who had been married to someone else when their illegitimate child was born to later marry and to make the child legitimate. It also allowed men to apply to the courts for access and custody right to their children.[60]

Therefore, the 1959 Act offered legitimate status to children who were conceived in an extra-marital relationship, and it also expanded the legal parental rights of the father. The timing of the 1959 Legitimacy Act is directly relevant to this research, as it was given

[56] Evans, 'The Other Woman', 52.
[57] Ibid.
1940-5: 34% were legitimated by adoption; 1955-9: 46% legitimated by adoption. While those legitimated through the 1926 Act only comprised 16% of illegimate births between 1955-59.
[58] Evans, 'The Other Woman', 58.
[59] Ibid.
[60] Ibid, 59.

Royal Assent whilst the Feversham Committee on artificial insemination conducted their interviews in 1959.[61] Both members and witnesses to the Committee commented on the archaic distinction that punished children for the actions of their parents. It was not until the Family Law Reform Act of 1987 that "the legal distinction between legitimate and illegitimate child" was finally removed.[62]

**Themes and 'Characters'**

The three characters at the center of this study are the mother, father, and child. The ways in which these roles and experiences were constructed in the 1940s and 1950s is central to this research. In the media, these characters became labeled in the context of infertility: 'childless wife', 'sterile husband', and 'test tube baby'. A fourth character – the anonymous donor – sometimes also appeared as the 'phantom father'. This dissertation is framed by the themes of science, fertility, and the family. It is important to note that 'the family' at this time referred to the hetero-normative nuclear family, widely assumed to be white and British-born. Therefore, there are two important absences that need to be addressed: the discourse of infertility in this period is largely silent on questions of race and sexuality. The assumption was made in both official and unofficial discussion that fertility treatments and assisted conception were a concern for white heterosexual married couples. This meant that discussion of infertility, and by extension sex and reproduction, was only acceptable within the confines of the hetero-normative family structure. This view was only challenged in the late 1950s by the Feversham Committee, whose members and witnesses discussed the possibilities of interracial

[61] The Legitimacy Act was given Royal Assent on 29 July 1959.
[62] Ibid, 60.

families and 'unmarried' motherhood.[63] Perhaps unsurprisingly, the language of unmarried motherhood still ignored same-sex parenthood at this time. This perspective was challenged in the 1970s as lesbian couples began using AID to conceive (consequently facing public backlash), and 'unmarried' women were choosing to have children on their own. That 'whiteness' and heterosexuality were assumed does not preclude race or sexuality from the dialogue, but rather positions it as an undercurrent rather than an articulated issue.[64] Remaining cognizant of these silences, this dissertation takes as its focus a broad idea of the family – including the role of children, and gender roles in marriage and parenthood – and of science, which is situated in a zeitgeist of technological advancements in a consumerist society.

**The Family Under Threat**

Infertility and artificial insemination were seen to pose a challenge and threat to the core of the family at a vulnerable moment when population fluctuation, marital breakdown, and immorality were perceived to be cracking the foundation of the country.[65] The hetero-normative family – seen as an unshakeable fixture of British life – was under threat in the postwar period. As Pat Thane has pointed out, a growing anxiety in the 1950s over moral decline became part of a political, social, and media agenda.[66] The number of divorce petitions grew exponentially immediately after the Second World

[63] See National Archives, London HO 342/58.
[64] As Kathleen Paul, Wendy Webster and others have shown, the significant migration of people of colour to Britain in the 1950s was one of the most pressing social concerns of the period.
See Kathleen Paul, *Whitewashing Britain: race and citizenship in the postwar era*, (Ithaca, NY: Cornell University Press, 1997); Wendy Webster, *Imagining Home: gender, 'race' and national identity, 1945-64*, (London: UCL Press, 1998); Elizabeth Buettner, 'Would you Let Your Daughter Marry a Negro?': Race and Sex in 1950s Britain, pp.219-235; Elizabeth Buettner, *Empire Families: Britons and late imperial India*, (Oxford: Oxford University Press, 2004), 219.
[65] The family is understood here as a social and cultural construct. It is not a static unit, but a concept that changes over time and is shaped by and reflective of contemporary concerns. The institution of the family unit was relied upon for political, economic, and social stability.
[66] Pat Thane, *Unequal Britain*: *equalities in Britain since 1945*, (London: Continuum, 2010), 134.

War and remained high throughout the 1950s, never again returning to the pre-war rates.[67] Similarly, illegitimacy began rising steadily from the mid-1950s onwards.[68] The policing of homosexuality escalated dramatically in the 1950s, marked by the number of recorded street offences which climbed from an annual average of approximately 2,000 in the 1930s to more than 10,000 in 1952 and up to 12,000 by 1955.[69] The regulation of homosexuality in the 1950s (and a preoccupation with how men were having sex) was one indication of heterosexuality and marriage in crisis. A series of royal commissions and inquiries were directed at these issues. As both Stephen Brooke and Jeffrey Weeks have pointed out, government anxiety concerning the state of marriage and the family was obvious in these investigations – including the 1946 Curtis Report on Children, the 1949 Royal Commission on Population, the 1956 Royal Commission on Marriage and Divorce, and the 1957 Wolfenden Committee on prostitution and homosexuality.[70]

**The Conflict of the Companionate Marriage**

The period from the 1930s to 1950s is often described as the 'golden age' of marriage, but marriage was changing and it was increasingly under pressure in the postwar period.[71] There was an expectation of marriage at mid-century; it was the norm.

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[67] Thane, 'Family Life', 198.
[68] Christie Davies, *The Strange Death of Moral Britain*, (New Brunswick, NJ: Transaction Publishers, 2004), 2.
[69] Thane, *Unequal Britain*, 135; Naomi Pfeffer, *The Stork and the Syringe, A Political History of Reproductive Medicine*, (Oxford: Blackwell Publishers, 1993), 120.
Chris Waters also gives statistics, but his are far smaller: from 400 in the 1930s to 2000 per year in the mid-1950s. Chris Waters, 'Disorders of the Mind, Disorders of the Body Social: Peter Wildeblood and the Making of the Modern Homosexual' in Becky Conekin, Frank Mort, and Chris Waters (eds), *Moments of Modernity*, (London: Rivers Oram, 1999).
[70] Stephen Brooke, *Sexual Politics: Sexuality, Family Planning, and the British Left from the 1880s to the Present Day*, (Oxford: Oxford University Press, 2011), 120; Jeffrey Weeks, *Sex, Politics, and Society: The Regulation of Sexuality since 1800*, (London ; New York: Longman, 1981).
[71] Claire Langhamer, 'Love and Courtship in Mid-Twentieth Century England', *The Historical Journal*, 50(1), 2007, (pp.173-196), 178.

More people were marrying at younger ages.[72] 'Companionate marriage' became the ideal image to which couples were meant to aspire.[73] Ideological constructions of companionate marriage, whether in sociological studies, the press, or on television "influenced perceptions of the lived reality of marriage in this period".[74] The general historical interpretation is that the ideology of 'companionate marriage' was on the rise from 1918 to 1963, becoming the norm in the 1950s and 1960s.[75] It can be seen as equality in all areas of married life including mutual sexual pleasure, or as an "equal but different partnership" combined with sexual intimacy.[76] Although companionate marriage was certainly not universal, it was an aspiration for many and suggests, "that gender roles were in a state of transition".[77] However, this ideology of marriage in the 1950s paints a contradictory picture: the idea "was being officially encouraged whilst at the same time there were anxieties that – if pushed too far – it could undermine other features of family life which were seen as central to its stability".[78] In other words, too much equality in marriage could pose a problem, and what this typically meant was that women's roles were changing too much too soon. The tension surrounding the companionate marriage ideal is demonstrated by a cultural preoccupation with marriage and divorce in the postwar period. For instance, from 1946 to 1958 Gallup conducted sixteen polls in Britain on marriage and divorce. In comparison, in the five years on either side of that period

[72] Langhamer, 'Love and Courtship', 178; Langhamer, 'Adultery', 95.
[73] Janet Finch and Penny Summerfield, 'Social reconstruction and the emergence of companionate marriage', *Marriage, Domestic Life and Social Change*, (London: Routledge, 1991), 8.
[74] Finch and Summerfield, 'Social reconstruction and the emergence of companionate marriage', 8.
[75] Simon Szreter and Kate Fisher, *Sex Before the Sexual Revolution: Intimate Life in England 1918 – 1963*, (Cambridge: Cambridge University Press, 2010), 34-35; also see Marcus Collins, *Modern Love: Personal Relationships in Twentieth-Century Britain*, (Newark: University of Delaware Press, 2003), 93, 35. Szreter and Fisher argue that Marie Stopes' *Married Love*, published in 1918, was the stimulus for the spread of the companionate marriage ideal.
[76] Szreter and Fisher, 36.
[77] Langhamer, 'Adultery', 91.
[78] Finch and Summerfield, 17.

only one poll on these topics was conducted.[79] After the Second World War, the 'companionate marriage' ideal was promoted broadly by marriage manuals and the marriage-guidance movement, as well as through women's magazines and Royal Commission Reports. As Lynne Segal has argued, both popular and academic writing of the 1950s celebrated "a new 'togetherness', domestic harmony and equality between the sexes". [80] But the ideal of the companionate marriage was not often the lived reality for couples. Marga Vicedo has pointed to this 'togetherness' of the 1950s as a response to conflict and tension, and a retreat to the home reinforced traditional gender roles.[81] The maintenance of this traditional family structure also relied on children.

**The Child-Centered Society**

By the mid-twentieth century, the British family was increasingly centred on the children. Parents' hopes became "inseparable from the happiness and success of their children".[82] As families decreased in size, "child-centred families" increasingly became the norm, and children were likely to receive more attention from their mother and father as parents made greater emotional and financial investments in them.[83] In the 1940s, strategies for raising children also began to change. There was a shift from behaviourism – a style of parenting that promoted regularity and control, advocated by Dr. Truby King – to attachment theory, which promoted affection and attentiveness to a child's desires

[79] George H. Gallup (ed.), *The Gallup International Public Opinion Polls, Great Britain 1937-1975*, Vol.1 1937-64, (New York: Random House, 1976).
[80] Lynne Segal, *Slow Motion, Changing Masculinities, Changing Men,* Third Edition, (Basingstoke: Palgrave Macmillan, 2007), 2.
[81] Marga Vicedo, 'The social nature of the mother's tie to her child: John Bowlby's theory of attachment in post-war America', *British Journal for the History of Science*, 44(3), September 2011, pp.401-426.
[82] Hugh Cunningham, *The Invention of Childhood*, (London: BBC, 2006), 215.
[83] Cunningham, 203, 204, 215.

and fears by a primary caregiver.[84] The popularity of attachment parenting placed heightened expectations on parents – particularly mothers – encouraging them to be home with children rather than in the workforce, therefore upholding traditional gender roles. In the postwar years, the works of Benjamin Spock and John Bowlby were central to the changing understandings of childhood and parenting. In 1946, Dr. Benjamin Spock published *The Common Sense Book of Baby and Child Care*.[85] This hugely popular book took a more relaxed approach to parenting and encouraged mothers to 'enjoy your baby', 'have fun', and respond in a 'natural' way.[86] Spock told mothers, 'you know more than you think you do'.[87] British psychiatrist John Bowlby's work also emphasized the importance of the mother-child bond. After the war, the United Nations commissioned the World Health Organization (WHO) to produce a study on "the needs of homeless children".[88] The resulting 1952 report by Bowlby, entitled *Maternal Care and Mental Health*, laid out guidelines for a psychologically healthy childhood, based on attachment theory, arguing that "maternal care and love are essential for a child's mental health".[89] Both Spock and Bowlby emphasized the importance and 'naturalness' of the mother-child bond. This discourse influenced both understandings of gender roles, and expectations for family life. Following the WHO study, Bowlby and his colleague James Robertson further emphasized the centrality and 'naturalness' of the mother-child bond in

[84] Cunningham, 198; Harry Hendrick, *Children, Childhood and English Society, 1880-1990*, (Cambridge: Cambridge University Press, 1997), 28-29.
Truby King, a New Zealand doctor, promoted "breast feeding…toilet training and sleeping according to fixed timetables". His approach was "disciplinarian and authoriarian", and while he insisted that mothers be "intimately involved" in childcare, they were at the same time expected to show minimal affection. However, there was a "growing antipathy towards behaviourism" by the mid-1930s.
[85] Cunningham, 202.
[86] Hendrick, 31.
[87] Ibid.
[88] Vicedo, 403.
[89] Ibid, 404.

a film: *A Two Year Old Goes to Hospital* (1952). The film documented the experience of two-year-old Laura during an eight-day stay at a hospital for umbilical hernia surgery. The film emphasized the distress she exhibited in being separated from her parents (particularly her mother), and the extent to which her behaviour changed in the course of a week. It suggested that such separation at a young age could result in long-term psychological trauma.[90] This focus on child psychology and parenting extended to debates on artificial insemination, in which commentators worried about the unanticipated consequences for both the child and parents when conception did not occur 'naturally'. Thus, by the early 1950s there were heightened expectations of parents – particularly mothers – and an increased sensitivity to child welfare, based on psychology, much of which was a direct result of the war.

Cultural anxieties about the mother-child bond were especially intense because of wartime separations. In September 1939, more than 800,000 schoolchildren and over 500,000 mothers with pre-school children were evacuated from cities across Britain, in "the most extraordinary and extensive intervention by the state in the lives of children and their families in history."[91] For many families, this separation was traumatic. The experience of war "focused the attention of policy-makers: it drove home the fact that the future of the nation was dependent on the skills with which its children were equipped".[92] Therefore, the health and education of young people became a key feature of the Welfare State, in the Education Act (1944), the Family Allowances Act (1946), the Children Act

[90] *A Two Year Old Goes to Hospital*. Online. James Robertson and Joyce Robertson. UK: Robertson Films, 1952. Accessed online: http://www.dailymotion.com/video/x3gc1ug; Mathew Thomson, *Lost Freedom: the landscape of the child and the British post-war settlement*, (London: Oxford University Press, 2013), 86; Cunningham, 202.
Although the film was controversial – and implied that the medical staff were not effectively fulfilling their roles – it ultimately led to the loosening of restrictions on parents visiting their children in the hospital.
[91] Ibid 191.
[92] Ibid, 196.

(1948), and the National Health Service Act (1948).[93] Children's experiences in the war led to investigations and legislation that further promoted the welfare of children. The Curtis Report of 1946 investigated children in care who had been "deprived of a normal home life".[94] The subsequent Children Act of 1948 required every local authority to create a children's committee with the aim of "furthering the best interests of children in care", whether that was keeping them in their families, or encouraging fostering.[95] In 1959, the United Nations implemented the Declaration of the Rights of the Child, underlining "the duty of adults to protect, feed and educate children".[96] The changing nature of childhood in this period – the increasing centrality of children in the family, coupled with growing concern for child welfare – played a central role in the discourse of sub-fertility and artificial insemination, and thus are critical themes to explore here.

**Gender Roles and Expectations**

Like marriage, gender roles were in flux during the postwar period and this had a direct effect on parenting. Gender identities were complicated and "destabilized" as significant changes in the workplace and home shifted ideas of masculinity and femininity.[97] For example, nursery schools were created during the war in order to support mothers involved in war work, but these were closed at the end of the war "amid fears that women might not return to the home to release jobs for men".[98] This was

[93] Ibid, 197.
The 1944 Education Act raised the school leaving age to 15 years old and made secondary school compulsory (with three streams – grammar school, technical school and secondary modern). Family allowances, which Eleanor Rathbone had campaigned for since after the First World War, were finally introduced in 1946. This did not resolve the problem of poverty, but went some way to providing a measure of relief. School meals were also increasingly provided to children in need.
[94] Cunningham, 195.
[95] Ibid.
[96] Ibid, 224.
[97] Stephen Brooke, 'Gender and Working Class Identity in Britain During the 1950s', *Journal of Social History*, 2001 (pp.773-795), 774.
[98] Cunningham, 188.

underscored by a message that women should be in the home with young children, promoted through the works of both Spock and Bowlby. However, the number of women working increased by nearly 1 million from 1948 to 1958, when close to 8 million women were working outside of the home. Over forty per cent of these working women were married, which marked a significant break with previous trends.[99] However, a woman's place was still largely considered to be in the home. Ideas of motherhood in the 1950s were heavily influenced by 'Bowlbyism' – the concept that children who were "separated from and deprived of parental (particularly maternal) love and affection" would be psychologically damaged – and pronatalism, which encouraged motherhood and family growth.[100] It was John Bowlby's report in 1952 that significantly influenced ideas of child welfare. The report was controversial, though influential. Feminist critiques have suggested that this Report fixed women as mothers in the home with their children – or else risk psychological disturbances supposedly characteristic of children of absent (read: working) mothers.[101] Bowlby's report – backed by the WHO – emerged at a moment when more women were working outside the home, and Bowlby's view was that any breakdown of the family bond would be harmful to the child, including a mother in full-time work.[102] However, recently, Mathew Thomson has called for a revision of assumptions that have "focused on implications of attachment theory for the persistence

[99] Denise Riley, *War in the Nursery, Theories of the Child and Mother*, (London: Virago Press Ltd., 1983); William Thomas Heyck, Stanford Lehmberg and Samantha Meigs, *The Peoples of the British Isles: a new history*, (Chicago: Lyceum Books, 2008), 230.
[100] Mathew Thomson, *Lost Freedom: the landscape of the child and the British post-war settlement*, (London: Oxford University Press, 2013), 79.
'Bowlbyism' does not reflect Bowlby's work itself, but is rather a reflection of the "popularization of some of his key assumptions".
[101] See Denise Riley, *War in the Nursery*.
[102] Vicedo, 409, 406.

of gender inequality".[103] Instead, Thomson stresses the context in which Bowlby was writing, emphasizing that these findings were based not on the specific desire to keep women in the home, but rather were informed by the negative emotional and psychological effects on children who were 'homeless' or in institutions.[104]

These heightened cultural expectations of motherhood, also applied to fatherhood in the postwar years. Men's return "from battlefield to bungalow" and new family expectations, created an ideology around the domesticated man in the postwar years.[105] However, both Lynne Segal and Claire Langhamer have questioned this notion of a domesticated masculinity. It was certainly not universal in nature, and particularly in industrial areas men's centres of activity continued to be outside of the home.[106] Fewer working hours and increased incomes expanded 'house-work' for men but it remained bounded by acceptable gender roles.[107] For example, when asked in 1948 what household tasks men most often perform, Mass-Observation panelists indicated the following: "mending and fixing, carrying the coal, chopping firewood, lighting the fire, washing up, table-setting and window-cleaning".[108] Although some men were certainly active in childcare duties, in practice it remained predominantly the role of women. For example, 'fathers' were rarely listed in the index of 1950s books on family, and when fathers were mentioned it was not in relation to childcare.[109] Similarly, a 1958 handbook entitled *The Man's Book*, aimed at middle-class men, talked of tools and gardening, with not a single

[103] Thomson, *Lost Freedom*, 83.
[104] Thomson, *Lost Freedom,* 83-86; 92.
[105] Segal, *Slow Motion*, 2.
[106] Claire Langhamer, 'The Meanings of Home in Postwar Britain', *Journal of Contemporary History*, 40(2), April 2005, 355.
[107] Ibid.
[108] Ibid, 355-6.
[109] Segal, 4.

reference to children, housework, or anything regarded as 'women's work'.[110] Masculinity was in a fragile state in the postwar period.[111] Artificial insemination by its nature drew attention to male inadequacies, and "threatened to split social and biological fatherhood".[112] Sex was seen as the 'man's job' and sexual performance was closely tied to masculinity and heterosexuality.[113]

Therefore, in the postwar years, there was a tension between the social performance and lived reality of marriage and parenthood. Both fatherhood and motherhood were invested with greater importance in the 1950s. In the case of AID, the anonymous donor – or the 'phantom father', as he was popularly known – posed an enormous risk to the ideal image of family life, particularly the father-child relationship. Informed by popular psychology, assisted conception presented a threat to marital and parental bonds. AID highlighted the distinctions between social and biological parenthood, while at the same time reversing gender roles, "with the husband being passive and the wife active".[114] These social expectations played out in requests from ordinary people for fertility treatment, as well as in the political and medical discussion of artificial insemination. It is important to stress that these discussions were only able to take place within the confines of traditional heterosexual relationships.

**The Scientific Age**

The new 'technology' of AI fit naturally in a period of scientific advancement and fantasy. Through the 1950s, science and technology were glorified in their ability to make everyday life better: from the growth in ownership of TVs, refrigerators, and washing

[110] Ibid.
[111] See Carolyn Herbst-Lewis, *Prescription for Heterosexuality. Sexual Citizenship in the Cold War Era*, (Chapel Hill: University of North Carolina Press, 2010).
[112] McLaren, *Reproduction by Design*, 129.
[113] See Herbst-Lewis, *Prescription for Heterosexuality*.
[114] McLaren, *Reproduction by Design*, 129.

machines to the availability of pharmaceuticals like antibiotics. For instance, a 1958 advertisement for the pharmaceutical manufacturer, Cyanamid, showed a close-up of a young boy peering through tall grasses in a field with the caption, "What wonders he will see". [Figure 1.1] Promoting the new antibiotics, the ad described the life this young boy and his peers had to look forward to: "Born into a scientific age, they'll see wonders that will eclipse all those we marvel at today. Science will be their guardian in health…their hope for a richer, happier life".[115] Over-confidence in the 'miracle' of pharmaceuticals would lead to the global thalidomide crisis in the early 1960s, but in the 1950s, affluence coupled with technological advances generated optimism and hope for the future based on the abilities of science. This was, of course, a decade that brought the discovery of DNA, the polio vaccine, the first satellite launched into space, and the testing of the first hydrogen bombs. At the same time, consumer technologies were booming, and claimed to make domestic life easier and more enjoyable. These exciting advancements were tempered by concerns: fears of radiation, human limits being pushed to extremes, and, in the case of AI, the experimental practice of 'creating' babies. The persistence of eugenic thought in this period, and headlines making claims of 'designer babies' and 'breeding supermen', suggested that such concerns for scientific design and commodification were not unfounded. Eugenic thought remained a presence in the discourse of sub-fertility and artificial insemination through this period, demonstrated by discussion about the 'right type' of parents, which pointed to the significance of class, race, and psychology. The relationship between the FPA and Eugenics Society through these years further complicates the interpretation and will be explored in Chapter 1. From the 1930s onward, the Eugenics Society actively sought out a partnership with the FPA with the ultimate

[115] 'What wonders he will see' advertisement, *The Times*, 26 August 1958.

aim of merging the two organizations. While this merger never came to fruition, the Eugenics Society provided the FPA with financial backing from the 1920s through to the 1960s as well as giving the Association office space at the Society's headquarters from 1938 to 1949. The significance of this relationship has often been understated, and it is one of the aims of this study to illuminate this complex alliance.

**Historiography**

This study draws together literature on health and medicine, gender and sexuality, family planning, eugenics, science and technology, media, religion, and the family. These disparate subjects coalesce around the issue of infertility in the 1940s and 1950s. This dissertation therefore presents an innovative approach to a medical topic through the lens of social and cultural history.

This work is situated among other histories of the 1940s and 1950s. In recent years, a number of historians have argued against the traditional conception of the 'swinging 1960s' as a "watershed break with earlier attitudes to sex and social morality".[116] Stephen Brooke, Claire Langhamer, Frank Mort, Pat Thane, Adrian Bingham and others have argued that the growth of the 'permissive society' existed well before the 1960s, and they root the significant social and cultural change that led to the liberal legislation of the late 1960s in the 1940s and 1950s.[117] This was not a direct or linear change. As Frank Mort put it:

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[116] Frank Mort, *Capital Affairs. London and the Making of the Permissive Society*, (London: Yale University Press, 2010), 4.

[117] See Stephen Brooke, *Sexual Politics*; Claire Langhamer, *The English in Love: The Intimate Story of an Emotional Revolution*, (Oxford: Oxford University Press, 2013); Frank Mort, *Capital Affairs. London and the Making of the Permissive Society*, (London: Yale University Press, 2010); Adrian Bingham, *Family Newspapers? Sex, Private Life, and the British Popular Press 1918-1978*, (New York: Oxford University Press, 2009).

> the permissive society was neither a revolution in English social life nor a radical break with the sexual cultures that preceded it; rather it was an extremely uneven acceleration of shifts that had a much longer period of incubation.[118]

This dissertation will therefore be set within this periodization.

Histories of family planning have neglected sub-fertility in favour of contraception. This study argues that these two sides of family planning are inseparable. It suggests that understanding the origin and development of sub-fertility services is an important piece of the history of family planning and reproductive medicine. This is a notable absence, particularly as both the Family Planning Association and Medical Women's Federation understood and treated fertility and infertility as two sides of the same coin. The recent historiography of family planning in Britain has emphasized fertility decline and reproductive control, largely ignoring involuntary childlessness. Hera Cook, Kate Fisher, and Simon Szreter all address fertility limitation through contraception, but they do not raise the issue of infertility.[119] Furthermore, histories of the Family Planning Association have neglected sub-fertility services, which became a key aim for the organization from the 1940s onward. Therefore, the dominant narrative of fertility decline has overshadowed infertility and assisted reproduction. This history cannot be easily separated from the narratives of eugenics and family planning. Many of the medical practitioners involved in treating infertility were also advocates of eugenics, abortion, and birth control. In many ways, suppressing fertility through contraception and encouraging fertility by means of assisted conception are intimately linked – both are about greater reproductive choice and control.

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[118] Mort, *Capital Affairs*, 4.
[119] See Hera Cook, *Long Sexual Revolution*; Kate Fisher, *Birth Control, Sex and Marriage*; Kate Fisher and Simon Szreter, *Sex Before the Sexual Revolution*.

A monograph-length study of infertility and AI in the 1940s and 1950s has not been written. In recent years, there have been an increasing number of histories of infertility and artificial insemination, in both the American and British contexts.[120] In particular, this study builds on the work of Naomi Pfeffer, Gayle Davis, Carolyn Herbst-Lewis, and Margaret Marsh and Wanda Ronner in its analysis of gender and familial expectations.

This thesis expands on key works in the history of infertility and artificial insemination. In the American context, it draws on Carolyn Herbst Lewis' work on AI and masculinity during the Cold War, in which she argues "artificial insemination simultaneously reinforced postwar gender ideology and undermined the structural framework of the American family and the moral security of the broader national community".[121] As Herbst Lewis has shown of the American context, in Britain physicians acted as 'gatekeepers', only offering infertility treatment to 'suitable' couples.[122] Yet, the way in which AI was perceived in Britain differed in important ways from the American experience. American physicians saw AID as a way to fulfill 'normal' family life, and in particular as a way "to preserve the ideals of manhood and masculinity".[123] Doctors therefore "placed new emphasis on social fatherhood", yet they still encouraged the maintenance of "the fiction of biological fatherhood".[124] In Britain, there was an intense focus on the threat AID posed to 'manhood', with a diagnosis of

[120]See Tracey Loughran and Gayle Davis (eds), *A Handbook of Infertility in History: Approaches, Contexts and Perspectives*, (London: Palgrave MacMillan, 2016); Margaret Marsh and Wanda Ronner, *The Empty Cradle. Infertility in America from Colonial Times to the Present*, (London: Johns Hopkins University Press, 1996); Carolyn Herbst Lewis, *Prescription for Sexuality*; Naomi Pfeffer, *The Stork and the Syringe*; Angus McLaren, *Reproduction by Design*; Gayle Davis, 'Test Tubes and Turpitude: Medical Responses to the Infertile Patient in Mid-Twentieth Century Scotland', *Western Maternity and Medicine, 1880-1990*, Edited by Linda Bryder and Janet Greenlees, (Abingdon: Pickering and Chatto, 2013); Elaine Tyler May, *Barren in the Promised Land. Childless Americans and the Pursuit of Happiness*, (New York: Basic Books, 1995).
[121] Herbst-Lewis, 115.
[122] Ibid, 117, 142.
[123] Ibid, 142.
[124] Ibid.

sterility often kept a secret from the husband. There was a concerted educative effort to reassure men that 'masculinity' and virility were unassociated with fertility. Long-standing laws of heredity and inheritance, which did not have the same significance in the United States, also complicated definitions of fatherhood in Britain. Also building on the work of Margaret Marsh and Wanda Ronner, on infertility in America, this thesis suggests that it was not only the medical profession but also ordinary people and the popular media that brought donor insemination into the mainstream.[125] Moreover, Marsh and Ronner have rightly emphasized that infertility is not a new phenomenon, and that white middle-class couples do not dominate those who experience infertility.[126] They point out that despite the perception that infertility is increasing, the rates have remained quite stable over the last hundred years, with a range from just under ten per cent to around thirteen per cent of the total number of married couples.[127]

The most comprehensive history of infertility and reproductive technologies in Britain is *The Stork and the Syringe* (1993)*,* Naomi Pfeffer's political history of reproductive medicine. In it, Pfeffer examines the way in which infertility was treated by the medical profession from the late nineteenth century to the late twentieth century. In particular, Pfeffer traces the gradual shift from a focus on the woman as the problematic partner, to an approach that examined both men and women. She sets this within the context of population concerns from the early twentieth century onward, and examines early hormonal treatments, tubal insufflation, semen analysis, AI, and IVF. My thesis takes inspiration from a chapter of *The Stork and the Syringe*: 'A Crutch in the Crotch'.

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[125] Margaret Marsh and Wanda Ronner, *The Empty Cradle. Infertility in America from Colonial Times to the Present*, (London: Johns Hopkins University Press, 1996), 166.
[126] See Margaret Marsh and Wanda Ronner, *The Empty Cradle. Infertility in America from Colonial Times to the Present*.
[127] Marsh and Ronner, *The Empty Cradle*, 2.

In it, Pfeffer presents a history of artificial insemination in the 1940s and 1950s – drawing together medical, political, eugenic, legal, and popular narratives – arguing that donor insemination became "associated with other complex issues" and can therefore "act as a focus for wider social anxieties".[128] Thus, the present work draws directly from Pfeffer's research but expands the analysis to closely examine key developments and discourses, which are only briefly addressed in *The Stork and the Syringe*.

Recent work on artificial insemination by Gayle Davis and Angus McLaren has offered new frameworks with which to approach the subject. This thesis draws on Gayle Davis' analysis of the Feversham Committee evidence. Davis argues that female sexuality was "pathologized, indeed psychiatrized, when it was perceived to deviate from a narrowly defined norm".[129] Therefore, the woman seeking infertility treatment was frequently labelled as 'obsessional' and 'neurotic', while the man was approached with a 'paternalistic' attitude, underscored by the belief that he was unable to "cope with the knowledge of his reproductive inadequacy".[130] My thesis also draws on Angus McLaren's approach to AI within the context of science fiction. Looking at discourses of reproduction in the interwar period, McLaren argues that, "anyone talking about the future of sex and reproduction, were in effect producing 'science fictions'. That is to say, many scientific theories and notions of the future, especially the forebodings, were in fact crystallizations of current social concerns".[131] While McLaren focuses on the interwar period, I have extended this approach to the postwar period. McLaren has also analyzed

[128] Pfeffer, *The Stork and the Syringe*, 112.
[129] Davis, 'Test Tubes and Turpitude', 113.
[130] Ibid, 122, 126.
[131] McLaren, *Reproduction by Design*, 2.

the correspondence and debates in the *British Medical Journal* from 1943 to 1945, from which I have drawn inspiration.

Outside of these aforementioned works, most existing histories that have recognized artificial insemination have treated it as a sub-narrative of a broader story. Even in *The Stork and the Syringe*, artificial insemination is one piece of a much larger picture and therefore is not extensively addressed outside of one chapter. Lesley Hall discussed AI briefly in the survey *Sex, Gender and Social Change* and in *Hidden Anxieties*, a study of male sexuality, arguing that it weakened socially accepted values linking gender, sex, and reproduction. Yet, in both works, AI acts as a minor example of broader perceptions of sexuality rather than a subject in its own right.[132] Interestingly, recent work done in the biomedical field by Sarah Wilmot, Abigail Woods, and John McMillan has focused on agricultural AI and the link between the study of animal and human reproductive technology.[133]

Few historical works have concentrated on the 1940s and 1950s as formative periods in the history of infertility and reproductive technologies. Earlier works, such as R. Snowden, G.D. Mitchell and E.M. Snowden's *Artificial Reproduction: A social investigation* (1983), have examined the practice historically, though the general nature offers little differentiation to address how the practice has changed over time. For

[132] Lesley Hall, *Sex, Gender and Social Change in Britain Since 1880*, (New York: St Martin's Press, 2000), 165; Hall, Hidden Anxieties.

[133] See Sarah Wilmot, 'Between the farm and the clinic: agriculture and reproductive technology in the twentieth century', *Studies in History and Philosophy of Biological and Biomedical Sciences*, 38 (2007), pp. 303 – 315; Sarah Wilmot, 'From 'public service' to artificial insemination: animal breeding science and reproductive research in early twentieth-century Britain', *Studies in History and Philosophy of Biological and Biomedical Sciences*, 38 (2007), pp. 411 – 441; Abigail Woods, 'The farm as clinic: veterinary expertise and the transformation of dairy farming, 1930 – 1950'. *Studies in History and Philosophy of Biological and Biomedical Sciences*, 38 (2007), pp. 462 – 487; John McMillan, 'The return of the Inseminator: Eutelegenesis in past and contemporary reproductive ethics'. *Studies in History and Philosophy of Biological and Biomedical Sciences*, 38 (2007), pp. 393 – 410.

instance, in the aforementioned book, the period from 1940 to 1980 is examined as a whole. Similarly, Gena Corea's *The Mother Machine* (1985) examines reproductive technologies in America from 1945 to 1980, and although it raises important theoretical and ethical issues, the treatment of artificial insemination is focused largely on the post-1960 period. Significant work has been done on the history of reproductive technologies after 1960, but the earlier origins of these practices require further exploration.

**Sources and Methodology**

The research for this dissertation has relied predominantly on three types of sources: the archives of organizations, government committees, and published journals and newspapers. This research is based in large part on the Family Planning Association archives at the Wellcome Library, and the Feversham Committee evidence at the National Archives. It owes a great deal to newspaper and journal archives, primarily the *British Medical Journal*, the *Eugenics Review*, *The Times*, *The Guardian*, *The Daily Mirror*, and *The Daily Express*, and to moving image media. These sources address multiple aspects of the history of infertility and artificial insemination.

The archives of the FPA laid the groundwork for this dissertation, the 'seed' of which came from research on the birth control movement. Combing through the *Eugenics Review* and *British Medical Journal* archives of the 1940s, I was surprised to find the topic of 'artificial insemination' popping up. What began as a focused study of medical debate during the war became the subject of this dissertation. This dissertation makes use of newly opened and previously underexplored archival sources on the subject, though the framework has largely been guided by the FPA archives. The Feversham Committee evidence, detailing the government-sponsored investigation into AID, was only opened at

the National Archives in 2010 and 2011. With over 1,200 pages of evidence, this source requires further exploration than what is presented here in Chapter 5. Furthermore, the FPA archives hold a breadth of material on sub-fertility clinics, public communications, and intimate letters documenting the experience of ordinary couples struggling with infertility. The Eugenics Society archives, similarly, hold a range of material on the Society's work on sub-fertility and AI during this period. Certainly, there is opportunity to further examine the complex relationship between the FPA and the Eugenics Society during this period.

This methodological approach focuses largely on official discourses (medical, political, religious, legal) but the study also examines the relationship between patients and practitioners, as well as the importance of popular sentiment. Popular ideas and fears about 'test-tube babies' and 'phantom fathers' were expressed in the press from the 1940s onward.[134] Although sensationalized reporting was common, newspapers offer important insight into popular attitudes, and also highlight legal concerns associated with reproductive technologies.

The dissertation also examines the pathways of knowledge. It attempts to present a history from below, as well as from above. It uses discourses to present a multi-faceted image of this postwar moment when the stability of the family was so deeply rooted in the culture's psyche. It also draws on the experience of ordinary people who were seeking out and going through fertility treatment. It considers the relationship between patient, practitioner and policy-maker and aims to balance the clinical history with cultural perspectives.

[134] 'Phantom fathers' was a phrase frequently used in the popular press. See 'The Phantom Fathers', *Daily Mirror*, 21 February 1958; 'A Quiz for A.I.D. Fathers', *Daily Mirror,* 20 October 1958; 'Phantom Fathers', *Daily Mirror*, 22 July 1960.

The foundation of my argument is based on the right to reproductive choice. As Linda Gordon argues, "conflicts about reproductive rights are political conflicts" and "even what appear to be technological developments and neutral social scientific surveys must always be understood in political context".[135] Feminism is utilized as an analytical framework – illuminating gendered power dynamics. From the 1970s and onwards, feminists have been deeply divided over reproductive technologies. These arguments center on issues of 'choice' and 'control': positioning reproductive technologies as the patriarchal control of women's bodies, and/or as expanding women's reproductive choices. Some feminists have argued that this perceived increase in reproductive choice reinforced traditional social expectations of women's role as mother. Moreover, some have argued that through medical intervention, women's reproductive choice is placed in the hands of male medical authorities. However, other feminists have argued that assisted reproductive technologies provide individual women and couples with the opportunity to fulfill a desire for biological parenthood. This tension has been characterized as two different approaches to feminist ethics: power-focused ethics, which aim to eliminate structures that perpetuate patriarchy; and care-focused ethics, that center on nurturing and compassion.[136] The most powerful opposition to reproductive technologies came from the Feminist International Network of Resistance to Reproductive and Genetic Engineering (FINRRAGE) in the 1980s. FINRRAGE argued that reproductive technologies represented men asserting power over women's bodies, and new technologies like IVF

[135] Linda Gordon, *The Moral Property of Women: a history of birth control politics in America*, (Urbana: University of Illinois Press, 2002), viii.
[136] Rosemarie Tong, *Feminist Approaches to Bioethics: Theoretical Reflections and Practical Applications,* (Boulder: Westview Press, 1997), 2.

only offered the 'illusion of choice' for women.[137] Feminist advocates of assisted conception, who focus on the benefit to the individual, believe that with proper safeguards women are not exploited and assisted reproductive technologies offer "a valuable affirmation of the genetic connection".[138] Several feminist activists have stressed the painful reality of infertility, calling for treatments to be made more accessible, and "criticized what they considered anti-technology feminists' romanticized construction of 'natural' motherhood".[139] However, this feminist critique of reproductive technologies only emerged in the 1980s.[140] Where one argument ends, and the other begins, is not always clear. This research explores the deeply rooted prejudices and inequalities at work in healthcare, and questions the gendered power dynamics involved. Therefore, this is not a celebratory narrative of women being offered more reproductive choice, but rather one that analyzes the limits of this 'choice'. This work is thus situated between the two dominant feminist arguments and ethical positions – suggesting that reproductive technologies can be about both 'choice' and 'control'.

## Contemporary Concerns

This research is particularly important because at the centre of this narrative are contemporary concerns about reproductive science and technology; concerns that question the limits and possibilities of human life and the formation of bioethical policies. Although the controversy over artificial insemination examined here is specific to the

[137] For discussion of feminist approaches, see Molly Ladd-Taylor, 'A Kind of Genetic Social Work': Sheldon Reed and the Origins of Genetic Counselling', in *Women, Health, and Nation: Canada and the United States Since 1945*, (Montreal: McGill-Queen's University Press, 2003), 68; Georgina Feldberg, Molly Ladd-Taylor, Alison Li, Kathryn McPherson, 'Comparative Perspective on Canadian and American Women's Health Care since 1945', in *Women, Health and Nation: Canada and the United States Since 1945*, (Montreal: McGill-Queen's University Press, 2003), 32; Rosemary Tong, *Feminist Approaches to Bioethics*.
[138] Tong, *Feminist Approaches to Bioethics*, 186.
[139] Feldberg, et al., *Women, Health and Nation*, 32.
[140] Marsh and Ronner, 231.

1940s and 1950s, there are continuities that extend through to present debates on bioethics and human reproduction. Developments in fertility treatments and debates over their practice in the 1940s and 1950s, helped to shape a discursive framework and patterns of articulation of debate and policy on reproductive technologies that followed in the 1970s and 1980s. These earlier discourses raised questions that underline ethical considerations that are still under discussion today: Is parenthood a right, a choice, and for and by whom? How far should an individual's freedom to choose extend? And what role should the State play in the reproductive lives of its citizens? These questions have been addressed in different ways in various national contexts, and continue to be debated in the United Kingdom, Canada, and elsewhere.[141] This research also offers a reflection on how new technologies enter the mainstream and become socially accepted.

**Sections and Chapter Outlines**

The structure of this dissertation reflects the two connected narratives – the development of sub-fertility services and debates on artificial insemination – which culminated in a government investigation into AI. The dissertation is therefore divided into three sections: first, the FPA and sub-fertility services; second, debates on artificial insemination; and, lastly, the investigation by the Feversham Committee. The structure also reflects the symbolic spaces in which the services and discourse were developed. These spaces included clinics, cultural spaces, and committees. Each of these spaces creates a different window with which to look at one particular issue.

[141] State subsidies vary by country, as do restrictions based on age, health, and reproductive history. Australia, New Zealand, and most countries in Europe provide public funding to IVF to some degree. Rob Ferguson, 'Ontario to cover in-vitro fertilization treatments', *Toronto Star*, 1 October 2015. http://www.thestar.com/news/queenspark/2015/10/01/ohip-to-cover-in-vitro-fertization-treatments.html

Section I relies on the clinic and its services to illuminate the practice of sub-fertility and the expansion of services. The work of the FPA, its clinics, and practitioners defined the practice of sub-fertility testing and treatment in these years. Both qualitative and quantitative patient records highlight the clinical experience, and address the patient-practitioner relationship. In this section, Chapter 1 examines the development of sub-fertility services in Britain during the Second World War, which was marked by tension between the medical establishment and the voluntary sector. It also underscores the relationship between the FPA and the Eugenics Society during this time, as Eugenics Society executives C.P. Blacker and Lord Horder often moderated negotiations for funding and credibility. It addresses developments in health care and access to services, which were mediated by power and privilege. Chapter 2 is concerned with the experience of infertility and draws on a collection of letters written to the FPA in the postwar years. By examining barriers to fertility treatment, and the link between public knowledge and press attention, this chapter highlights patient agency in seeking out infertility treatments and the different ways in which gender roles influenced approaches to infertility. Infertility was particularly challenging in a period associated with the so-called 'golden age' of marriage, in which the social expectation to have children was so high, while at the same time information and access to fertility treatment was so difficult to reach. An analysis of patient agency and the role of the press in disseminating information is revealing of these challenges.

Section II uses cultural spaces and committees to showcase debates on AI. The media landscape is central to this as both newspaper readership and television viewership increased through the 1950s, creating a competitive media marketplace. In this section,

Chapter 3 examines the political, medical, and religious responses to AI from 1943 to 1948. It begins at a 1943 House of Lords discussion, follows with a debate in the correspondence pages of the *British Medical Journal*, and closes with the Archbishop of Canterbury's Committee, which concluded that artificial insemination was a 'breach of marriage'. These varied responses demonstrated conflicting views on the family, technology, and the role of the medical profession, and set the stage for the later debates. Chapter 4 concentrates on the years from 1949 to 1958 and argues that artificial insemination acted as a barometer to gauge the social sensitivity around particular issues like marriage, legitimacy, and sexuality. The way in which the media approached AID, as recognition of its existence bubbled to the surface, revealed the diffuse public concern over the state of marriage and heterosexuality – demonstrated by sensationalized legal cases and government intervention that gave rise to the Royal Commission on Marriage and Divorce and the Wolfenden Committee. The controversy was not so much about the "technology" of AI itself, as it was about a moment characterized by a fascination with science and technology, and apprehension over family breakdown. But when AID became an issue of public concern – it did so because it reflected other social anxieties and offered a new forum in which to debate marriage, sex, and family relationships.

Section III relies on the evidence of the governmental committee tasked with investigating the state of human artificial insemination in 1958. Chapter 5 examines the medical and religious evidence provided to the Feversham Committee on Human Artificial Insemination. This chapter analyzes the implications for understandings of class, race, and gender embedded in the discourse of reproductive politics and healthcare policy-making. Furthermore, it questions the so-called 'permissiveness' of the period and

situates the investigation of this relatively unknown Committee into a broader context of governmental inquiries. The Feversham Committee was a typical government response, which sought to document and understand a 'social problem' that appeared to threaten the institutions at the core of family life. This particular Committee was more controversial, in terms of serving as a member, than previous investigations into family law reform (like the Wolfenden Committee of 1954 to 1957, or the Royal Commission on Marriage and Divorce of 1951 to 1956). This chapter also considers the religious evidence of the Feversham Committee and argues that it both shaped the Committee's report and reflected broader religious change in Britain.

The Conclusion retraces the key arguments of the dissertation and casts ahead from the 1960s to 1990, when the Human Fertilization and Embryology Act put into law questions around assisted reproductive technologies that had been under discussion since the 1940s.

# *Chapter 1*

## *Forging a Sub-Fertility Service at the Family Planning Association, 1943–60*

In 1943, *The Lancet* published a letter from Lord Horder, President of the FPA, in which he announced a new initiative to address cases of sterility:

> In view of the fact that at least 10% of married couples suffer from involuntary sterility, it is obvious that the problem of such sterility is one of great national importance, not only because of the personal unhappiness it may cause, but because of the urgent need to increase our present birth-rate if a falling population is to be averted.[1]

In the midst of the Second World War and with a perceived population crisis due to the declining birth rate, the Family Planning Association established 'Sub-Fertility' as a cornerstone of their services. Contraceptive provision – the focus of the FPA's services before the war – was still mired in controversy and continued to work against the organization, particularly given the persistence of religious opposition. By addressing the concern over a falling birth rate and extending their organizational priorities to include sub-fertility, marriage advice, and sessions for men, the FPA began 'rebranding' their organization, a move that made its work more palatable to both officials and to the public. This research places a spotlight on a historically neglected aspect of the Association's work, and argues that 'sub-fertility' played a valuable role in the rise of a more favourable public opinion on family planning through its focus on supporting all aspects of family life.

When the National Birth Control Association changed its name to the Family Planning Association in May 1939, the organization also expanded its core aims.

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[1] Lord Horder, 'Sterility', *The Lancet*, 22 May 1943, 664.

Therefore, the term 'rebranding' is employed here to signal that not only was the FPA a new name, but it also presented a new communications strategy to reframe the organization's identity for 'consumers', investors, and other stakeholders. This rebranding can be viewed in multiple ways: as a more favourable repositioning in a changing 'market', by making contraception more palatable to the public; as the de-radicalization and de-politicization of the birth control movement; as the influence of 'positive' eugenics; or simply a shift in communication to convey the extended service offerings of the organizations. In contrast to previous attitudes toward the Association's activities of advocating birth control and restricting family growth, the FPA's revised aims had, by the early 1960s, elevated its reputation with the press, religious authorities, politicians, and the public at large by extending the meaning of 'family planning'.[2] While attitudes to birth control changed substantially over this period, this chapter argues that it was also the promotion of sub-fertility services that bolstered the organization's recognition as a legitimate health care provider.

This chapter tells the organizational, clinical, and communications history of sub-fertility services at the FPA, the establishment of which was not without controversy. It situates the work of the FPA in a wider health care context, and examines the structure of sub-fertility services, the clinical practice, and how the FPA communicated its work and developed alliances. Two of the FPA's clinics will be examined in this chapter: the Exeter and District Women's Welfare Centre and the North Kensington Marriage Welfare Centre. These centres will serve as brief case studies of how sub-fertility work evolved during the 1940s and 1950s, as they were the first two prominent FPA clinics to

[2] Family planning shifted the focus to a more positive vision of 'spacing' births, encouraging 'healthy' families, providing wider guidance services and offering sessions specifically for men.
Leathard, *The Fight for Family Planning*, 95.

address sub-fertility and substantial records from both clinics survive. This examination of administrative and clinical work is balanced with an analysis of the Association's communications. By developing relationships with the press, politicians, and with religious leaders, the FPA formed alliances with critical influencers of public opinion. The FPA further extended its reach (and publicity) through educative efforts in publications and film. This rebranding must also be considered in a broader context particularly in light of the complex relationship between the FPA and Eugenics Society.

Thus, from 1943 onwards the FPA redirected some of its attention to sub-fertility work, becoming an important resource for information, testing, and treatment of infertility, alongside hospitals. The FPA's role underlines the continued importance of voluntary health organizations after the establishment of the NHS. By building sub-fertility as a core component of their work, the Association was addressing a void in medical school training on subjects of 'family planning'. Most medical schools reserved the subjects of birth control and sub-fertility for postgraduate training or specialist lectures in Obstetrics and Gynaecology, which translated into a knowledge gap in general practice as only a relatively small number of doctors were qualified for sub-fertility work. The FPA aimed to expand sub-fertility from a strictly specialist realm and increase the number of practitioners qualified for sub-fertility testing (particularly the preliminary work of post-coital tests). For patients trying to resolve fertility concerns, the aim was to provide an accessible service – both geographically and financially.

Female physicians were at the center of the FPA's sub-fertility initiative; it was a strategy led by women, for women. Women like Dr. Joan Malleson, Dr. Helena Wright, Dr. Margaret Jackson, and Dr. Eleanor Mears advocated a more holistic approach to the

subject of fertility, with the aim of moving away from invasive procedures for women when the male partner had not even been tested.[3] As Dr. Eleanor Mears explained, the "anatomical approach" taken in hospitals resulted in "unnecessary operative procedures" on women.[4] Representing the interests of female doctors across Britain, the Medical Women's Federation also played a significant role in advocating on behalf of the FPA for greater financial support from the state for its operations. Therefore, this narrative is also about female physicians creating a space for themselves in the medical arena.

As a voluntary medical organization, the FPA played a significant role in Britain's health care system throughout the 1940s and 1950s. The establishment of the NHS in 1948 shifted the infrastructure of medical services in Britain. For example, until the NHS was founded, many of Britain's hospitals "were the products of the voluntary sector", including Guy's Hospital, St. Bartholomew's, and St. Thomas' in London. However, in 1948 the NHS brought "the voluntary hospitals into public ownership".[5] Yet despite this significant change in the post-war years, it "did not mark the eclipse of voluntarism in the medicine and health fields".[6] The FPA can be seen as an example of an NGO that was active in sexual and reproductive health, which was an expression of the 'permissive society' in that it sought "both to provide services in [its] own right, and to ensure that the assumptions and priorities behind statutory provision kept up with changing social norms".[7]

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[3] In a letter to Helena Wright, Margaret Pyke said that "Joan Malleson largely originated the whole idea" for the Sub-Fertility Committee and its work.
Wellcome Library, London, SA FPA A5/103, 'Papers and correspondence', July 1943 to June 1949.
[4] Wellcome Library, London SA FPA A3/23, 'Sub-Fertility', 1943 to 1966.
[5] M. Hilton, N. Crowson, J. Mouhot and J. McKay (eds.), *Historical Guide to NGOs in Britain: Charities, Civil Society and the Voluntary Sector since 1945*, (London: Palgrave Macmillan, 2012), 33.
[6] Hilton, et. al., *Historical Guide to NGOs*, 33.
[7] Hilton, *Historical Guide to NGOs*, 35.
This publication dates the establishment of the FPA to 1966, rather than 1939.

Although sub-fertility comprised a small portion of the FPA's overall clinical work, it became a central part of their communications strategy from the mid-1940s onward. In clinical practice, sub-fertility work played a relatively minor role as only a small number of clinics specialized in this work (six in the early 1950s). Furthermore, as approximately one in ten couples experienced fertility problems requiring such services, a statistically small percentage of patients were seeking sub-fertility advice. The data tells this story quite clearly: of the 220,000 patients advised by the FPA in 1960, 96.5 per cent were there for birth control advice, while the remaining 3.5 per cent attended for sub-fertility advice and other special sessions.[8] However, by increasingly focusing their public image on sub-fertility work and marital support, the organization was attempting to foster and create a more sympathetic public audience, one that had previously been highly critical of its work as a birth control provider.

This chapter offers both a chronological and thematic narrative: it follows the development of the FPA's sub-fertility services and communications from 1943 to 1960, and a shift toward public acceptance of the Association's work, which is examined at both a clinical and discursive level. The chapter underscores the importance of female physicians to the development of sub-fertility services; the initiatives of women in the FPA promoted patient accessibility, medical training, and a holistic view of medical practice. It argues that sub-fertility was a key feature in making the FPA's work more acceptable to both the public and official bodies, which was done through promotional communications and developing strategic alliances. It also interrogates the persistence of eugenic thought in the postwar period and the extent to which it may have influenced and shaped messages of 'family planning' through to the late-1950s.

[8] Leathard, *The Fight for Family Planning*, 118.

This chapter aims to reveal the importance of sub-fertility services to the work of the FPA at both the local and national level, while examining the motivations for and influences on this new direction in 'family planning'. Existing studies of family planning services, and the FPA's work in particular, have concentrated on the provision of contraceptives and birth control advice, which comprised the majority of clinical work.[9] The development and expansion of sub-fertility services from the mid-1940s has been largely neglected. In the major study of the FPA during this period, Audrey Leathard's *The Fight for Family Planning* (1980), the issue of sub-fertility is mentioned in passing as a small proportion of the FPA's work; elsewhere it has been treated as extraneous, and often not mentioned at all.[10] Statistically, sub-fertility work did comprise but a minor part of the Association's clinical practice; however, this chapter will argue that it was an important feature of the FPA's aims, services, and public relations after 1943. As suggested, this meant that the FPA extended the meaning of 'family planning' to include the control of infertility as much as fertility.

The historiography of family planning has concentrated on national rather than local developments. As both Leanne McCormick and Emma Jones argue, while the history of birth control and family planning has covered a wide range of topics, "the development of local family planning clinics and the politics surrounding their establishment and operation", particularly after 1945, has remained "largely tangential to

[9] See Leathard, *The Fight for Family Planning*; Emma Jones, 'The Establishment of Voluntary Family Planning Clinics in Liverpool and Bradford, 1926-1960: A Comparative Study', *Social History of Medicine*, 24(2), pp.352-369; Kate Fisher, *Birth Control, Sex, and Marriage in Britain 1918 – 1960*, (Oxford: Oxford University Press, 2006); Hera Cook, *The Long Sexual Revolution*, (Oxford: Oxford University Press, 2004); Lesley Hall, *Sex, Gender and Social Change in Britain Since 1880*, (New York: St Martin's Press, 2000).

[10] In discussions of the family planning movement, sub-fertility has not been included in the major studies. See Leathard, *Fight for Family Planning*; Kate Fisher, *Birth Control, Sex, and Marriage*; and Lesley Hall, *Sex, Gender and Social Change*.

its historiography".[11] With the importance of regional developments in mind, this chapter examines the expansion of services at both a local and national level, to present a more complete picture of the FPA's work in the 1940s and 1950s. Histories of the FPA have tended to ignore the complicated relationship with the Eugenics Society and the potential conflicts of interest such cooperation suggests. For instance, while Leathard makes brief mention of interactions with the Eugenics Society, no analysis of this relationship is offered. The FPA's refashioning of its name and aims was in alignment with the pronatalist policy of the period, and also draws attention to the persistent influence of eugenic thought. Doctors associated with the FPA came from a variety of backgrounds – certainly not all were eugenicists, but there was a large degree of membership cross over particularly among those prominently involved in sub-fertility work. Therefore, the complicated relationship with the Society, and the influence it may have had on the FPA's aims, cannot be ignored.

## Eugenics and 'family planning', 1943-60

The work of the Family Planning Association is central to this dissertation and as such, this chapter aims to provide an overview of the Association's work. However, this is not a straightforward narrative. Sub-fertility work was complicated by eugenic influences: the FPA and Eugenics Society shared office space for a decade, Lord Horder was President of both organizations from 1935 to his death in 1955, and the FPA relied on funding from the Eugenics Society to function. It is essential to question the attitudes and motives of both organizations, and where eugenics and 'family planning'

[11] Emma Jones, 'The Establishment of Voluntary Family Planning Clinics in Liverpool and Bradford, 1926-1960: A Comparative Study', *Social History of Medicine*, 24(2), (pp.352-369), 352; Leanne McCormick, 'The Scarlet Woman in Person: The Establishment of a Family Planning Service in Northern Ireland, 1950-1974'. *Social History of Medicine*, 21(2), 2008, (pp.345-360).

converged.[12] On the surface, this relationship between family planning and eugenics appears to have been mutually beneficial: the FPA was provided with financial support, and in turn the Eugenics Society salvaged its reputation by aligning itself with 'family planning'.[13] But this was a complicated relationship and the motivations and aims of the organizations are not always clear. It would be grossly inaccurate to paint all practitioners associated with the FPA as eugenicists, just as it would be to paint all eugenicists as Nazi sympathizers. Sub-fertility work, and the associated practice of artificial insemination, could be viewed as a form of 'positive' eugenics and it therefore generated interest across the Eugenics Society. This complex relationship between the two organizations has been obscured in most historical work, though historians of population and demography have explored it more recently, and therefore this chapter aims to question the implications of this collaborative work.[14]

In Britain, the meaning of 'eugenics' changed over time, as did the aims of the Eugenics Society.[15] Francis Galton, an English scientist and cousin to Charles Darwin,

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[12] "Of the seventy-five officers of council members of the Eugenics Society at some time during the six years 1930-6, fourteen held some kind of official position in the National Birth Control Association (N.B.C.A., ancestor of the Family Planning Association), and some were very active in both. Lord Horder was president of the N.B.C.A. throughout the period, and vice-president of the Eugenics Society for five of the six years." Most members of the ALRA at the time of the Bourne case were also members of the Eugenics Society: Lord Horder (first president of the NBCA; president of the ALRA); Gerald Thesiger (Bourne's counsel); Joan Malleson (E.S. fellow). C.P. Blacker was secretary of the BCIC; Eardley Holland, the President of the RCOG, was also a fellow of the Eugenics Society; in 1937, Lord Horder was President of the NBCA; Lady Denman was Chairman of its Executive Committee.
Ann Farmer, *By Their Fruits: eugenics, population control, and the abortion campaign*, (Washington, DC: Catholic University of America Press, 2008), 70-71; Soloway and Edward Griffith, *Voluntary Parenthood*, 48; Connelly, *Fatal Misconceptions*, 109, 163; Brian Harrison, 'Women's Health and the Women's Movement in Britain: 1840-1940', in *Biology, Medicine and Society 1840-1940* (ed. Charles Webster), 61-2.
[13] See Connelly, *Fatal Misconceptions*.
[14] See in particular Matthew Connelly, *Fatal Misconception: the struggle to control world population*, (Cambridge, Mass: Belknap Press of Harvard University Press, 2008); Richard A. Soloway, *Demography and Degeneration: eugenics and the declining birthrate in twentieth-century Britain*, (Chapel Hill: University of North Carolina Press, 1990).
[15] In Britain, the Eugenics Education Society was founded in 1907 by Galton, and was later renamed the Eugenics Society in 1926. After Galton's death in 1911, Leonard Darwin (son of Charles Darwin, and

coined the term 'eugenics' in 1883.[16] The term was derived from the Greek root, meaning 'good in birth' or 'noble in heredity'. It began as a 'scientific' biological theory based on principles of statistical probability, heredity, and genetics, but became tied to views of a human hierarchy that would benefit from 'selective scientific breeding'.[17] Thus, eugenics was fashioned as a 'science' to improve the human race by encouraging the 'fit' to reproduce and discouraging the 'unfit'.[18] This led to two broad eugenic philosophies: 'positive' and 'negative' eugenics. The former encouraged 'breeding' among those with 'desirable' qualities, while the latter discouraged (and forcibly restricted) reproduction among 'undesirable' groups. In this way, the idea of eugenics moved from a 'science' to an 'ideology', that was put into practice through social policy, which ranged from forced sterilization of the 'unfit' to providing sub-fertility services to the 'fit'.[19] Although there were always opponents of eugenics, this was not a fringe movement. Many respected professionals were advocates of the idea, and the concept of "improving the genetic makeup of humankind counted adherents all over the world".[20]

In the early twentieth century, the British Eugenics Society promoted both 'positive' and 'negative' eugenic measures, while in the aftermath of the Second World War, and as the popularity of the ideology declined, the Society reworked their strategy to focus on supporting 'healthy, planned families'. Eugenics has multiple meanings, and therefore the policies and application of eugenic beliefs varied widely based on national

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cousin of Francis Galton) became President of the Society until 1928 -- 'Leonard Darwin', *Eugenics Review* 1943 Jan, 34(4)

[16] Galton died in 1911.

[17] See Diane Paul, *Controlling Human Heredity*; Galton Institute.

[18] Daniel Kevles, *In The Name of Eugenics* (1985, 1995), xiii.

[19] Philippa Levine, 'The History of Eugenics', Not Even Past, Interviewed by Joan Neuberger, 2013, https://www.youtube.com/watch?v=9sIs1-sve_w; Philippa Levine, 'The History of Eugenics in the 20th Century', The 50th Annual Arthur L. Throckmorton Memorial Lecture, Lewis and Clark College, Portland Oregon, 2013 https://www.youtube.com/watch?v=ToAr3lP9Jgo ; Connelly, 8.

[20] Connelly, 8.

context.[21] For example, in the early 1930s, twenty-seven American states had compulsory sterilization, as did Germany, but Britain never passed a bill for compulsory sterilization (even though it was proposed in Parliament in 1931).[22] Yet from 1945, the way in which the Society defined its 'eugenics' changed. This new brand of eugenics was described as "the science which deals with all influences that improve the inborn qualities of a race; also with those that develop them to the utmost advantage".[23] This focus on 'positive' eugenics during this period marks a broader shift that took place from the 1930s to 1950s in the eugenics movements of both Britain and the United States, which was undoubtedly impacted by the Second World War. Eugenics was "protean" and "mutable" in nature; it "signified different things to different people and defied conventional progressive/conservative distinctions".[24] For historians, the challenge is to investigate how "such protean concepts evolve into norms, practices, and institutions that empower people or manipulate them, enrich or impoverish, give life or take it away, sometimes all at the same time."[25]

In the aftermath of the Second World War, and the war crime trials that brought Nazi horrors to light, the Eugenics Society denounced the "perversions of eugenics, by

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[21] See, for example, Philippa Levine and Alison Bashford (eds.), *The Oxford Handbook on the History of Eugenics*, (New York: Oxford University Press, 2010); Philippa Levine, 'The History of Eugenics', Not Even Past, Interviewed by Joan Neuberger, 2013, https://www.youtube.com/watch?v=9sIs1-sve_w; Philippa Levine, 'The History of Eugenics in the 20th Century', The 50th Annual Arthur L. Throckmorton Memorial Lecture, Lewis and Clark College, Portland Oregon, 2013 https://www.youtube.com/watch?v=ToAr3lP9Jgo

[22] Levine, 'The History of Eugenics' interview; 'Sir Francis Galton', Galton Institute, http://www.galtoninstitute.org.uk/sir-francis-galton/eugenics-and-final-years/

[23] See for example, 'Notes of the Quarter', *Eugenics Review*, 1945 Oct., 37(3), 87; 'Notes of the Quarter', *Eugenics Review* 1958 Jan., 49(4), 165.

[24] Molly Ladd-Taylor, 'Eugenics, Sterilisation and Modern Marriage in the USA: The Strange Career of Paul Popenoe'*, Gender & History,* Vol.13 No.2, August 2001, pp.298-327)*,* 299; Diane Paul, *Controlling Human Heredity, 1865 to the Present*, (Amherst, NY: Humanity Books, 1995), 3.
Also see *Eugenics Review*, 1943 Jan, 34(4), 110: "Eugenics is not an immutable doctrine and we should not esteem it a virtue if we pursued tomorrow the same policies as serve us today"

[25] Connelly, 8.

racial theories and by authoritarian practices for the control of human fertility which have arrogated to themselves the name eugenics and become regarded as its true progeny".[26] While the British Eugenics Society launched a campaign to separate their aims from those of Nazi Germany, 'negative' eugenics – including coercive forms of 'family planning' like forced sterilizations – continued even after the Holocaust in some American states, Scandinavia, Japan and China.[27] In Britain, C.P. Blacker endeavored to pivot the Eugenics Society away from any association with Nazi policies, not only because he thought them 'ridiculous' but also because the Society had a number of Jewish members.[28] Blacker wanted to achieve a respectable status in academic circles, and by the 1940s the Society's membership included "a number of distinguished geneticists, physicians, psychologists, and demographers".[29]

As Daniel Kevles has argued, from the 1930s onward there was a broad shift in both Britain and the United States from 'mainline' eugenics – focused on the 'race' – to 'reform' eugenics – focused on the 'population' and the belief that "the best in human variation was to be encouraged".[30] These 'reform' eugenicists supported social welfare initiatives, including health care, education, and housing. As Julian Huxley said: "We can't do much practical eugenics…until we have more or less equalized the environmental opportunities of all classes and types – and this must be by leveling *up*".[31] It is this type of 'positive' eugenics – that encouraged voluntary 'family planning' – which largely defined the work of the British Eugenics Society in the 1940s and 1950s. This shift in focus also took place in the United States. Both Molly Ladd-Taylor and

[26] 'Notes of the Quarter', 1945 Oct., 87.
[27] Connelly, 10.
[28] Kevles, 172.
[29] Ibid, 172.
[30] Ibid, 175.
[31] Ibid, 174.

Wendy Kline have emphasized the focus of this new 'eugenic vision' of promoting 'healthy heterosexual marriage' and 'family values' through, for instance, marital and genetic counseling.[32] This emphasis on family stability extended to the belief that healthy children – "sound in mind and body" – could only be raised by "happily married couples".[33] Thus, from 1930, American eugenicists shifted their focus "from preventing procreation of the unfit to promoting the marital and family stability of the white middle class".[34] Ladd-Taylor has argued that this 'under the radar' ordinary 'positive' eugenics of the postwar years has gone largely unnoticed by historians. Rather than being in decline after the Second World War, eugenics took on a new shape and form. Using the example of Paul Popenoe – the 'father of modern marriage counselling', but also a fervent eugenicist – Ladd-Taylor argues that there were "deep affinities between eugenics…and the pronatalist domestic culture of the postwar period".[35] Yet Popenoe's brand of eugenics has been largely neglected "perhaps because it seems so mundane", for it was not simply the negative eugenics of steering the 'unfit' to have fewer children – it was about "promoting the rewards of marriage and family life among the 'better' part of the population".[36] It is these intersections between eugenics, pronatalism, and marital and genetic counseling, which are relevant to this thesis.

It is in the 'mundane' and banal family planning work of the postwar years in Britain where this revised eugenics strategy can be located, and within the Eugenics

[32] See Molly Ladd-Taylor, 'Eugenics, Sterilisation and Modern Marriage in the USA: The Strange Career of Paul Popenoe', *Gender & History*, Vol.13 No.2, August 2001, pp.298-327); Molly Ladd Taylor, 'A Kind of Genetic Social Work': Sheldon Reed and the Origin of Genetic Counselling', in *Women, Health, and Nation*, (Montreal: McGill-Queen's University Press, 2003); Wendy Kline, *Building a Better Race: gender, sexuality, and eugenics from the turn of the century to the baby boom*, (Berkeley: University of California Press, 2001).
[33] Kline, *Building a Better Race*, 125.
[34] Kline, 126.
[35] Ladd-Taylor, 'Paul Popenoe', 299.
[36] Ibid, 299.

Society it was aptly called "crypto-eugenics". Postwar eugenics became intricately tied to the family – and in particular to organizations like the FPA and IPPF. By the late-1950s, C.P. Blacker and the Eugenics Society began advocating an organizational policy on 'crypto-eugenics' or 'hidden eugenics', apparently shrouding their motives under the guise of healthy families and population control. This shift in strategy and in the way their principles were articulated was largely a response to a decline in popularity. From 1932 to 1956, the Society witnessed a forty per cent drop in membership and, at the same time, fewer books and articles were published on the subject.[37] In 1955, the growing concern over the negative association with 'eugenics' was aired in the *Eugenics Review* and suggestions were made to revise the terminology, though not the principle. A "crypto-eugenic" policy was recommended:

> The crypto-eugenist, while saying nothing about eugenics but having the subject in mind, advocates and assists measures designed to bring about a varied pattern of planned families. He wishes to see families planned on a generous or a small scale according to how the parents are innately inclined. In so doing, he allies himself with hosts of people who wish to improve the well-being of the family. These, without knowing it, are also crypto-eugenists.[38]

Despite this opaque definition of the 'crypto-eugenist', on the same page the *Eugenics Review* was entirely transparent in its continued aims for "lowering the high fertility of problem families" and "promoting the fertility of promising or uncommon families".[39] Thus, the recognition of the negative association to 'eugenics' in the aftermath of the war led to a change in strategy, rather than principle.

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[37]Faith Schenk and A.S. Parkes, 'Activities of the Eugenics Society', *Eugenics Review*, September 1968, pp. 142-161 (p.154).
Ann Farmer, *By Their Fruits*, 223; Kevles, 169-70.
Also see Clare Hanson, 124; Stefan Kuhl, 148.
[38] 'Notes on the Quarter', *Eugenics Review*, April 48(1) 1956, 5.
[39] Ibid.

In 1957, C.P. Blacker (then Honorary Secretary of the Eugenics Society) suggested that "the Society should pursue eugenic ends by less obvious means, that is by a policy of crypto-eugenics", which had shown to bring some success to the US Eugenics Society.[40] Blacker further recommended that, "the Society should concentrate on the eugenics aspects of current problems and should campaign for the control of immigration, and for a reduction in the total population of Great Britain".[41] No action was taken on Blacker's suggestions in 1957 but in February 1960, senior members of the Society's Council presented his policy recommendations in a memorandum on reform:

> The Society's activities in crypto-eugenics should be pursued vigorously, and specifically that the Society should increase its monetary support of the FPA and the IPPF and should make contact with the Society for the Study of Human Biology, which already has a strong and active membership, to find out if any relevant projects are contemplated with which the Eugenics Society could assist.[42]

This proposal was agreed to in "a general way".[43] The Eugenics Society continued to offer financial support to the FPA in the post war period, with grants from £50 up to £300 made between 1946 and 1959.[44]

The Eugenics Society was conscious of the opposition to its work, and there was a self-awareness of its legacy. In 1959, an article in the *Eugenics Review* expressed hopes that the 'future historian' would not overlook the Society's contributions to "the financial encouragement of the Family Planning Association in its early stages".[45] The self-

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[40] Schenk and Parkes, 154.
[41] Schenk and Parkes, 154.
[42] Schenk and Parkes, 155.
This memorandum also recommended the Society change its name to 'The Galton Society'
[43] Schenk and Parkes, 155.
[44] Farmer, *By Their Fruits*, 223.
Grants were also made to the IPPF for as much as £1000.
[45] 'Notes on the Quarter', *Eugenics Review*, October 51(3) 1959, 142.

consciousness about its tainted past, and desire to be remembered for doing good in its work with the FPA, further underscores its strategic relationship with the Association.

That 'sub-fertility' services were developed in coordination with the Eugenics Society, and that Lord Horder continued to serve presidential posts at both the FPA and the Eugenics Society, raises a number of questions. This line of inquiry requires more research than is presented here, however this dissertation aims to problematize the relationship between the FPA and the Eugenics Society in the postwar period.

## From 'birth control' to 'family planning'

The renaming of the National Birth Control Association (NBCA) to the Family Planning Association (FPA) in May 1939 signaled the beginning of an important period in defining the Association's work and extending its services. Through this, 'family planning' came to encompass birth control, birth spacing, and contraceptive provision, and also the treatment of infertility, gynaecological disorders, and advice on marital problems. The shift in focus from 'birth control' to 'family planning' was reflective of the unpopularity of 'birth control' at this time.[46] The name change to the FPA was in part to shift opinion from 'limiting' to 'regulating' births, which Margaret Spring Rice described as a more accurate reflection of "the ethical basis of the movement".[47] It also reflected population concerns. With the birth rate reaching an all-time low in the early 1930s, there was a growing reluctance to limit births. Executive committee members of the NBCA had suggested a name change as early as 1937 with the 'population crisis' and unfavourable public opinion in mind. Some members resisted a name change for its

[46] Rogers Davidson and Gayle Davis, *The Sexual State: sexuality and Scottish governance, 1950-80*. (Edinburgh: Edinburgh University Press, 2012), 132.
[47] Richard A. Soloway, *Demography and Degeneration: eugenics and the declining birthrate in twentieth-century Britain*, (Chapel Hill: University of North Carolina Press, 1990), 212.

"abandonment of the term birth control after so many years of struggle to get accepted".[48] As Linda Gordon has argued, the shift signaled in the renaming can be interpreted as a depoliticizing of the birth control movement, as the focus moved away from the woman and individual, to the social stability of the family.[49] The term 'birth control' had been radical – even in the interwar years – and the renaming altered this dramatically.[50]

The FPA – under the new name – expanded its objectives to include treatment for involuntary sterility and gynaecological disorders, and help with marital difficulties, but despite a continued working relationship with the Eugenics Society the new organization's aims made no reference to eugenics.[51] The Eugenics Society's desire for a strategic partnership with the FPA had been apparent for some time. For example, in 1936, C.P. Blacker suggested a merger, which would offer the benefit of "consolidating the two groups into a more positive, family-oriented institute".[52] Matthew Connolly has described these merger negotiations as "damage control operations meant to distance [the Eugenics Society] from the Nazis."[53] However, the merger proposal was quickly rejected.[54] Despite the FPA's reluctance to establish an official partnership, C.P. Blacker continued recommending funding grants, and provided them with low rent office space (which became free during the war).[55] .

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[48] Soloway, *Demography and Degeneration*, 213.
[49] In the US, the Birth Control Federation of America was renamed the Planned Parenthood Federation of America in 1942.
Gordon, *The Moral Property of Women*, 242.
[50] Gordon, 244.
[51] Soloway, 213.
[52] In the autumn of 1936, C.P. Blacker began discussing with Margaret Pyke the potential of a merger between the Eugenics Society and what was then the NBCA (the FPA's predecessor)
Soloway, *Demography and Degeneration*, 209.
[53] Matthew Connelly, *Fatal Misconception: the struggle to control world population*, (Cambridge, Mass: Belknap Press of Harvard University Press, 2008), 106.
[54] Soloway, 211.
[55] Ibid, 212.

The relationship between the Eugenics Society and the FPA developed over many years. C.P. Blacker, General Secretary of the Eugenics Society, played a significant role in the formation of the Birth Control Investigation Committee (BCIC). In 1935, Blacker lobbied for the Eugenics Society to support the BCIC by explaining how a "simple, reliable, and fool proof contraceptive" would be far more beneficial in terms of 'racial consequences' than sterilization.[56] Early on, eugenicists were interested in the birth control movement, based largely on the concern that those using birth control were the well-off and educated class (not the 'unfit', who they believed should be limiting births). It was therefore an interesting development when, in 1938, the NBCA (the FPA's predecessor) took up residence at the Eugenics Society Headquarters at 69 Eccleston Square, London. The FPA and the Eugenics Society shared an address until 1949 when the former purchased office space on Sloane Street. The Eugenics Society provided financial support to the FPA from the late 1920s through to the 1960s. Early in the war, Blacker offered the FPA their existing office space free of rent with an additional £100 grant. The FPA was still £700 in debt, and had lost many staff to wartime duties. In the early months of war, an emergency Eugenics Society council was established and they "agreed to lend income and staff to the FPA on the understanding that it would encourage the teaching of eugenics in its welfare centres", although "[t]here is no evidence it ever did".[57] Richard Soloway has suggested that the Eugenics Society saw the FPA as a beacon in desperate times.[58] Blacker and Horder were keen to have the FPA work with other organizations supported by the Eugenics Society (like the Marriage Guidance Council) "in a vain hope that after the war eugenics would somehow be carried along as

[56] Connelly, 96.
[57] Soloway, 215.
[58] Ibid, 215-16.

part of a centralized comprehensive plan for the reconstruction of the family".[59] Blacker's aim was to increase eugenic thought through influencing other organizations, especially those concerned with population and social reforms.[60] Soloway has depicted the relationship as the Eugenics Society courting the FPA, while the FPA kept the Society at a polite distance.

This study supports literature that argues that eugenic ideology did not die off in the aftermath of the Second World War but rather changed its outlook and reworked its focus in a way to promote the postwar pronatalist culture.[61] The relationship between the Eugenics Society and the Family Planning Association is an important example of the continuation of this work.

## Infertility on the rise?

Amid concerns over population, rising rates of illegitimacy, divorce, and adultery, the prevalence of infertility was seen to be on the rise during the war. Dr Mary Barton, a practitioner of AI in London's Royal Free Hospital, offered as fact that individual sterility was increasing in 1943.[62] This assertion was tied to the biological and psychological impact of war. Barton's claim was followed by evidence compiled by British and American investigators stating that one-tenth of marriages were 'childless' – which was "rarely deliberate" – and ninety percent of these couples who had been married for five or

[59] Ibid, 216.
[60] Ibid, 259.
[61] See Molly Ladd-Taylor, 'Eugenics, Sterilisation and Modern Marriage in the USA: The Strange Career of Paul Popenoe', *Gender & History,* 13(2), August 2001, pp.298-327; Wendy Kline, *Building a Better Race: gender, sexuality, and eugenics from the turn of the century to the baby boom*, (Berkeley: University of California Press, 2001); Clare Hanson, *Eugenics, literature, and culture in post-war Britain*, (London: Routledge, 2013); Stefan Kuhl, *For the betterment of the race: the rise and fall of the international movement for eugenics and racial hygiene*, (Palgrave MacMillan, 2013); Ann Farmer, By Their Fruits: eugenics, population control, and the abortion campaign, (Washington, DC: Catholic University of America Press, 2008), Connelly, *Fatal Misconceptions*.
[62] Mary Barton, *British Medical Journal*, 4 September 1943, 312-13.

more years had "impaired reproductive power".[63] The investigators estimated that one in five men had 'impaired' fertility, and believed that small families were generally associated with low fecundity.[64] Although there were few specialized clinics dealing with sterility, those that did recorded significantly greater numbers of women using them as a source of advice during the war. One Glasgow hospital with a women's sterility clinic admitted 303 sterility cases in 1938, and 505 in 1942.[65] Similarly, the prevalence of sterility cases at the Exeter and District Women's Welfare clinic, under the supervision of Dr Margaret Jackson, increased from nine per cent of cases in 1939 to thirty-three per cent in 1943 [Figure 1.2].[66] Both Mary Barton and Margaret Jackson argued that the decline in population could not be solved until sterility could be better diagnosed in more facilities. Some speculation was made over the possible causes of the perceived growth of infertility. Jackson suggested that 'war conditions' and an overall increased availability of medical knowledge on the subject might have contributed to higher rates of consultation on infertility. However, environmental causes were also suspected. Dr Mary C. Jeffries called for more research to investigate the risk of x-rays on fertility. Jeffries referred to three cases personally known to her in which female radiologists were found to be infertile.[67] Historian Lesley Hall has suggested that the increase of cigarette-smoking and

[63] Mary Barton, F.J. Browne, R. Christie-Brown, Gladys Dodds, Greta Graff, A. Green, V.B. Green-Armytage, Clare Harvey, M.H. Jackson, R.W. Johnstone, W.C.W. Nixon, C. Lane-Roberts, A. Sharman, M. Moore White, B.P. Wiesner, and Kenneth Walker, 'Sterility and Impaired Fertility', *British Medical Journal*, 16 October 1943, 493.
[64] Barton et al, *British Medical Journal*, 16 October 1943, 493.
[65] Ibid.
[66] Margaret Hadley Jackson, 'A Medical Service for the Treatment of Involuntary Sterility', *Eugenics Review*, 36(4), January 1945, p.119.
[67] Mary C. Jeffries, *British Medical Journal*, 17 February 1945, 236.

nicotine consumption may have been linked with greater impotence in men during this period.[68]

Sociological studies were also concerned that sterility in the population was increasing. The 1945 Mass Observation (M-O) report on *Britain and Her Birth-Rate* was convinced that the decline in the birth rate was "not a war problem, however lethal bombs or bullets may be"; just as it was "not a health problem, however deadly epidemics or plagues may be", asking "Why are the quivers empty? Why is the stork reluctant?"[69] The report suggested that the war could force the birth rate in different directions, as it encouraged some women to conceive their first child earlier, while on the other hand, the separation of husbands and wives in wartime "ma[de] it impossible for many war brides to have their first children as soon as they want them".[70] Although decreased fecundity had not been proven, various causes had been suggested:

> [from] the association of the spermicidal qualities of soap with the modern tendency to bodily hygiene – to … the sensitivity of the testicles to change of temperature with the modern tendency to work in stuffy offices and go out into the cold evening air.[71]

In asking whether there was a difference in fertility in the 1940s compared to the previous generation the report was inconclusive, but stated that "it is probably more self-conscious than it used to be".[72]

It is not clear whether infertility was increasing during the 1940s or whether it can be attributed to other factors. With fifty-two per cent of the adult male population (nineteen to forty years of age) in war service, limited periods of leave from duty that

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[68] Lesley A. Hall, *Hidden Anxieties. Male Sexuality, 1900 – 1950*, (Cambridge: Polity Press, 1991), 118.
[69] *Britain and Her Birth Rate*, A report prepared by Mass Observation, (London: John Murray, 1945), Foreword.
[70] *Britain and Her Birth Rate*, 87.
[71] Ibid, 92.
[72] Ibid, 93.

failed to coincide with ovulation (exacerbated by inadequate public knowledge of fertility and reproductive organs) likely contributed to difficulty conceiving that was based solely on 'bad' timing.[73] The M-O birth-rate report told of a woman who had written for fertility advice, having stopped the use of contraception four months before. She expressed her worry about her inability to conceive, but explained that her husband was in the army and "we do not meet very often".[74] While such separation made conception difficult, Margaret Jackson pointed out that commanding officers were "remarkably sympathetic" to requests for certificates for husbands in the Forces to time their leave to align with their wives' fertile days.[75] Physical limits imposed by war service may have skewed perceptions of infertility but, as suggested by Jackson, may have provided impetus for couples to improve their knowledge of ovulation and fertility to plan for conception within a limited time frame.

## The Beginning of Sub-fertility Work, 1943-45

By 1943, the FPA – along with many other governmental and social organizations – was looking ahead to the post-war future. It was in this context that sub-fertility services were established, becoming the FPA's "main war-time development" being "of national importance in view of population trends".[76] While in the early years of the war the work of the FPA was significantly reduced, by 1943 this had shifted and the Association began making plans for expansion. In 1940, the FPA headquarters were evacuated from London to Bournemouth. Many FPA members were contributing to war

[73] June Purvis, *Women's History: Britain 1850 – 1945 an introduction*, (New York: St Martin's Press, 1995), 315.
[74] *Britain and Her Birth Rate*, 95.
[75] Jackson, 'A Medical Service for the Treatment of Involuntary Sterility', *Eugenics Review*, 124.
[76] Leathard, *The Fight for Family Planning*, 73.

work, which seemed like "a more 'useful' occupation" at the time.[77] In the midst of heavy bombing, particularly in London, the development of FPA clinics was brought to a halt. However, by late 1942 and early 1943, Britain was increasingly looking ahead to a postwar world. In December 1942, the Beveridge Report was published, outlining social reforms dealing with education, social security, and health care. And although the war was far from over in early 1943, the tides had turned for the Allies.[78] At home, this success for the Allies translated into a focus on rebuilding society – and the health of the population was central to that strategy. Moreover, publications such as the leaflet, *How Many Children* (1943), which encouraged overall population increase, and the booklet, *For Childless Wives* (1944), which provided a self-help guide to couples having difficulty conceiving, focused on this aspect of the Association's work. The announcement of the Royal Commission on Population in March 1944, in response to the declining birth rate, further underlined the importance of addressing fertility problems and, according to Leathard, "perceptively influenced [the] FPA outlook".[79] By 1944, the FPA had also established a seminological clinic under the guidance of Dr Hans Davidson, which provided fertility testing and treatment services for men that was not available in most hospitals. It was no coincidence that the FPA's sub-fertility initiatives were aligned with public interests and national reform goals. As Dr. Helena Wright commented, through sub-fertility the work of the FPA was finally "in sympathy with public opinion instead of being controversial".[80] The FPA's new attention to sub-fertility was a product of a

[77] Leathard, 70.
[78] In February 1943, German troops surrendered at Stalingrad and the Soviet Army began an offensive, pushing back the Eastern Front.
[79] Leathard, 73.
[80] Ibid.
Helena Wright made this comment in 1973.

historical moment: a desire to create more families and provide more comprehensive health care.

In May 1943, a letter to the Editor of *The Lancet* marked the beginning of the FPA's work on subfertility. In it, Lord Horder (President of the FPA and Eugenics Society) explained that the FPA had formed a committee in order to organize clinics to deal with infertility.[81] He emphasized that this was a natural extension of their existing role:

> …[the FPA] has long been in touch with working-class family life…It believes that there is a great opportunity to reach a certain type of patient who is not likely to present herself at a hospital out patients' department complaining of sterility, but who is nevertheless deeply disappointed by finding herself barren. Many such women have already asked for help at F.P.A. clinics, thereby demonstrating the reality of the demand.[82]

Such special sessions would be called 'Motherhood Clinics', he explained, and would take place occasionally and be held at existing birth control clinics. Horder concluded by explaining that these clinics would "be the beginnings of a nation-wide effort to eliminate the present distressing wastage of potential maternity".[83] Thus, this new service was directly addressing the existing anxieties over the birth rate, particularly in light of looking to the future and post-war reconstruction, and was underscored by pronatalist thought. Conflicts within the medical profession over who would be responsible for sub-fertility were suggestive of the various power dynamics at work.

The news of this initiative was not entirely well received and generated disagreement among medical professionals. Shortly before the *Lancet* letter was published, Eardley Holland (then President of the RCOG) explained to C.P. Blacker

[81] The draft letter listed the committee members as follows: Aleck Bourne, Margaret Jackson, Cedric Lane-Roberts, Joan Malleson, Margaret Moore-White, W.C.W. Nixon, Kenneth Walker.
[82] Lord Horder, 'Sterility', *The Lancet*, 22 May 1943; Wellcome Library, London, SA FPA A3/20, 'Sub-Fertility', 1943-66.
[83] Horder, 'Sterility', *The Lancet*, 22 May 1943; Wellcome Library SA FPA A3/20, 'Sub-Fertility'.

(General Secretary of Eugenics Society) that he thought 'Sub-fertility clinics' were a waste of time and resources – personnel would need to be trained and if such clinics did exist they should be attached to a hospital.[84] He further claimed that, "infertile couples show no reluctance, in my experience, to complain to their doctors".[85] Holland described the FPA sub-fertility clinics as "the setting up of a lot of petty clinics with half-trained medical officers. Low standards of work would inevitably result".[86] He did not believe that Dr. Margaret Jackson's sub-fertility clinics (already active in Exeter) were required, and had numerous objections to them.[87] This can be read as a conflict between official and voluntary medical bodies, but it was also a conflict between female physicians and male specialists with divergent interests and aims. Women doctors represented 'family planning' work in far greater numbers than their male counterparts. They were paid substantially less and, particularly in the voluntary sector, worked with little financial compensation. While on one hand the FPA was filling a void in medical services, there were those – particularly connected with the Royal College – who believed that only specialists in obstetrics and gynaecology should investigate and treat cases of infertility. In correspondence with Joan Malleson, C.P. Blacker explained Holland's belief that the FPA was infringing on the work of the RCOG: "[Holland] doubtless feels that the F.P.A. is occupying some of the ground which he would like the College to occupy in the future, and that it (the F.P.A.) is staking claims on more of this ground".[88] Blacker recommended that Malleson placate Holland by telling him that voluntary services undertaking sub-fertility work was a temporary solution:

[84] See L.J. Witts, 'Horder, Thomas Jeeves', *ODNB* for further biographical details.
[85] Wellcome Library, London, SA FPA A3/20, 'Sub-Fertility', 1943-66.
[86] Wellcome Library, London, FPA A3/20.
[87] Wellcome Library, London, FPA A3/20, 19 May 1943.
[88] Wellcome Library, London SA FPA A5/103, 'Papers and correspondence', July 1943 to June 1949.

> …as a long-term objective, it is certainly to be hoped that in due course the things which have hitherto been done by voluntary organisations should be taken over by official ones; and that the F.P.A. will do its best to bring about the state of things which make that possible.[89]

On this issue, C.P. Blacker came to play the role of mediator and liaison, advocating for the FPA while also encouraging hospital work. As General Secretary of the Eugenics Society, Blacker was in a curious position as he was caught between an official medical organization and a voluntary one, both of which had representation from members of the Eugenics Society. The Eugenics Society walked a fine line between supporting the medical establishment, and maintaining good relations with the FPA, which was an important strategic alliance.

The Eugenics Society played the role of both mediator and financier in this sub-fertility initiative. From July 1943, after the official announcement of the establishment of sub-fertility clinics in the *Lancet*, the FPA was trying to secure funding for its work, primarily from the Eugenics Society with which it shared its Headquarters on Eccleston Square from 1938 to 1949. The FPA issued a memo to the Eugenics Society explaining their aim of developing widespread "Sub-Fertility sessions" at branch clinics for those "non-fertile women who would not seek advice from a general hospital or private practitioner but who could be encouraged to come to the clinic through the medium of the regular patients".[90] Such open clinics would hopefully remove any stigma attached to infertility by combining them with birth control clinics. The aim was that FPA clinics would provide an accessible welcoming space (for women). The sub-fertility clinic already active in Exeter (run by Margaret Jackson) was used as an example of the effectiveness of the work, and the need for the FPA to address infertility. A number of

[89] Wellcome Library, London, SA FPA A5/103.
[90] Wellcome Library, London, SA FPA A5/103.

prominent physicians agreed to serve on the FPA's sub-fertility committee, including Aleck Bourne[91], Annis Gillie, Margaret Jackson, Cedric Lane-Roberts, Joan Malleson, Margaret Moore White, W.C.W. Nixon, Albert Sharman, and Kenneth Walker. Lord Horder and C.P. Blacker had also agreed to provide support and advice to the committee, unofficially representing the interests of the Eugenics Society. The initial costs to develop this program were estimated at £800 to cover the London Centre ("including the salary of a worker, rent and equipment, for one year"), a part-time salary for Mrs. Harvey in Exeter, and the cost of instruction, special apparatus, and other expenses for Branch clinics short of funds. It was hoped that patients' fees would cover other costs, where possible. It was this £800 that was requested from the Eugenics Society. As mentioned, the Eugenics Society had been providing financial grants to the FPA since the late 1920s, and continued to do so through to at least 1960.

Funding for the clinics was not so easily obtained. C.P. Blacker explained that the Society could not provide the £800 grant that had been requested, primarily because the critical supporters were away during the summer meeting. There was not specific opposition to the grant, but rather a perception that the FPA could source financing from elsewhere.[92] Blacker believed that if Lord Horder gave the grant request strong backing, it was possible it could be approved. However, in early August, Lord Horder explained to Margaret Pyke that while he was in favour of a sub-fertility committee and the setting up of clinics, he thought it would be best if it was connected to a hospital rather than being "a small laboratory with a private address".[93] He also wanted to see the 'fusion' of the

[91] Despite his conflict with the initiative, Bourne remained Chairman of the Committee. See *British Medical Journal*, December 1946.
[92] Wellcome Library, London, SA FPA A5/103.
[93] Wellcome Library, London, SA FPA A5/103.

National Marriage Guidance Council and the FPA.[94] The Marriage Guidance Council promoted marriage and sexual morality:

> During the war and the postwar decade, marriage guidance pursued new strategies to keep sex inside marriage: first, using national anxieties about the disintegration of the family to argue for a high standard of sexual morality that included chastity before marriage and fidelity in marriage; second, arguing that women's needs were above all for traditional marital relationships; and third, helping couples to achieve a high degree of sexual satisfaction inside marriage.[95]

Horder encouraged such partnerships to help strengthen the position of the Eugenics Society. This strategy also existed in the American context. As Molly Ladd-Taylor has analyzed, the seemingly 'mundane' and neglected connections between marital counseling, family planning and eugenics in the postwar years sought to promote "the rewards of marriage and family life among the 'better' part of the population".[96] This strategic partnership that the Eugenics Society was courting, aimed to bolster its soured reputation as well as provide new outlets for the continuation of 'positive' eugenics work.

Conflict between 'official' and 'voluntary' medical bodies continued over the question of sub-fertility services, while C.P. Blacker played the role of mediator. Eardley Holland continued to argue against any work that the FPA was offering. Joan Malleson described her frustration with Holland's position in a letter to C.P. Blacker describing Holland as presenting "[e]very type of 'obstructionist' argument":

> His main contention is that all work should be done in hospital institutions, and that it is a pity for <u>any</u> clinics…to spring up which are not incorporated in hospitals…He admits there is only <u>one</u> sterility clinic in a hospital at present (the London, and he has just started it) and

[94] The Marriage Guidance Council was established in 1938 by David Mace (Methodist Minister) and his wife, Vera. The work of the Council was paused with the outbreak of the Second World War, but reconvened in 1942 in the West End of London where they recruited "doctors, ministers, and other lay counsellors to volunteer".
Alana Harris, 'Mace, David Robert'. *Oxford Dictionary of National Biography*. Oxford University Press, 2004. Online edition, September 2012.
[95] Jane Lewis, 'Public Institution, Private Relationship', *Twentieth Century British History*, 1990 (pp.233-63), 235.
[96] Molly Ladd-Taylor, 'Eugenics, Sterilisation and Modern Marriage in the USA: The Strange Career of Paul Popenoe', *Gender & History,* 13(2), August 2001, (pp.298-327), 299.

> he regrets this, and hopes that a National service will some day be organized. Apparently it would be better for the work to [go] undone than that we should do it.[97]

The principle of accessibility – both physical and financial – was a central aim of the FPA's proposal, but was not valued in the same way by Holland, who was dismissive of the FPA's work. Holland further told Malleson that all birth control clinics should have been in hospitals from the beginning, that the FPA was "responsible for the drop in the English birth rate", and described the establishment of sub-fertility clinics as their latest 'stunt'.[98] Although Malleson said that their conversation was entirely cordial, she found herself "transposing this argument back fifteen years, and hearing officialdom oppose the establishment of contraceptive clinics, maintaining they should be in the hands of hospital authorities: a lot of use they would have been!"[99] Malleson's main concern was that the lack of approval from a prominent figure like Holland would put a stop to any financial assistance the Eugenics Society might give to the project. Having been the initiator of the proposal for sub-fertility services, Malleson was naturally frustrated by what was seen as a blockade. This exchange brings to light the murky relationship between medical organizations and the Eugenics Society. Although there are no overt eugenic aims discussed in this particular correspondence, the fact that key figures of the Society were closely involved and mediating the establishment of this new branch of services (while the FPA was under its roof) implies the possibility that the FPA was aligned with the Eugenics Society.

[97] Wellcome Library, London, FPA A5/103.
[98] Wellcome Library, London, FPA A5/103.
[99] Wellcome Library, London, FPA A5/103.

The conflict over the establishment of sub-fertility services was not only characterized by tension between voluntary and official bodies, but also between women and men in the medical profession. Malleson's frustration was heightened when original supporters of the plan rewrote the initiative, cutting the FPA from the equation. Aleck Bourne, who was a close colleague of Malleson's in the 1938 trial over criminal abortion, appeared to have turned against the FPA (as he did with the ALRA when he became concerned with the falling birth rate). By September 1943, a new proposal overriding that of the FPA recommended the establishment of a Sterility Clinic at St. Mary's Hospital under the supervision of Aleck Bourne (with Dr. Suchet being hired as a seminologist). Bourne wrote to Joan Malleson with his concerns over the FPA's efforts to establish an independent sub-fertility clinic.[100] By the end of September, Bourne had changed his mind about supporting the FPA in establishing a separate laboratory, believing that it would be a very difficult project – it would not have support from other laboratories or public bodies, the work would be isolated, and not helped by "parallel chemical or bacteriological investigations".[101] Bourne was dismissive of the value of a stand-alone clinic for seminological work, closing his letter by saying he "[did] not think that [the FPA clinic] could ever do work of real value".[102] C.P. Blacker had also shifted his position by the end of September, as he wrote to Horder explaining that the arrangements made with Bourne at St. Mary's were "better than those originally proposed by the F.P.A.", and that he supported the Eugenics Society making a grant to the hospital-

[100] Both Bourne and Malleson had played active roles on the Abortion Law Reform Association (ALRA). Bourne was a prominent obstetrician and gynaecologist, most recognized for his 1938 trial for criminal abortion (for which Malleson acted as defense witness), and was also a founding fellow of the RCOG and a consulting surgeon and teacher at St. Mary's Hospital in London.
John Keone, 'Bourne, Aleck William'. *Oxford Dictionary of National Biography*. Oxford University Press, 2004.
[101] Wellcome Library, London, FPA A5/103.
[102] FPA A5/103.

affiliated clinic. Blacker also saw this development as an important step in the history of medicine:

> If the project is successful, [the hospital] should come to recognise the national importance of the step they have taken – which amounts to the establishment of the first 'Sterility Unit' in the county. This should have historical significance in the annals of demography and population policy.[103]

Malleson, who initiated the FPA plan for sub-fertility clinics, was frustrated by these obstacles, telling Margaret Pyke: "I can't help feeling Bourne has double crossed us a bit", and expressing that she was "a bit peeved" by the situation.[104] Indeed, it seemed as though he had double-crossed them, for by early October he had secured a £250 grant from the Eugenics Society for the Sterility Clinic at St. Mary's Hospital (while £800 had been denied to the FPA). It was made clear in correspondence from Bourne that this clinic was not a partnership with the FPA but a hospital-affiliated clinic alone. However, in his desire to keep things amicable with the FPA, Blacker attached conditions to the Eugenics Society grant which included a commitment that the clinic undertake seminological tests for patients outside the hospital, particularly those referred by doctors affiliated with FPA clinics. The establishment of sub-fertility services required some political maneuvering, which the Eugenics Society had a clear hand in. As tedious as some of this negotiating may seem, it offers insight into the power dynamics of these organizational relationships. And, as Matthew Connolly has advised, it is important to examine such details, and to look beyond slogans to how finances were acquired and distributed.[105]

[103] FPA A5/103.
[104] FPA A5/103.
[105] Connelly, 8.

While in principle the development of a clinic at St. Mary's Hospital was positive, many of the original aims of the FPA's proposal had been lost. Margaret Pyke and Joan Malleson were particularly disappointed with the overall outcome, writing to Blacker that though they welcomed the establishment of a sterility clinic at the hospital (as every hospital should have one) they believed that "the original aims of the F.P.A. were wider than this" and hoped that "they [would] not be lost sight of".[106] They believed that Dr. Jack Suchet[107] (anticipated to take the role of seminologist at St. Mary's) was not properly trained for the work, and such training would take much longer than Bourne proposed. Furthermore, one of the central aims in the FPA proposal was to teach skills and provide training to medical professionals for the preliminary investigation of infertility: "imparting this knowledge to other people, and making it possible for other pathologists to learn to do seminal counts reasonably well".[108] The clinic at St. Mary's did not allow for such work. The FPA had also "hoped to ensure that working-class patients could have their semen examined for nominal fees", with one of the aims of the original scheme to provide services on a sliding scale.[109] Malleson and Pyke told Blacker that they would "be greatly disappointed [to] find that these objects have become lost in the establishment of an ordinary hospital sterility unit".[110] At the heart of the FPA's aims in setting up sub-fertility clinics was accessibility – both geographical and financial – which at the time were lost in a private hospital setting in London. These letters are

[106] FPA A5/103.
[107] Jack Suchet (1908-2001) was an obstetrician and gynaecologist born in Johannesburg, South Africa, the son of a Jewish immigrant from Dvinsk. In 1932, Suchet moved to London and enrolled at St Mary's Medical School. During the Second World War, he worked with Alexander Fleming on the application of penicillin for venereal disease, and became a consultant at St Mary's in 1953.
William D. Rubenstein, 'Suchet, Jack', *The Palgrave Dictionary of Anglo-Jewish History*. Edited by William Rubeinstein, Michael Jolles, and Hilary Rubinstein. (New York: Palgrave MacMillan, 2011), 968
[108] FPA A5/103.
[109] FPA A5/103.
[110] Wellcome Library, London, FPA A5/103.

suggestive of the extent to which the FPA relied on the Eugenics Society, in order to support its work both politically and financially, and the ongoing conflicts over not just voluntary and official organization, but also gendered perceptions of medicine.

This series of correspondence from May to October 1943 suggests that finding a place for sub-fertility work was not a straightforward task; there was significant resistance to this work being done by the FPA, particularly outside of a hospital. Furthermore, the close involvement of Horder, Blacker, and Holland raises unanswered questions about eugenic motivations in sub-fertility work. Despite these obstacles, the FPA continued to expand their sub-fertility work for both women and men, with the Seminological Centre in London established in 1944 under the leadership of Dr. Hans Davidson. The Centre conducted semen analysis, post-coital tests, and testicular biopsies. Six years after its establishment, at the end of 1950, the centre had served 8,000 patients, proving its worth.[111] From 1949, the Seminological Centre was housed at the new FPA Headquarters at 64 Sloane Street and became a central piece of the Association's sub-fertility services.[112] It is unclear how or if the FPA's move from the shared premises with the Eugenics Society in 1949 affected the long-standing relationship of the two organizations. Despite the move to independent headquarters, the FPA continued to function on "a financial shoe-string" with, for instance, the 1949 income of £6345 falling short of the expenditures of £6993.[113] The Association therefore remained reliant on

[111] Wellcome Library, London, MWF/J.24/3, 'Correspondence and other papers about MWF memorandum on Family Planning', 1950-1954.
[112] Leathard, *The Fight for Family Planning*, 81.
The location of the seminological centre between 1944 and 1949 is unclear.
For further information on the seminological centre, see Wellcome Library, London, SA/FPA/A3/20/22-25, 'Seminological Centre', 1943-66.
[113] Incomes came mainly from donations, subscriptions, fees and sub-fertility centre rates.
Leathard, *The Fight for Family Planning*, 82.

financial support from external sources, including the Eugenics Society, despite gaining greater autonomy.

## The Establishment of the National Health Service, 1946-1949

It is important to set this conversation in the broader context of health care in the 1940s. When the discussion over sub-fertility services began in 1943, the National Health Service (NHS) was not yet formed. The Beveridge Report (1942) pointed to the need for a national health system, and once the Government expressed its commitment to follow through with the recommendations, the idea of the NHS "was virtually accepted".[114] Following this significant report, in March 1943 the Ministry of Health issued "a draft plan for a unified health service", following in 1944 with a revised white paper entitled *A National Health Service*.[115] The medical profession was largely opposed to the notion of a national system, as they thought it would downgrade medicine and health care and they wanted to maintain professional freedom.[116] With widespread support, in 1946 the National Health Service Act established universal health care as the central feature of the post-war Welfare State.

When the NHS was formed in 1948, family planning had no part in it, and the FPA did not push for it to be included. This has been explained in various ways: that the FPA wanted to maintain independence and believed the work was best left to their expertise, rather than the ignorance of the NHS[117]; that the framework for the National Health Service Act (1946) blatantly ignored family planning[118]; that Lord Horder

[114] Audrey Leathard, *Health Care Provision: Past, Present, and Future* 1st ed, (London; New York: Chapman & Hall, 1990), 25.
[115] Leathard, *Health Care Provision*, 25.
[116] Ibid, 25.
[117] Ibid, 73.
[118] Ibid, 74.

(President of the FPA) opposed "socialized medicine"[119]; that official bodies involved in the formation of the NHS were concerned and busy with other issues[120]; and that the "continued squeamishness about birth control" acted as a deterrent.[121] To put it simply, 'family planning' and 'birth control' were not a priority for the NHS at this time, and the FPA was content to maintain its autonomy as a voluntary organization.

The Ministry of Health had general control of the NHS, with the Service divided into three components: hospital services, family practitioner services, and local health authority services.[122] Maternity and Child Welfare Centres (overseen by Local Authorities) provided family planning services on medical grounds, which meant that the provision of such services remained uneven. As Audrey Leathard has said, family planning services were an 'anomaly':

> It was neither free nor comprehensively covered by the NHS. Local Health Authorities…tended to subcontract this work to the FPA…who, by 1969, was still running 90% of the family planning clinics in England and Wales.[123]

Practically speaking, this meant that the FPA was essentially the sole provider of family planning services – with little to no involvement from the State. Financing structures varied from clinic to clinic but income was often derived from a combination of regional and local councils, personal donations and patient fees. Many of the FPA's members were happy to remain independent from the NHS, believing that "voluntary centres provided a better service than did the ministerially restricted local authority clinics".[124] As Dr Helena Wright recalled thirty years later:

> …[in] about 1945 the N.H.S. and its doctors were far too ignorant of contraception and its techniques even to be approached on the subject. Our wish was to be left alone as we

[119] Hall, *Sex, Gender and Social Change*, 128.
[120] Ibid, 128.
[121] Ibid.
[122] Ibid, 28.
[123] Ibid, 42-3.
[124] Leathard, *The Fight for Family Planning*, 74.

> were, to work out and devise our own machinery for each new development as it appeared.[125]

The FPA remained a separate entity from the state-run health service, and had not been consulted during its formation. It can therefore be situated within a group of voluntary bodies and pressure groups that continued on in the post-war years – providing services not covered by the State.

The FPA's work was bolstered by the Report of the Royal Commission on Population, published in June 1949. The Report supported the work of the FPA by recommending that "the giving of advice on contraception to married persons who want it should be accepted as a duty of the National Health Service".[126] This recommendation was not actioned until eighteen years later with the National Health Service (Family Planning) Act in 1967. The FPA welcomed the Commission's recommendations, and extended an offer of cooperation to the Minister of Health. However, the Catholic Church condemned the report for its recommendations on birth control, and although the report was supported in the press, there was not any extended interest in it nor was it ever debated in Parliament.[127] The population concerns that had existed when the Commission began in 1944 had proven to be far less alarming by the time it reported in 1949, with the birth rate growing quickly after the war, and until the proliferation of the birth control pill in the 1960s, state provision of family planning services was a moot point.

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[125] Ibid, 73-4.
[126] Leathard, *The Fight for Family Planning*, 83-4.
The Royal Commission on Population also "stated that it would be harmful to restrict the contribution that women could make to the economy and there should be 'a deliberate effort…to devise adjustments that would render it easier for women to combine motherhood and the care of a home with outside activities'" Jessie Bernard, *Women, Wives, Mothers: Values and Options*, (Chicago: Aldine Publishing Company, 1975), 245.
[127] Leathard, *Fight for Family Planning*, 84.

## The push for medical training in 'family planning'

A deeper issue underscored the continued importance of the FPA and its services, after the establishment of the NHS in 1948: qualifying doctors were not receiving training or education in 'family planning' subjects. If the NHS was to be relied on for the investigation and treatment of sub-fertility as well as consultation and advice on birth control, general practitioners would require training and knowledge in these areas. However, a survey on family planning services, conducted by the Medical Women's Federation after the first year the NHS was in existence, suggested that such medical training was not nearly as widespread as was needed. From 1949 to 1950, the Medical Women's Federation (MWF) investigated to what extent the subjects of family planning were being taught at medical schools. What their questionnaire to universities and medical schools across Britain revealed was that only a very small number of schools addressed family planning, contraception, or sub-fertility.[128] Of 24 schools that responded, only Aberdeen, Liverpool, UCH, and Edinburgh gave 'special' lectures on the subjects, and four said sub-fertility clinics were held but attendance was voluntary (except at Oxford University where students were required to attend a specified number of sub-fertility clinic sessions).[129] Three of the schools believed the subjects of contraception and sub-fertility were more suitable for postgraduate study (rather than the undergraduate curriculum of medical schools), meaning that it was suitable for specialists rather than GPs. The conclusion was that family planning, contraception, and sub-fertility – increasingly important issues in general practice – were not being taught as subjects in

[128] Birmingham and Liverpool universities, for instance, included family planning subjects in the curriculum (of Obstetrical and Gynaecological lectures and Social Medicine courses) though attendance at Sub-fertility Clinics and contraceptive clinics was voluntary.
[129] Leathard, 86.

the curriculum of most medical schools in 1950. If the subjects were dealt with at all, they were reserved for specialized lectures, with clinical experience remaining voluntary.[130] This also meant that those doctors who were already practicing medicine, "very rarely have had any training in this direction".[131] The MWF stressed:

> The subject of Family Planning is clearly of fundamental importance to the welfare of the community. The Royal Commission on Population, after sifting evidence from many sources, expressed itself as in no doubt of the need for a positive family planning policy. The National Health Service Act makes provision for the care of pregnant and parturient women but does not lay down any positive plan of action in respect of family planning, though it may be argued that this should come under the heading of general medical services.[132]

Further to this inquiry into medical school curricula, the MWF surveyed the Medical Officers of Health from 197 Local Authorities on whether facilities existed for providing advice on family planning, and if so whether that included contraception, sub-fertility and marriage services. 160 replies were received and the MWF commented that, "[t]he most striking fact that emerges from this enquiry is that in well over 50 per cent of all areas no clinics or special hospital out-patient facilities were available [for family planning services]". At the same time, the subjects were not treated as "an essential part of the curriculum". There were two main facts that emerged from the MWF inquiry:

> First, that the facilities for family planning which existed in 1949…are totally inadequate for the needs of the community…Secondly, the majority of medical students are qualifying without receiving an adequate introduction to all the aspects of family planning and cannot therefore be expected to give authoritative advice to their patients, or to recognise the need for postgraduate training in this subject.[133]

As a result of the inquiry, the MWF made the following recommendations:

1. That family planning services be made an integral part of the National Health Service, with Local Authorities required to provide clinics.
2. That 'adequate financial support' be given to voluntary clinics.

[130] Wellcome Library, MWF J.24/3, 'Correspondence and other papers about MWF memorandum on Family Planning', 1950-1954.
[131] Wellcome Library, London, FPA A3/23.
[132] Wellcome Library, London, MWF J.24/3.
[133] Wellcome Library, London, MWF J.24/3.

3. That advice for family planning should be available to women who 'require it on medical grounds' and for women who would like it 'for the purpose of family spacing'.[134]

Further, the MWF called for medical undergraduate courses "to include 'opportunities for definite instruction in family planning' in order to emphasise the importance of the subject to the public".[135]

The MWF inquiry and Report was meant to bolster the Royal Commission on Population's recommendation, but to no avail. Ultimately, the inquiry did not lead to any change, but it demonstrates the importance of the services provided by the FPA at this time – not readily available elsewhere. Two years later, in 1952, after no action had been taken on the MWF's Report, the Federation's Family Planning Committee published a memorandum in the *British Medical Journal*, once again emphasizing the deficiencies in both education and services:

> …the facilities for family planning which existed in 1949 – and there is little reason to suppose that there has been any great improvement since then – are totally inadequate for the needs of the community…the majority of medical students are qualifying without receiving an adequate introduction to all aspects of family planning and cannot therefore be expected to give authoritative advice to their patients.[136]

By 1954, in both London and beyond, medical schools were more receptive to receiving training in family planning issues at the FPA, however opposition still existed.[137] For instance, while the Royal Free Hospital was already sending students to the FPA for training, Charing Cross Hospital was "openly hostile" to the suggestion.[138] If sub-fertility services were to effectively serve communities, GPs needed to be informed, which meant

[134] Wellcome Library, London, MWF J.24/3.
[135] Leathard, *Fight for Family Planning*, 86.
[136] 'Memorandum on Family Planning, With Particular Reference to Contraception', *British Medical Journal*, 15 March 1952, p.596.
The group that published this memorandum included Margaret Hadley Jackson.
[137] Leathard, *Fight for Family Planning*, 87.
[138] Ibid, 87.

changing the education system to see family planning as an essential medical service rather than a specialized topic for postgraduate study.

## Patient demand and the growth of sub-fertility clinics

The rebranding of the FPA was, in part, shaped by the clinical experience of local clinics. The growth of the FPA's sub-fertility services happened rather quickly, despite early resistance. By 1950, there were six sub-fertility clinics in Britain, with over sixty other FPA clinics conducting preliminary testing (four of which were in Scotland, one was in Wales, and the rest in England).[139] The two most prominent sub-fertility clinics under the FPA umbrella were the Exeter and District Women's Welfare Association and the North Kensington Marriage Welfare Centre, under the medical lead of Drs Margaret Jackson and Helena Wright, respectively. For the purposes of this chapter, the two clinics serve as case studies for the scale and scope of sub-fertility activities.

The Exeter and District Women's Welfare Association was opened on 1 January 1930 with the aim "to provide medical advice on Contraception to those married women who are unable to afford the fees of a Doctor, and who would otherwise have to rely upon hearsay, or other unreliable and undesirable sources".[140] Dr Margaret Hadley Jackson was appointed as Medical Officer from the beginning and worked voluntarily alongside a nurse.[141] In the clinic's first year there were 145 patients, with 125 return visits. Mrs. Clare Harvey joined Jackson early in the clinic's life to work on sub-fertility (Harvey becoming "an authority on semen analysis and the morphology and activity of spermatozoa").[142]

[139] Wellcome Library, London, MWF J.24/3
[140] Wellcome Library, London, SA FPA A4/B6/1, 'Exeter: Annual Report, 1931'.
[141] For further details on Dr. Margaret Jackson, see the biographical appendix attached.
[142] Wellcome Library, London, FPA A4/B6/1, 'Exeter', 1929-1966.

Clinical work in Exeter was marked by collaboration with other medical services. From 1947 to 1963, the Exeter clinic functioned from the Out-Patients Dept of the West of England Eye Infirmary. In 1963 having outgrown the space, the clinic moved to 4 Barnfield Hill, purchasing and modifying a house (with the financial support of external sources). It is at this location where the Margaret Jackson Clinic still exists today. The clinic worked closely with the regional hospitals, with which it had a positive professional relationship. Margaret Jackson described how, in the Devon and Exeter region, sub-fertility work was a collaborative practice. The FPA Exeter clinic worked with the X-ray department at the Royal Devon and Exeter Hospital and with the laboratory at the University of the South West in diagnosing and treating infertility.[143] By 1944, 90 per cent of patients at the Exeter clinic were being referred by family doctors, hospitals, and nurses, and it was therefore essential to maintain a close connection with the local hospital.[144]

Like the FPA itself, the Exeter clinic was in a troubled financial state. The annual income was not sufficient to pay Dr. Jackson and a nurse, though they were given a small honorarium. For example, from 1945 to 1949, Margaret Jackson received an honorarium of approximately £72 per year.[145] The Exeter clinic staff received minimal monetary remuneration for their work, as budgets remained tight to keep costs down for patients;

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From as early as 1937, Jackson had worked with pharmaceutical companies, and the British Drug Houses which "led on to co-operation with them in the early development of their oral contraceptive Volidan – and with other manufacturers who needed help with trials".

[143] Jackson, 'A Voluntary Medical Service', *Eugenics Review*, 117.

[144] Ibid, 118.

[145] In 1949, Margaret Jackson received an honoraria of £145 19s. for two years. In 1945, Jackson received an honoraria of £72 19s. Other clinic staff were paid significantly less: Assistant Medical Staff, £15 15s; Nursing Staff, £80 15s.; Scientific and Clerical Staff, £75 10s.
Wellcome Library, London, FPA A4/B6/1, 'Exeter and District Women's Welfare Association Annual Report 1949'.

the 1949 budget was £1825, with patient fees contributing only £96 to the total income.[146] The Exeter clinic, and many others like it, relied on donations and subscriptions from generous members of the community that supported the cause.[147] The local county councils also provided financial support to the clinic with, for instance, a grant of £180 from the Devon County Council and £21 15s. from the Exeter City Council in 1949.[148] The clinic operated on a part-time basis, offering sessions every Friday afternoon, with additional clinic hours at Totnes and Barnstaple once per month.[149] Thus, there was limited accessibility in addition to minimal financial resources.

Sub-fertility work in Exeter began much earlier than Lord Horder's announcement in *The Lancet* in 1943. As early as 1932, patients began attending the Exeter clinic, "for advice on account of involuntary sterility".[150] The Annual Report of that year explained that sub-fertility was "a branch of constructive Birth Control in which we hope to do more work in the future".[151] From the outset, sub-fertility was framed as part of the broader aims for birth control. The infrastructure for such a clinic took time to establish. Although many patients came to the clinic on their own accord, doctor's referrals were becoming more common. In 1931, the annual report from Exeter explained that a large proportion of cases now came on a doctor's recommendation, which was considered "a move in the right direction".[152] However, even in 1945, the referral process was still quite ad hoc. There was typically communication between the GP and Dr. Jackson, but not necessarily – and it was not a requirement. There was no official referral but rather a

[146] Wellcome Library, London, FPA A4/B6/1.
[147] Wellcome Library, London, FPA A4/B6/1.
[148] Wellcome Library, London, FPA A4/B6/1, '1949 Annual Report'.
[149] Wellcome Library, London, FPA A4/B6/1, '1947 Annual Reports' and '1949 Annual Report'.
[150] Wellcome Library, London, FPA A4/B6/1
[151] Wellcome Library, London, FPA A4/B6/1
[152] Wellcome Library, London, FPA A4/B6/1, '1945 Annual Report'.

general written communication between parties. Jackson explained that they always asked patients to bring a note from their family doctor ("and really it is essential for sterile patients to have a general practitioner with whom I can communicate" Jackson said).[153] She would always write to the family doctor, unless she was asked not to. They would not refuse a patient who did not have a letter from their GP, but if the clinic was busy it would prioritize those who had doctors letters. The focus was on providing a service, rather than following protocol.

The Exeter and District Women's Welfare Centre owed a significant proportion of its new patients to sub-fertility work. Sub-fertility patients increased dramatically between 1940 and 1945, by which time the investigation and treatment of sterility was one of the listed aims in the clinic's annual report.[154] In 1940, sub-fertility patients represented 9 per cent of the total; by 1943 this proportion had climbed to 33 per cent, and in 1945 it had dropped to 20 per cent.[155] The war invariably had an effect on these rates. [Figure 1.3] Although declining slightly after 1945, sub-fertility patients continued in relatively large numbers for the area. By 1950, Exeter had 916 new patients, 156 were attending for 'the investigation and treatment of sterility' (17 per cent of the total).[156] In addition to general sub-fertility services, Margaret Jackson conducted artificial insemination from this clinic,

[153] Wellcome Library, London, FPA A4/B6/1, '1945 Annual Report'.
[154] Wellcome Library, London, FPA A4/B6/1
[155] The infrastructure for such a clinic took time to establish. Although many patients came to the clinic on their own accord, doctors' referrals were becoming more common. In 1931, the annual report from Exeter explained that a large proportion of cases now came on a doctor's recommendation, which was considered "a move in the right direction". However, even in 1945, the referral process was still quite ad hoc. There was typically communication between the GP and Dr. Jackson, but not necessarily – and it was not a requirement. There was no official referral but rather a general written communication between parties. Jackson explained that they always asked patients to bring a note form their family doctor ("and really it is essential for sterile patients to have a general practitioner with whom I can communicate" Jackson said). She would always write to the family doctor, unless she was asked not to. They would not refuse a patient who did not have a letter from their GP, but if the clinic was busy it would prioritize those who had doctors letters. The focus was on providing a service, rather than following protocol.
Wellcome Library, London, FPA A4/B6/1, '1945 Annual Report'.
[156] Wellcome Library, London, FPA A4/B6/1

though on a private basis unconnected to the FPA. It is this work that Section II and Section III of the dissertation will address in greater detail.

The other prominent early sub-fertility clinic was the North Kensington Women's Welfare Centre (later renamed to the North Kensington Marriage Welfare Centre), which was established in 1924 with Margery Spring Rice as its chairperson.[157] Spring Rice helped found the clinic in response to concerns for the "appalling levels of poverty and overcrowding in North Kensington", and she oversaw work at the Centre until 1958 after resigning due to organizational changes.[158] Richard Soloway has emphasized the eugenic leanings of some FPA members, including Spring Rice who supported eugenic principles.[159] For example, Spring Rice was of the mind that there was a "eugenic principle at the bottom of all birth control doctrine", and that "in principle…the birth control movement should take part in, or rather be part of the wider one of eugenics".[160] In 1932, the North Kensington Centre's premises were expanded, as were its services. It was not until 1945 that the Centre began offering sub-fertility services.[161] The Centre was located in central London and was one of the more prominent FPA clinics, with Dr. Helena Wright as chief medical officer from 1930 to 1960.[162] Significant growth in NK patient attendance was not seen until after 1945. Coinciding with the Blitz in London, attendance dropped by forty per cent in 1940 and fell further in 1941, before starting to

[157] Sylvia Dunkley, 'Rice, Margaret Lois Spring'. *Oxford Dictionary of National Biography*. Oxford University Press, 2004. Online edition. Accessed 11 November 2015.
[158] Spring Rice served on the FPA executive from 1930 to 1958.
Dunkley, 'Rice, Margaret', *ODNB*.
[159] Soloway, *Degeneration*, 214.
[160] Soloway, 214, from Wellcome Library, London FPA/A1/2.
[161] In the mid-1950s, the North Kensington Centre, still a branch of the FPA, offered advice on sub-fertility, gynaecology, birth control and marital problems. Mrs Peers was the Superintendent of the Centre. Dr. Philip Bloom was the consultant at what was then "the new Male Session for advice on premarital and sexual problems, birth control and sub-fertility".
Wellcome Library, London, SA FPA NK/198, 'North Kensington: Clinic attendance statistics', 1936-1958.
[162] Hall, 'Wright, Helena Rosa', *ODNB*.

increase again in 1942.[163] It is not surprising that while London was heavily bombed, 'family planning' was not a high priority. However, from 1942 to 1945 there was a steady climb with a spike in new patients in the immediate post-war period. An even more significant spike in patient attendance occurred in the early 1950s. [Figures 1.4] However, sub-fertility patients remained a small proportion of clinic attendances – far less than in Exeter. At most, between 1947 and 1956, sub-fertility patients comprised 6.4 per cent of the overall patients at North Kensington (1951) and, at the lowest point (1956), sub-fertility patients comprised only 2.65 per cent of the total new patients.[164] This evidence stresses that sub-fertility work was a statistically small portion of the Association's overall offerings, as were the other 'special sessions'.

Clinic attendance statistics are useful to gauge patient demand, but are not indicative of fertility issues as a whole. The NK clinic was often the first step along a diagnostic path, and many patients who attended for sub-fertility were referred elsewhere or never returned. For example, of the 143 patients who attended the sub-fertility clinic between March 1952 and February 1953, only forty-one had ongoing treatment at North Kensington. Among all sub-fertility patients, there were fourteen pregnancies, forty-two patients referred for further treatment, fifteen who abandoned treatment, and thirty-one cases that were closed (thirteen of which were a result of the husband refusing testing, nine where patients moved away, and nine where pregnancy was unlikely).[165] It is useful to consider the demographic characteristics of the average female patient attending the Centre in the early 1950s, not only for sub-fertility services, but the whole of the Centre's services. In 1953, the average woman attending North Kensington was between twenty

[163] Wellcome Library, London, FPA NK/198; FPA NK/95, 'Sub-fertility statistics', 1950-1952.
[164] Wellcome Library, London, FPA NK/95.
[165] Wellcome Library, London, FPA NK/198.

and twenty-five years old (42 per cent of all patients), not yet married (21.5 per cent) or married for under a year (20.4 per cent), had one pregnancy (25.4 per cent) or no pregnancies (18.2 per cent), was Anglican (67.4 per cent), had a primary education (55.2 per cent), used coitus interruptus as a method of birth control (31.5 per cent), and earned £10 to £15 per week (27 per cent).[166] In response to patient demand and with limited access to sub-fertility clinics outside of London and Exeter (and a continued lack of birth control services across Britain), Dr. Helena Wright proposed an initiative for a travelling family planning clinic to reach underserviced areas [Figure 1.5].

Despite the growth of family planning clinics after the war, accessibility to sub-fertility services remained an obstacle and led to a design for a mobile clinic. Outside of Exeter, London was the service hub for treatment (with a clinic opening in Manchester after the war). To remedy this geographical gap, Dr. Helena Wright attempted to implement a caravan clinic to reach unserviced areas – perhaps inspired by the initiative of Marie Stopes in the late 1920s.[167] In July 1951, Wright prepared a preliminary memorandum, presented at the FPA Annual Meeting, outlining the plans for caravan clinics. The project would require at least one doctor who had experience in minor gynaecology, treatment of sub-fertility, and experience in contraception, as well as one nurse (preferably a midwife who was married). The caravan clinics would provide services for contraception, minor gynaecology, preliminary sub-fertility, and marital

[166] Ibid.
[167] In 1927, Marie Stopes established a Caravan Clinic (a mobile clinic for birth control), however it was burned in Leeds by Miss Ellis the following year. However, Stopes resurrected the mobile clinic touring through south Wales from 1929 to 1930.
On the caravan clinic, see 'Stopes, Marie Charlotte Carmichael (1880-1958)', PP/MCS, Wellcome Library, London,
http://archives.wellcome.ac.uk/DServe/dserve.exe?dsqIni=Dserve.ini&dsqApp=Archive&dsqCmd=Show.tcl&dsqDb=Catalog&dsqPos=0&dsqSearch=((AltRefNo%3D'pp%2Fmcs')AND(Level%3D'Collection'));
See also Joanna Bornat, Robert Perks, Paul Thompson, and Jan Walmsley (eds), *Oral History, Health and Welfare*, (London: Routledge, 2000), 253.

difficulties. To operate, they would need room to interview and examine patients. The idea was that the clinic would be very flexible and would depend on local conditions. It would stay a minimum of two to three days in each place, and potentially longer once "the caravan clinic gets to be known and appreciated".[168] It was hoped that financing would come from FPA Headquarters, or special local support where the caravan would operate. While the running expenses would be covered by patient fees, they needed initial capital to equip and move a caravan that had already been offered. Wright imagined that one caravan clinic would eventually multiply into a fleet. She also saw the importance of obtaining community support from the local NHS, GPs, nurses, ecclesiastics, women with influence, Women's Institutes, and Marriage Guidance Councils. It was outlined that the fees should vary with people's incomes, with a minimum of 10/- for two birth control visits, 5/- for gynaecological treatment, and 10/- per visit for sub-fertility. It was thought to be very advantageous for the doctor of the caravan clinic to have a good relationship to the local hospital in order to refer patients with ease. Thus, maintaining cordial professional relations between 'official' and 'voluntary bodies' could be mutually beneficial.

The response of the FPA Executive to the caravan proposal was not entirely favourable. A member of the FPA's Executive was skeptical about the financial implications of the caravan and could not see that the scheme would be self-supporting, nor would it be cheaper or more efficient than opening a permanent clinic. The FPA also anticipated official opposition if the caravan were to step on the toes of the NHS in offering an "all-purposes" caravan. However, Wright continued to fight for mobile services and emphasized the importance of persistence in the face of opposition:

[168] Wellcome Library, London, SA FPA A14/96/01, 'Correspondence: Dr Helena Wright', 1945-1951.

> That does not mean we should give in, of course, but we must not underestimate official resentment of our good intentions, since it would probably reduce numbers, and therefore affect us economically. We are discovering this resentment in connection with our sub-fertility efforts as you know.[169]

Wright suggested that the conflicts between the 'official' and 'voluntary' medical establishment of the 1940s continued into the 1950s, and the dominance of 'official resentment' had the power to shut the initiative down. There was, nevertheless, support for the idea. Dr. Helen Barlow (Rochdale) offered to try out the scheme in the Lake District with an existing caravan that was sitting unused. She said: "[the idea] has certainly occurred to me and I threatened to park it in Bolton last year when we were under great stress".[170] Although Dr Wright was appreciative of the offer, she explained that the matter had to be discussed with Mrs Howard and the Executive, and the areas "carefully surveyed" before any plans were made.[171] Ultimately, nothing came of the caravan proposal but it serves as an example of the initiatives led by female physicians to broaden service areas and accessibility for family planning work, including sub-fertility. While developments at local and regional clinics were often in response to patient demand, at the national level, the FPA's communications strategy also aimed to extend the reach of sub-fertility services.

## Communicating Sub-Fertility

The sub-fertility work of the FPA was proportionally small, but this important service became a cornerstone of their work, which was communicated through publications, the press, religious outreach, and even a promotional film. The purpose of such communication was both to disseminate knowledge and to normalize the clinic

[169] Wellcome Library, London, SA FPA A14/96/01.
[170] Wellcome Library, London, SA FPA A14/96/01.
[171] Wellcome Library, London, SA FPA A14/96/01.

environment, and in so doing the FPA helped define the discursive framework of 'sub-fertility'. The significance of voluntary bodies is not only in their provision of services, but perhaps just as significantly in their discursive impact.[172] In promoting their work, through publications, documentary film, and establishing relationships with key groups invested in the public's trust, the FPA's national strategy encouraged acceptance of the Association's aims, support for local clinics, as well as providing general sex education. In light of the complex relationship between the FPA and Eugenics Society, we must be cognizant of the potential sub-texts of such communication.

## Educative Literature

One of the first publicly available guidebooks for infertility was a booklet published by the FPA in 1944, entitled *For Childless Wives*, which provided general sex education on the subject of fertility. First published during the Second World War, the year the Royal Commission on Population was announced, the booklet was in step with Britain's domestic national aims and concerns – providing advice to couples to conceive 'naturally'. This 24-page guidebook, aimed at the general population, was distributed to both doctors and patients. Lord Horder, President of the FPA and Eugenics Society, introduced the 1950 edition with a foreword emphasizing the overarching message of the booklet: hope should not be lost, and there was often a simple solution to the problem of 'childlessness'. The introduction explained to readers that "a family is the ideal towards which every married man and woman should, and generally does, strive".[173] Horder encouraged potential parents who had not been successful in conceiving to not "accept their disappointment without taking some thought and some pains to find if a childless

[172] See Nick Crowson, Matthew Hilton, and James McKay (eds), *NGOs in contemporary Britain: non-state actors in society and politics since 1945*, (Basingstoke: Palgrave Macmillan, 2009).
[173] Wellcome Library, London, MWF/J.24/3, 'For Childless Wives', 1944.

marriage is inescapable".[174] The importance of seeking fertility support was set in the context of the birth rate being under threat:

> …faced as we are with a falling trend in the national birth-rate, our attention is to-day directed especially towards the positive aspect of child-bearing. That does not mean that there is no longer any need for teaching parents the principles and the practice of birth-control in respect of the unwanted child. It means that, in family planning, there is a special and a growing need to instruct husbands and wives as to the steps they should take in respect of the wanted child which fails to arrive.[175]

The FPA therefore felt that birth control practices were well-established, and the more urgent matter was promoting conception. The dichotomy drawn here between the 'wanted' and 'unwanted' child is a persistent theme in the FPA's public communications. The booklet introduction explained that "doctors have learned a great deal more about how a child is conceived", but often all that was needed was "a little simple advice and help" to remedy childlessness. Reassurances were given that it was entirely normal for it to take some time to conceive, but after two years of marriage a couple should seek medical help. The booklet estimated that one couple in ten was unable to have children, and approximately one-third of those could be helped with medical assistance. The FPA encouraged the 'childless wife' to try to conceive early in marriage, particularly if she was over thirty years old; though the booklet stressed that it was "not very unusual for excellent first babies to be born to mothers of 45, or even 50".[176] The text also assured readers that infertility was "seldom due to actual ill-health", nor was it the result of "using ordinary methods of birth control". It aimed to dispense with typical fears:

> [Birth control] cannot damage a person in any way, nor can any personal sexual habits. Some people dread to go to the doctor for fear they should be told they have in some way harmed themselves. This fear is quite unfounded. It is true that a forced

[174] Wellcome Library, London, MWF/J.24/3
[175] Wellcome Library, London, MWF/J.24/3
[176] Wellcome Library, London, MWF/J.24/3
There were no illustrations included in the booklet.

> miscarriage or an attack of venereal disease may cause some harm to the child-bearing organs, but even so it is frequently possible to cure the condition.

Addressing a generation who had not received any formal sex education in school, and a culture in which discussion of sex and reproduction was still taboo, the booklet spelled out common issues that were not, at the time, widely understood. Dealing with the basics of human reproduction, the section 'How Conception Occurs' explained the process of fertilization:

> The small male seeds (called sperms) reach the vaginal passage during intercourse and need to swim up into the womb where they meet with the 'egg'. At this point one of the sperms and the egg join together and the life of the baby begins.[177]

Using colloquial language, the booklet aimed to address common problems and misunderstandings. It was, in essence, a self-help book though it also aimed to equip readers with the language and knowledge to approach their doctor or the FPA. The booklet emphasized the importance of investigating both husband and wife, and explained the need for testing the husband:

> The energy of the sperm cannot in any way be measured by the sexual vigour or 'manliness' of the husband; this can only be done by examining its movement under a microscope. Shortage of vitamins, or some old infection, or some slight glandular disorder, may account for the lazy sperms, and these are things which can often be corrected by medical attention.[178]

The text aimed to protect notions of masculinity by reassuring readers that 'lazy sperm' had nothing to do with 'manliness'. While the booklet was directed to the 'childless wife', there was much in the contents that suggested it was also an indirect communication to reassure a husband who was reluctant to undergo testing. This sympathetic approach with men, emphasizing that sperm behaviour had no connection to

[177] Wellcome Library, London, MWF/J.24/3
[178] Wellcome Library, London, MWF/J.24/3

the stability of masculinity, is a consistent feature through the discourse of this period.[179] The booklet also explained the process of ovulation and the importance of charting temperature to determine the proper timing for conception:

> …usually only one egg is made every month, and since it probably lives only two or three days, it is clear that many unions during the month will be unlikely to produce a child…It is possible for people to use a more accurate method of finding when the egg-cell actually is freed. The technique depends on taking careful records of the daily temperature throughout each month.[180]

It went on to explain the ideal positioning of the female body after intercourse in order to improve the chance of conception; that 'coldness' in the wife would not prevent conception, though K.Y. Jelly might help; that couples should track attempts at pregnancy on a calendar; and that after a year without conception a couple should visit their doctor (who could also advise on any pain or nervousness). The section 'What a Doctor Will Suggest' prepared readers for the types of tests and examinations that would take place: a doctor would suggest both a general examination and a post-coital test eight to twelve hours after intercourse to perform "microscopic examination of the remaining sperms". If the sperms were "lazy" the husband may be prescribed medicine, and "[h]usbands should understand that this is the only proper way of proceeding". The booklet stressed the routine nature of such investigations:

> Most men are quite willing to collect a self-produced specimen into a bottle and take it to the laboratory; or they can have union and withdraw in time so that the semen is passed in the bottle. Scores of these investigations are made every day.

In this rather subtle way, the test reassured readers that 'self-collection' was acceptable in this situation. The booklet explained that once the husband was deemed to be 'normal', the wife would be treated. This is an important point, since traditionally the female

[179] For example, see Herbst-Lewis, *Prescription for Heterosexuality*; Davis, 'Test Tubes and Turpitude'.
[180] Wellcome Library, London, MWF/J.24/3

partner was treated as the one in need of medical intervention. A key feature of the FPA's communications was that both husband and wife had to be examined and tested. The FPA's sub-fertility work did much to encourage a more equal approach, where both parties would be investigated, and part of this was done through greater sexual education in medical literature, like *For Childless Wives*. The booklet explained that if the concern was with the female partner, potential causes of sub-fertility included cervical or fallopian tube blockages, a tilted uterus, or irregular periods that could present difficulties but were often treatable. Yet if the cause was not apparent, an "X-ray picture is then taken of the womb and tubes, so that the doctor can see at what point the tubes are blocked". If this did not resolve the issue, "electric heat and glandular injections" would be applied, and if all else failed surgery was the final option. The booklet aimed to "show that the medical investigations are not alarming and at any point the reason for the delay in pregnancy may be discovered and treated". The message was that this was a very normal and manageable health issue.

The importance of biological kinship was positioned as the ideal. There was a final reminder that if it was found that conception was not possible, adoption was always an option and could bring "much happiness" to couples. However, the FPA stressed that "[c]are should always be taken in the selection of such a child". This is representative of broader attitudes to adoption at this time, which will be explored in Chapter 2. Ultimately, though, the booklet stressed that "it is generally best for a woman to bear her own child if it is in any way possible".[181] In some ways, the booklet offered people what Marie Stopes' *Married Love* had provided in 1918: an easily accessible and educative

[181] An addendum to the *For Childless Wives* booklet included instructions on how to keep the temperature chart, how to use the thermometer, and what this meant for 'ovulation day' and the days around it. The FPA provided three-month charts to women for a small fee.

handbook on sex and reproduction. In other ways, it attempted to address and allay concerns of the period: the declining birth rate, a crisis of masculinity, and fears of scientific intervention. Though the booklet's content is fairly banal today, this source is an excellent example of sex education literature of the 1940s and 1950s, and is also representative of the FPA's communications strategy.

## Developing strategic alliances

The FPA's success relied upon courting support from credible individuals and organizations. Developing strategic alliances was essential to build public acceptance of the Association's work. This bears similarity to the strategy of the ALRA, which gained 'legitimacy and respectability' by "girding itself in the armour of the reputations of the great and good".[182] The FPA did this in part through its executive and membership, but also by courting endorsements from religious leaders, and in reinforcing relationships with political officials and the press.

Beyond such direct publications as *For Childless Wives* (1944), the press became the most effective public tool for reproductive and sex education. In the late 1940s and early 1950s, the FPA began making a concerted effort to engage with the press as a way to disseminate information about their services. As Lesley Hall has pointed out, into the 1950s contraception remained 'distasteful' and "restrictions on advertising and promoting services" remained in place.[183] However, the cause of sub-fertility was more sympathetic and appealed to a wider audience than contraception. This was largely a conversation between print media and the FPA, who sometimes even collaborated on articles. For the

[182] Stephen Brooke, 'The Sphere of Sexual Politics: The Abortion Law Reform Association, 1930s to 1960s' (pp.77-94), *NGOs in contemporary Britain: non-state actors in society and politics since 1945*, (Basingstoke: Palgrave Macmillan, 2009), 82.
[183] Hall, *Sex, Gender and Social Change*, 139.

FPA, the press became a means for both free and paid advertising and this had measurable results in terms of attendance figures. For example, of the new sub-fertility patients to North Kensington in 1955, seventeen per cent said that they had heard about the clinic's fertility services in the press.[184] As clinic statistics demonstrated, press publicity was a significant driver for patient visits. Some articles focused specifically on the clinical experience, for instance in 1949 two magazines (the *Leader* and *Picture Post*) published photographs of the North Kensington clinic: the images included women and children sitting in the waiting room; a clinic worker examining a specimen under a microscope; a doctor and mother celebrating the birth of a young baby who was 'the result of sub-fertility advice'; and a typical interview and examination. [Figure 1.6] These documentary photographs visually communicated the North Kensington clinic's work to the public.

Despite the FPA's rapid expansion in the 1950s, its work remained controversial and many press outlets avoided the Association. By early 1955, the FPA was opening a new clinic every two weeks, on average. The FPA also expanded its training facilities (with 29 training clinics in existence in 1955).[185] Yet because of Catholic opposition, many media outlets (including the BBC) refused to publicize family planning or advertise appeals for funding, however the *Daily Mirror* and *Reynolds News* were more sympathetic. In 1953, the FPA attempted to improve press relations by inviting twenty-five journalists to its headquarters, which Margaret Pyke hoped would combat "the astonishing 'hush-hush' about family planning".[186]

[184] Wellcome Library, London, FPA NK/198.
[185] Leathard, *Fight for Family Planning*, 92.
[186] Ibid, 93.

As newspapers and magazines became one of the best ways to reach potential patients, it was in the FPA's best interests to maintain an open dialogue, and in return they received indirect publicity. In August 1949, the FPA's General Secretary wrote to *Housewife Magazine* in response to recently published letters from married women on the subject of childlessness. The Association's letter explained that many such women had been helped by the FPA clinics for sub-fertility, and they would be happy to provide more information to readers and mentioned that some might be interested in the booklet, *Childless Wives*.[187]

The press was an effective medium to advertise for new patients, and it was also a useful method of fundraising – particularly invoking pronatalist sentiment. In February 1950, as sub-fertility patients began to decline, the FPA's General Secretary wrote to *The Times* with a request to insert an ad in the personal column once a week for a month. The ad read:

> WANTED – A BABY. Eight out of every hundred married couples are sub-fertile. Our research department and information centre can help but receives no Government grant. Will you help by giving to the Family Planning Association Sub-Fertility Clinic, 64 Sloane St., S.W.1.[188]

The advertisement cost the FPA seventy shillings per insertion over the course of four weeks. *The Times* responded to the ad request that "the normal [publication] delay is approximately one week, [but] in view of the nature of the announcement we shall be pleased to give you priority".[189] This response from *The Times* suggests a good relationship with the FPA and support for its sub-fertility work.

[187] Wellcome Library, London, SA FPA A3/20, 'Sub-Fertility', 1943-1966.
[188] Wellcome Library, SA FPA A3/23, 'Sub-Fertility', 1943-1966.
[189] Wellcome Library, SA FPA A3/23.

However, the push in 1950 for additional funding and new patients did not make a significant difference for the FPA. Sub-fertility patients had been declining from the early 1950s. In April 1954, the sub-fertility committee reported to the Executive that as the decline of sub-fertility patients has continued, they were recommending "more advertising for the next three months in the hope of increasing the number of new patients".[190] If the advertising strategy failed, they would be forced to reduce a doctor's session to cut expenditure. It is not clear from the archives whether it came to this.[191] When the FPA began engaging with the press to advocate for their services – particularly sub-fertility – it encouraged readers to be more sympathetic towards couples seeking a solution for their 'childlessness', despite contraception remaining taboo.

## Political and Religious endorsements

Political recognition of the FPA's work also played a significant role in shifting public perceptions. Audrey Leathard marks 1955 as a turning point in the public perception of the FPA, associating this change with one individual: Iain Macleod, Minister of Health.[192] After hearing how "birth control was kept under the table" Macleod wanted to pay a visit to the FPA, and though Margaret Pyke said the Association would be discreet about the visit, he "insisted that [they] 'made the most of

[190] Wellcome Library, SA FPA A3/23.
[191] The next year, in June 1955, the General Secretary was in touch with Mrs. King from the *Woman's Sunday Mirror*, which was publishing an article on the sub-fertility work of the FPA. The Association was providing editorial comments before it was published – including that there were over 100 FPA clinics providing sub-fertility services and that looser fitting undergarments were advisable for males. The FPA was also in touch with *Woman* magazine about an article on sub-fertility work in November 1956. Not surprisingly, the press did not always get the story right. In November 1951, Irene James (the FPA's General Secretary) wrote to the Editor of the *Picture Post*, pointing out that the paper had made multiple incorrect statements regarding issues of sub-fertility – first that often there is nothing wrong with people presenting with fertility problems, and second that there is little to do to 'cure sterility'
Wellcome Library, SA FPA A3/23; SA FPA A5/106, 'Sub-Fertility Sub-Committee: Additional papers including presscuttings', April 1950 – July 1952.
[192] On the importance of the visit my then Minister of Health, Iain MacLeod, see Leathard, *Fight for Family Planning*, 93; Dally, 'Pyke', *ODNB*; Dunkley, 'Rice', *ODNB*.

the occasion' by full-scale publicity".[193] The visit took place on 29 November 1955, and Macleod praised the work of the FPA, giving them "an accolade of respectability previously denied".[194] Leathard argues that the impact from this visit was so dramatic that opinions changed overnight: the "virtual media ban on FPA news was lifted"; Margaret Pyke appeared on the BBC; inquiries from the public increased significantly, and leading articles appeared in papers and journals that had previously ignored the FPA (*The Times*, and *British Medical Journal*).[195] The FPA later said that Macleod's visit "dispelled in large measure the clouds of prejudice and hypocrisy which had obscured our work and made free and frank discussion the order of the day".[196] By publicly endorsing the work of the FPA, Macleod improved the public perception of all family planning services.

Further visits to the FPA from government Ministers came in 1958 and 1959. In September 1958, Derek Walker-Smith (Minister of Health, 1957-60) visited the FPA. This was followed by R.A. Butler's visit in March 1959. They both "expressed appreciation of the work" and the visits attracted publicity and lent further credibility to the Association's work. Growing media attention to the work of the FPA by the late 1950s further helped propel its reach. By 1960, the FPA was regularly requested by the BBC to weigh in on programming associated with family planning issues, despite the broadcaster's staunch opposition to the Association a decade earlier.

While these public moments of recognition – particularly the 1955 visit from Iain Macleod – were no doubt significant in the growing acceptance of the Association's work, I would suggest that there were multiple factors at play, which together helped

[193] Leathard, *Fight for Family Planning*, 94.
[194] Hall, *Sex, Gender, and Social Change*, 139.
[195] Leathard, *Fight for Family Planning*, 94; Hall, *Sex, Gender, and Social Change*, 139.
[196] Leathard, *Fight for Family Planning*, 94.

weave a stronger argument in favour of family planning.[197] Both religious endorsement and the promotion of sub-fertility work boosted the overall acceptance of the FPA as well.

Between 1955 and 1960, religious support for the work of the FPA grew substantially. The Methodist Conference publicly endorsed the work of the FPA in April 1955, with Kenneth Greet taking a position on the Association's Executive Committee.[198] The Methodist support for the FPA came more than six months before the Minister of Health's visit to Headquarters. Three years later, at the 1958 Lambeth Conference, the Anglican bishops "firmly expressed approval of birth control".[199] The Report from this conference supported the use of contraception within marriage and the idea of 'responsible parenthood', and received considerable press coverage. By 1960, Anglican clergy members even took part in FPA courses.[200] In 1960, the Church of Scotland also came out in strong support of family planning, and although the Catholic Church still held its traditional position, there was less opposition compared to the early 1950s.[201] Leathard stresses the significant shift in religious opinion; however, she does not attribute shifts in public perception to religious favour.[202]

## 'Family planning' in documentary film

[197] Leathard may overstate the significance of the 1955 visit, particularly when a public endorsement was made by a religious denomination earlier that year. Further, I would argue that the FPA's expanded services had created a more favourable outlook on the work as a whole – rather than a straightforward acceptance of birth control and contraception. For instance, when a request was put in for an ad to *The Times* for the FPA's subfertility work, the newspaper put a rush on it due to the subject matter. This seems to break with Leathard's point that perceptions changed overnight.
[198] Leathard, *Fight for Family Planning*, 95.
[199] Ibid, 95.
[200] Ibid, 96.
[201] Ibid.
[202] Ibid, 97.

Fourteen years after the first publication of *Childless Wives*, the FPA produced a documentary "public information" film, which profiled the Association's work while addressing the broader issue of world population concerns.[203] In 1958 the FPA released *Birthright*, a 24-minute black and white film, written and directed by Sarah Erulkar (1923-2015) and produced by Samaritan Films/Basic Films.[204] The film's producers included Leon Clore, best known for the *French Lieutenant's Woman* (1981), and Anne Balfour-Fraser, who ran Samaritan Films. Margaret Rawlings, an English actress known for her role in *Roman Holiday* (1953) was the commentator.[205] A recent assessment of the film remarked that "Erulkar's signature freshness of approach drives the essential points convincingly and the enactments are on a par with the 'kitchen-sink drama' trends in British feature film-making" of the postwar period.[206] The film was financed by the FPA, along with pharmaceutical companies (including the British Drug Houses Ltd., W.J. Rendells, the London Rubber Company, Coates & Cooper, Ortho Pharmaceutical, Ward

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[203] 'Birthright (1958)'. British Film Institute. http://explore.bfi.org.uk/4ce2b69ca36de, , accessed 28 January 2016; John Wyver, Blog Archive: Films from another country, 9 November 2010, Illuminations Media, http://www.illuminationsmedia.co.uk/blog/index.cfm?start=9&news_id=855; *Shadows of Progress: documentary film in post-war Britain 1951-1977*, Booklet to accompany DVD Collection, (UK: BFI, 2010), 3.

[204] Sarah Erulkar was an Indian-born, Jewish documentary director and "was something of an outsider in the realm of postwar British film-marking". Erulkar moved to London at the age of five with her family (her father had been a barrister who represented Mahatma Gandhi). During her 40-year career, she directed more than 80 documentaries, covering "an eclectic range of subjects and genres". She was hired at the Shell Film Unit in 1946 and was quickly, and untypically, promoted to director in 1947. Marrying in 1950, Erulkar experienced gender discrimination at Shell with the presumption that she should no longer be working after marriage. Therefore, in 1951, she moved into freelance work. Erulkar won two BAFTA awards for her work in short film in 1970 and 1978.
Katy McGahan, 'Sarah Erulkar obituary', *The Guardian*, 15 June 2015
http://www.theguardian.com/film/2015/jun/15/sarah-erulkar, accessed January 28 2016; see also Awards.bafta.org

[205] *Shadows of Progress*, DVD booklet.

[206] Patrick Russell and James Piers Taylor (eds), *Shadows of Progress*: *Documentary Film in Post-War Britain*, (New York: Palgrave Macmillan on behalf of the BFI, London, 2010), 240.
Other still images found at John Wyver, Review of *Shadows of Progress: Documentary Film in Post-War Britain, 1951-77*, Illuminations Media,
http://www.illuminationsmedia.co.uk/blog/index.cfm?start=9&news_id=855

Blenkinsopp, and Gilmont Products).[207] Contributing between £500 and £1000 each, the contraceptive manufacturers were keen to have the film made as "commercial advertising [was] out of the question".[208] Despite the involvement of the drug companies, there was no direct mention of any particular contraceptive method or device. The purpose of the film was "[f]or direct propaganda where a new clinic is being started", "[f]or Conferences and public meetings", and "indirectly through other societies".[209] It was an educative and promotional tool concerning both service provision and the broader issue of family planning. [Figure 1.7]

The film focused on both global population concerns and individual fertility, stressing the importance of *planned* parenthood – that children should be conceived by 'choice' rather than by 'chance'. It suggested that the FPA could address a variety of needs, including both encouraging and restricting conception. The film was divided into six sections: 'wanted' children, infertility, pre-marital counseling, gynaecological problems, contraception, and concern for global population growth.[210] According to Tim Boon of the Science Museum, London, *Birthright* "is a valuable record of the organisation of contraception and fertility services before the introduction of the contraceptive pill", and conveys "the social attitudes of this era, and the spirit in which those services were conceived and delivered".[211] However, Boon points out that while most of the film's content is liberal in its tone, "there is a nagging air of deference to

[207] Wellcome Library, London, FPA A17/34, 'FPA Film Birthright: Script, list of showing and other papers', 1958-1961.
[208] Wellcome Library, London, FPA A17/34.
[209] Wellcome Library, London, FPA A17/34.
[210] The pre-marital counseling was set up as several middle-class couples sitting around discussing potential challenges they might face in the marriage relationship.
[211] Tim Boon, '*Birthright* (1958)'. BFI Screen Online. http://www.screenonline.org.uk/film/id/1402554/

middle class values and to doctors and senior professional figures".[212] There is also a palpable eugenic sub-text through the film, demonstrated in the 'fictional' clinical settings as well as in the broader narrative, which this section will explore in detail. The value of the film for the purposes of this dissertation is in its narrative on sub-fertility, which included clinical consultation reenactments, and in its broader message about the 'right type' of families, which was framed by 'whiteness' and 'respectability'.

*Birthright* promoted the wide scope of the services available at the FPA, while also making the argument that every child should be 'wanted'. The film began in the delivery room of a hospital, with the birth of a baby. It followed by focusing on the difference between a 'wanted' and 'unwanted' child, presenting 'dramatic reconstructions' of various family situations and clinical investigations conducted at FPA clinics. Using real patients, rather than actors, the film aimed to normalize the clinical setting. The film concluded with a staged discussion by three men involved in reproductive medicine and eugenics – an authoritative commentary – on problems of overcrowding and starvation, particularly in India. Notably, sub-fertility services are treated as being equal in importance to contraceptive services.

In offering up an image of the 'right type' of family, the film contrasts multiple family situations: the 'Robinsons' were a large, happy, working-class family where both parents were involved in childcare; the 'Wrights' were a large, unhappy, working-class family with an absent-father, living in overcrowded accommodations; and even worse conditions were shown with unnamed children abandoned, neglected, and physically abused. Finally, the film presented a middle-class 'childless' couple sitting in Hampstead Heath with their dog, who were suggested to be deserving of a family. [Figure 1.8] It is

[212] Ibid.

useful to briefly explore the representations of those families in order to assess the meaning and message of the film. At the Robinson's home, a large group of children sit around a table with the mother in the foreground feeding a baby, and the father ladling out stew to the other children as the narrator explains:

> Large families don't necessarily mean misery whenever a new baby arrives. In fact, if the parents welcome him and if the family is a happy one, the baby is very fortunate to be part of a large protective group like this.[213]

The next sequence takes place at the Wright's home, where the narrator warned, "things can too often be like this": a 9-year-old boy lies on the ground reading "a lurid comic", while a 3-year-old girl sits screaming; in the background, a clothes horse is overflowing and the mother is at the stove.[214] The narrator explains that "[e]ach new arrival has made the mother more tired and less able to cope", as the film cuts to a greasy plate at the stove and the mother putting out a cigarette.[215] The film stresses that in Mrs Wright's house there is barely enough food to go around, and it is over-crowded: "A family like this is doomed by insecurity".[216] The father has little presence in the home: "[he] comes in, and looks around, he shrugs and goes out again".[217] Yet it could also be much worse, the film suggests. The children of Mrs Wright are positioned as 'unwanted' in a 'depressing' situation of neglect, but it is 'not serious'. The next sequence examines the extreme neglect experienced by some children, cutting to two small girls sobbing in dirty clothing, sitting in the corner of a shed with a mattress and dirty bedding on the floor. Abuse is

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[213] Wellcome Library, London, SA FPA A17/34, '1958 Film 'Birthright', Master Scene Script, July 1958.
[214] SA FPA A17/34; *Birthright*. VHS and DVD. Directed by Sarah Erulkar. UK: Family Planning Association, Basic Films Ltd., Samaritan Films, 1958. Videocassette, Wellcome Library. DVD, York University Libraries, *Shadows of Progress: documentary film in post-war Britain 1951-77*, Disc 1. UK: BFI, 2010.
[215] SA FPA A17/34, Master Scene Script, July 1958.
[216] Ibid.
[217] *Birthright*. VHS and DVD. Directed by Sarah Erulkar. UK: Family Planning Association, Basic Films Ltd., Samaritan Films, 1958

suggested as they are bruised and living in terrible conditions: "Unwanted and unloved, their spirit broken or twisted unless they are discovered in time".[218] The film then cut to a childless couple longing for a baby. A quarter of the short film was dedicated to the sub-fertility work of the FPA. While this middle-class, white, heterosexual 'happy couple' played with a dog in a London park, the narrator explained that "there is so much love to spare in couples that desperately want children", yet "for one couple in ten, a baby seems to be impossible".[219] The viewer is told that in recent years the FPA had undertaken investigations into infertility, to support "happy family life" in Britain. [Figure 1.9]

The first clinical reenactment takes place in Dr Margaret Jackson's office in Exeter. Mrs Clare Harvey is at a microscope when the patient, Mrs Cox, comes in. Dr Jackson appears, and she and Harvey exchange clinical notes on a case. The film cuts to Jackson sitting down with another patient, Mrs Appleyard, who is encouraged that she and her husband are on the way to conceiving, as Jackson reminds her that her husband needs to "carry on with the pills", as she writes out another prescription. Panning back to Mrs Harvey and Mrs Cox, the patient is being told about how to keep her temperature charts in order to track her ovulation. Next, Mrs Cox goes for an examination with Dr Jackson. Much of the dialogue addressed the issues covered in *Childless Wives*, which is played out through a consultation between Dr. Jackson and a female patient[220]:

> Narrator: Often, the patient has come to the clinic as a last resort after several years of hoping against hope.
>
> Doctor: I see you've been married since 1954.
> Patient: Yes
> Doctor: And you didn't start trying for a baby until early 1957.
> Patient: I tried.

[218] Ibid.
[219] *Birthright*. VHS and DVD. Directed by Sarah Erulkar. UK: Family Planning Association, Basic Films Ltd., Samaritan Films, 1958. Videocassette, Wellcome Library. DVD, York University Libraries, *Shadows of Progress: documentary film in post-war Britain 1951-77*, Disc 1. UK: BFI, 2010.
[220] The film used actual patients, rather than actors, which lent an authentic if amateurish feel to the project.

Doctor: As a matter of interest, why?
Patient: Well my husband was a student and we couldn't really afford it.
Doctor: Fair enough. Were there any housing difficulties as well?
Patient: Yes there were some.
Doctor: But you're all right now.
Patient: Yes
Doctor: Quite ready to start
Patient: Yes
Doctor: When did you start thinking about this seriously?
Patient: Oh, about a year ago.
Doctor: And you sought advice?
Patient: Yes
Doctor: From your general practitioner?
Patient: First of all, yes.
Doctor: I see that your husband is one of quite a big family
Patient: Yes he is
Doctor: And you're an only.
Patient: Yes
Doctor: And you have no idea why there's a hold up
Patient: No
Doctor: No idea at all
Patient: No
Doctor: Very few people have. All right, well now will you go behind the screen and take your things off and sister will help you. And I'll come along and finish which won't take very long. Good.
Is your husband as keen as you are to have a baby?
Patient: Oh Yes
Doctor: And he'll cooperate in any way?
Patient: Oh Yes[221]

The dialogue emphasized that the couple were financially secure, had a house of their own, and that the husband was cooperative in the testing process.

From here, the film cut to Mr Beier's experience at the Seminological Centre at FPA Headquarters. Dr Hans Davidson calls the patient into his consulting room. Mr Beier was forty-four years old and had been married for ten years. He explained that his wife wanted him to have testing done, but he did not believe there was anything wrong. Davidson reassured him that there likely was not anything wrong, but hundreds of men see him for testing each year. Davidson further explained the difference between 'low fertility' and 'sterility'. The narrator establishes the importance of testing both partners:

[221] *Birthright*. VHS and DVD. Directed by Sarah Erulkar. UK: Family Planning Association, Basic Films Ltd., Samaritan Films, 1958.

> Too often the wife is blamed if she fails to conceive, but in about 50 per cent of the cases the man is at fault. But wherever the fault lies, the doctor must convince his patient that there is no shame involved. At this particular clinic, the doctor expects to improve the husband's chances of full fertility in 60 per cent of cases.[222]

The film then cut to a scene in a laboratory where a technician examines semen on a slide under the microscope, with a "micro-shot of a swarm of live sperm busily darting around".[223] The narrator explains that the testing process requires patience, but when "the sperm are active and plentiful there is every reason to hope that in a few months the wanted child will be conceived".[224] Like *For Childless Wives*, the film stressed the importance of the husband being tested in sub-fertility cases and presented a reassuring and encouraging message that most likely everything was normal. From here, the film transitions to a scene at a nursery school as children sing and play, and the narrator tells the audience that it is such 'wanted' children that the FPA is concerned with; quickly cutting to the neglected children from earlier, the film reminds viewers that an 'unwanted' child is an unhappy one that "usually becomes an unbalanced adult".[225]

It is significant to note that the film scripts differed from the final film cut. The dialogue was often improvised since real patients were used rather than actors, so there are some minor inconsistencies. This analysis draws on the script and the final film to describe both the intent and the outcome of the project. For instance, in some scenes, the script provides further descriptive detail indicating the director's intent. Notably, earlier versions of the script were more negative and focused on the fault being with the husband, likely in an effort to stress the importance of testing. That the final film took a

[222] Ibid.
[223] FPA A17/34, Master Scene Script.
[224] *Birthright*. VHS and DVD. Directed by Sarah Erulkar. UK: Family Planning Association, Basic Films Ltd., Samaritan Films, 1958.
[225] FPA A17/34, Master Scene Script.

more sympathetic, or 'paternalistic' approach, is consistent with Gayle Davis' findings.[226] There were obvious implications in the message of the film about which families the FPA thought should or should not have more children. 'Respectability' and 'whiteness' were generally held as the ideal. This is apparent in one clinical enactment involving 'Mrs Sinclair' who was described as a young immigrant from Jamaica and was the only non-white patient in the film whose 'race' was mentioned in the final script.[227] The interaction between Mrs Sinclair and the doctor differed from the other clinical situations: she had been sent to the FPA by a local authority, rather than being recommended by a friend or deciding to attend on her own (as other patients had described earlier). [Figure 1.11] The final script described these sequences which took place at the Walworth clinic in south London: Mrs Sinclair, "a Jamaican girl, is struggling to drag in a pram and two small children".[228] Dr. Stewart invited Mrs Sinclair to sit down and said, "I hear some children outside. Did you bring them with you?" The doctor then reassured Mrs Sinclair that a staff member would look after them.[229] Mrs Sinclair had three children in three years, and would like to wait a little to have any more. There is a cut to the waiting room where a clinic worker is looking after Mrs Sinclair's children. The doctor establishes that she has been sent by the local authority, but asks whether she wanted to come. Mrs Sinclair says, "I hadn't thought about it" but wanted to wait for more children, and when asked what her husband thought, she replied, "He says he's had enough for the moment".[230] The commentator explained that while Mrs Sinclair "is still a happy, relaxed young woman,

[226] Davis, 'Test Tubes and Turpitude', 126.
[227] In the final script, this patient was referred to as Mrs Sinclair, however in the final film she was referred to as Mrs Day.
[228] FPA A17/34, Master Scene Script.
[229] In the final script, the doctor asked if it was Mrs Sinclair's child "howling" in the waiting room, but in the film this language was tempered.
[230] *Birthright*. DVD. Directed by Sarah Erulkar. UK: Family Planning Association, Basic Films Ltd., Samaritan Films, 1958.

able to cope with her three small children…in five more years and five more pregnancies, small accommodation and a limited income" could lead to an unhappy situation, as the film cuts back to earlier scene of Mrs Wright smoking at the stove with a screaming toddler on the floor.[231] This was followed by a splicing of shots of mothers and their children that aimed to demonstrate the "dangers" of having too many children who would have "little chance of a full and happy life": white, middle-class families sit in a FPA clinic waiting room, while poor, South Asian families sit on bare floors spinning and weaving.[232] [Figure 1.12]. This footage of "underprivileged women in India and Africa overburdened by their numerous offspring (who accompany their mothers to their factory jobs)" was meant to demonstrate the importance of the work done by the FPA.[233] A recent assessment of the film pointed to the message conveyed through depictions of class:

> Scenes of large working-class families in their overcrowded domestic 'hell holes' are interlaced with more salubrious and tranquil depictions of small middle-class families dining together in harmony.[234]

This message was delivered "with more bluntness than eloquence and is primarily directed at working-class women, among whom, we are told, fear and ignorance prevails".[235] The film reminded viewers of the many reasons women attend these clinics: there are many "happy wives leading normal easy lives", but there are also marriages "being ruined by too many children and a neglected husband"; there are women scared of another pregnancy, "girls entering marriage in ignorance and fear", "women dreading the

[231] Ibid .
[232] Ibid.
[233] Patrick Russell and James Piers Taylor (eds), *Shadows of Progress*: *Documentary Film in Post-War Britain*, (New York: Palgrave Macmillan on behalf of the BFI, London, 2010), 239.
[234] Russell and Piers Taylor, *Shadows of Progress*, 240.
[235] *Shadows of Progress*, 240.

menopause", and "women so ill and tired they almost don't care if their marriages break up".[236]

The final sequence of the film is an intimate discussion among authorities in the field of 'population studies' – Professor W.C. Nixon, Dr Alan Parkes, and Sir Russell Brain – discussing global population growth and related reproductive concerns. [Figure 1.13]. Notably, all three men held prominent positions in the Eugenics Society. Nixon (1903-66) was an obstetrician and gynaecologist, and one of the founders (and President) of the Hong Kong Eugenics League (established in 1936), which by the 1950s had been renamed the Family Planning Association of Hong Kong.[237] Brain was President of the FPA after Horder's death, as well as a member of the Eugenics Society Council.[238] Parkes (1900-90) was specialist in reproductive biology (both human and mammal), and was also a member of the Eugenics Society.[239] In the planning of the film, the sequence of this authoritative discussion by Brain, Parkes, and Nixon about the global population problem was to be accompanied by "stills of starved children and diseased people", which " 'come to life' in library shots of misery in Asia (people sleeping in the streets of Calcutta, disease, beggary, etc. etc.)".[240] In the final film cut, footage from the World

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[236] *Birthright*. DVD. Directed by Sarah Erulkar. UK: Family Planning Association, Basic Films Ltd., Samaritan Films, 1958.

[237] Warren Robinson and John Ross (eds), *The Global Family Planning Revolution: Three Decades of Population Policies*, (Washington, DC: The World Bank, 2007), 193; *Plague, SARS and the Story of Medicine in Hong Kong*, Hong Kong Museum of Medical Sciences Society, (Hong Kong: Hong Kong University Press, 2006), 263; 'Nixon, William Charles Wallace (1903-1966)'. Plarr's Lives of the Fellows: Royal College of Surgeons. http://livesonline.rcseng.ac.uk/biogs/E005988b.htm, accessed 28 January 2016; Margaret Pyke, 'Family Planning: An Assessment', Galton Lecture, 27 February 1963, http://library.bsl.org.au/jspui/bitstream/1/4569/1/Pyke-M_Family-planning-an-assessment_BSL_1963.pdf Nixon returned to Britain in the late 1930s and remained a prominent figure in obstetrics and gynaecology, and a respected figure in the medical profession throughout his life; also serving as a Vice President of the FPA

[238] For a list of the Executive and Members see *Eugenics Review*, Vol XLV, April 1953-January 1954, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2973471/pdf/eugenrev00053-0002.pdf

[239] Soloway, *Degeneration*, 342.

[240] Wellcome Library, London, FPA A17/34, 'Birthright: Master Scene Script', 25 July 1958.

Health Organization showed families in India experiencing death and starvation – a mother lies dying, while children sit on a bare floor sobbing – whilst Brain explains that this is caused by the "physical damage of over breeding and not spacing her family".[241] [Figure 1.14]. Throughout the film, the mother is often blamed for her lack of 'family planning', even when the reality is much more complex (socioeconomic and political factors, and where is the father?). As Molly Ladd-Taylor and Lauri Umansky have pointed out, mother blaming increased during and after the Second World War, and particular groups – "the poor, the unmarried, women of color – have been portrayed as bad mothers continuously".[242] [Figure 1.15] Brain provides a voice-over explaining that three-quarters of the world's population lives at a level of starvation. With developments in medical sciences cutting down the death rate, and the birth rate maintaining, the world population was estimated to double in fifty years, which would lead to an increase of famine, illiteracy, housing problems and unemployment. Therefore, "[m]an must face the fact that his power to lower the death rate will destroy him unless he learns to control his birth rate". Alan Parkes weighed in that "voluntary parenthood should be possible for everyone". He explained that "mechanical or chemical devices are of course adequate in the hands of trained and careful people…", represented by 'Mrs Adams' who was white and middle-class. [Figures 1.16, 1.17] However, Parkes continued, such methods were "quite inadequate when it comes to other people…", at which point the film cuts to the bustling East Street Market in the working-class area of Walworth, London. He continued

[241] *Birthright*. DVD. Directed by Sarah Erulkar. UK: Family Planning Association, Basic Films Ltd., Samaritan Films, 1958.
[242] Criticism was also directed at 'selfish' working mothers, who were seen to be creating juvenile delinquent children who had been abandoned. This position was supported by psychological theory of the period, including the work of John Bowlby.
Molly Ladd-Taylor and Lauri Umansky (eds), *'Bad' Mothers: the politics of blame in twentieth-century America*, (New York: New York University Press, 1998), 12-14, 18.

to say that such methods were "particularly quite inadequate when it comes to underdeveloped communities", as an image of a group of black women wearing traditional African dress appeared on screen.

This film established a hierarchy of 'wanted' and 'unwanted' children based on environmental and cultural conditions, rather than genetic reasons. It was suggested that middle-class and 'respectable' working-class families produced happy, loved children (though could benefit from 'spacing'); while lower-working-class families, as well as those in 'developing' countries risked producing 'unwanted' and unhappy children (and needed more guidance in limiting births).

The FPA seemed cautious about the implications of the film. It aimed to represent Britain as racially diverse, and the FPA clinics as welcoming, friendly spaces open to all (tea was even served in the waiting room). [Figure 1.18] Yet contrasts are drawn along class lines, and between 'developed' and 'developing' nations, which is most apparent during the discussion between Brain, Nixon, and Parkes. In this way, the film is internally inconsistent. Tim Boon has flagged the relevance of the relationship between the FPA and Eugenics Society in the production of this film, particularly as these men were involved in the Society: although the Eugenics Society "was moving away from the hardline biological reductionism views of the inter-war period…this is a reminder that the roots of the FPA had been close to the Society".[243]

In the years following its release, *Birthright* received wide screening with interested parties, however it never met the desired distribution. The premiere of the film

[243] Tim Boon, *Shadows of Progress: documentary film in post-war Britain 1951-1977*, Booklet to accompany DVD Collection, (UK: BFI, 2010), 25.

took place at the Royal Commonwealth Society, London on 10 March 1959.[244] The screening coincided with the return of British delegates from an International Planned Parenthood Conference, held in Delhi, India. The message of the film aimed to be international in scope: "it is the birthright of every child to be wanted and welcomed in a home and a society which can offer love and a reasonable start in life".[245] At the premiere, Sir Russell Brain (the President of the FPA) commented on "the remarkable change in the climate of opinion towards [family planning] in the last three or four years" with political, medical, and even religious support.[246]

Public appetite for the film was limited due to its promotional nature, however it had broad reach across FPA branches, social and medical organizations, media outlets, and internationally.[247] Between 1959 and 1962, *Birthright* had been screened at the House of Commons, at 145 FPA branches, and at 138 other organizations. Copies of the film had been sold to Australia, Barbados, Ceylon, Germany, Holland, Jamaica, Korea, Malaya, Norway, Scotland, Singapore, and Yugoslavia.[248] In 1959, it was hoped by Samaritan Films that *Birthright* would be seen by more than a million people over the years following. Grenada Television planned to use extracts from the film, if there was a suitable programme, and Contemporary Films was going to distribute it for film clubs and youth organizations to use across the country. However, most distributers said that it

[244] Wellcome Library, London, FPA A17/34.
[245] Wellcome Library, London, FPA A17/34.
[246] Wellcome Library, London, FPA A17/36, 'Birthright: Premiére at Royal Commonwealth Society', 1959.
[247] Another showing took place on 22 April 1959 at the British Council Theatre, where 41 social organizations attended. Over the course of 1959, the film was shown at 58 FPA-associated clinics and organizations, and 37 other organizations (including hospitals, College of Midwives, Colleges, social workers groups, mother's clubs, young wives groups, moral welfare association, Red Cross, and the Women's Institute). In 1960, it was shown at 64 FPA branches, and 30 other social and medical bodies. During 1961, the film was screened across the UK at 13 FPA-associated organizations as well as at 29 other organizations, including women's groups, medical groups, and church organizations. Wellcome Library, London, FPA A17/34; FPA A17/36.
[248] Wellcome Library, London, FPA A17/38, 'Plans for a new film (not executed', 1962-1963.

did not have appeal for a general audience because "it is too much a sponsored film, i.e. like an advertising spot".[249] The film remains an excellent representation of the aims and ideas of the Family Planning Association in the late 1950s, and affirms the continued link with the Eugenics Society. While birth control increasingly became about choice and liberation, the older principles of promoting 'healthy' families and discouraging 'problem' families remained.

## Conclusion

The development of sub-fertility services in Britain is not without controversy. Key figures in the Eugenics Society were closely tied to the establishment of sub-fertility, and in the communications of family planning work. As an organizational, clinical, and cultural history, this chapter has examined the expansion of FPA services from 1943 to 1960, while also looking at its public communications over the same period.

In the aftermath of the Blitz, and as focus turned to the future and reconstruction, anxiety over a falling birth-rate was a considerable social concern. And although sub-fertility services came to form an important part of the FPA's work, they remained a statistically small proportion of the overall patient base. Patient records from both the Exeter and North Kensington clinics attest to the small number of infertility patients dealt with annually. However, this chapter has argued that despite the relatively small number of patients, sub-fertility work opened opportunities previously closed to the FPA. By

[249] In August 1959, the film was going to be included in the television programme 'This Week' – an ITV series on current affairs. This apparent success led to the proposal for a second film. In 1962, the FPA began pitching another film on its work (to replace *Birthright*) that would give attention to the new oral contraceptives, however it never came to fruition. It was going to be 25 minutes long, in colour, and cost £7500 to produce. As with *Birthright*, the FPA reached out to all of the major pharmaceutical companies with an interest in contraceptives. Two of the original supporters agreed to provide funding for the new film, two declined, and two failed to respond. Those that were interested were not willing to give exact figures of support. Essentially, there was a lack of funding to execute on the project, and it never developed beyond the conceptual phase.
Wellcome Library, London, FPA A17/34; FPA A17/38.

emphasizing their role in growing the family, supporting marriage, and treating infertility, the Association effectively rebranded their organization and extended the meaning of 'family planning', which had long been strictly connected to birth control and contraception. This 'rebranding' was bolstered by official support from religious officials, the press, and politicians in the late 1950s.

This chapter has raised questions about the aims and motivations of the FPA's sub-fertility initiative. On one hand, sub-fertility work was women-centered. The demand for sub-fertility services was largely patient-driven, and the development of services was led by female physicians at the FPA, who had the goal of providing greater access for women and minimizing surgical intervention. These female physicians in the FPA met resistance from some male physicians, who wanted control over sub-fertility. At the same time, this discussion over sub-fertility services was mediated and financed by the Eugenics Society. Many of the (female) doctors involved in infertility work had seemingly altruistic motives: they did this work for many years with very little pay, and expressed their desire to help couples longing for children.

On the other hand, sub-fertility work was influenced by 'positive' eugenics. Most of the doctors mentioned in this chapter were also involved in the Eugenics Society; and the renaming of the 'Birth Control' Association to the 'Family Planning' Association was (in part) politically motivated, and perhaps the development of sub-fertility services was as well. Discussion by the Eugenics Society in the late-1950s about a policy of 'crypto-eugenics' to hide their motives, coupled with their continued financial support of the FPA and the substantial membership cross-over, suggests that the FPA's motives at this time could have been influenced by this strategy of 'hiding' eugenics in plain sight. And yet,

correspondence from the FPA gives the impression that while they maintained a good relationship with the Eugenics Society (since they received financial backing for over thirty years), they did their best to keep their organization separate and resisted any official partnership (despite sharing office space for ten years).

By the early 1960s, public opinion had shifted in attitudes to family planning. In 1959, while introducing *Birthright*, Sir Russell Brain (FPA President) remarked on how significantly "the climate of opinion towards the family planning movement" had changed in the previous three or four years: "'We have supporters in all political parties. Medical opinion is behind us; and presidents of the three royal medical colleges…figure among our vice-presidents'".[250] By 1960, the FPA had 276 branches, which in that year had 495,903 patients (more than a fifty per cent growth since 1955).[251] This is not the end of the story in the FPA's expansion of services, but this period marked an important step in the development of the Association's identity and public acceptance of their work. The knowledge of and demand for the FPA's sub-fertility services in the postwar period will be demonstrated in the next chapter through correspondence with potential patients.

[250] Leathard, *Fight for Family Planning*, 100.
[251] Ibid, 101.

# *Chapter 2*

## *The Experience of Infertility from the Family Planning Association correspondence, 1945–51*

> My age is twenty-four years and my wife is twenty-two years and we have been married two years. We are longing for a child of our own and feel that Artificial Insemination is a blessing and the answer to our troubles.[252]

So wrote a young man to the Family Planning Association (FPA) in 1947. He was one of forty-six correspondents who wrote to the FPA between 1945 and 1951 for assistance in conceiving a child. By examining this collection of correspondence, this chapter aims to explore the experience of infertility within marriage during the immediate postwar period. These letters, sent by married men and women to the Family Planning Association (FPA) asking for help in conceiving, provide an opportunity to investigate attitudes toward family planning, the practice of infertility treatment, and popular understandings of reproductive science in the postwar period.[253] The letters offer new insights into the influence of the media on understandings of infertility, access to fertility treatment, attitudes toward adoption, gendered roles within marriage, and the role of the medical profession. This chapter suggests that this correspondence represents a narrative of patient agency in the face of infertility, which was bolstered by press coverage, but was consistently mediated by barriers to access and gendered roles within marriage.

The letters underscore the agency of women and men in seeking out treatment for infertility. Not surprisingly, these letters reveal that there was no standard way in which couples dealt with the inability to conceive. Some actively sought treatment after one or

[252] Wellcome Library, London, SA/FPA/A3/2, 'Artificial Insemination', 1945-1964.
[253] Of the correspondents, 37 were married; the other 9 were medical practitioners or other professionals writing on behalf of a married couple.

two years, while others looked for help after more than a decade. Most commonly, individuals and couples tried a number of other avenues for treatment before contacting the FPA. In the 1940s and 1950s, infertility treatment relied heavily on patient initiative that was driven by the press and word of mouth. Medical referrals were not common practice until the mid-1950s; and, moreover, most doctors had not been trained in these areas and did not know how best to test and treat patients. Even among physicians with knowledge of treatments – like AI – moral opposition persisted.[254] These letters to the FPA confirm that the press played a significant role in prompting interest and growing public understanding of infertility during these years. With routes to infertility treatment remaining opaque for prospective patients, the press played an increasingly important role in disseminating information to the public and acting as liaison between the FPA and potential patients. This publicity benefitted both the FPA and patients: the work of the FPA was being promoted in the press, and potential patients gained knowledge about infertility. At this time, particularly before medical referrals were commonplace, the onus was on the patient to seek out the help of specialists, and press coverage made this possible. In taking responsibility for their personal and reproductive health, these correspondents exhibited a strong sense of agency. However, significant barriers to medical treatment remained: clinics were concentrated in London, and treatment options remained costly for the average person.

An analysis of these letters from working and middle-class married men and women can deepen our understanding of attitudes toward family planning in a number of ways. By contextualizing gendered roles in the experience of infertility, these letters help illuminate perceptions of marriage and heterosexuality in the postwar years. They also

[254] See Chapter 3 for examples of moral opposition to AI.

draw out the duality of the patient and practitioner perspectives. Patients were both agent and negotiator in their own health care; while doctors were often both gatekeeper of and advocate for infertility treatment. Therefore, this correspondence can also tell us about the patient-practitioner relationship during this postwar period.

These letters bring to light the various roads to infertility treatment experienced by couples in the post-war period, roads that often presented obstacles. Although this correspondence represents a relatively small sample size – eighty-nine letters, between forty-six individuals and the FPA – it reveals both patient perspective and the practical barriers to treatment. This source has not been examined elsewhere and offers unique insights. On a superficial level, the correspondence can tell us *who* had access to treatment, and more importantly who did not. Treatment for infertility was largely confined to urban centres, and the fees charged were often out of reach for ordinary people on an average wage. Even further out of reach was artificial insemination, which was more specialized and inaccessible than the standard testing and treatment offered by hospitals and the FPA.[255] The practicalities of artificial insemination – the cost of treatment, and allocations of suitable clinics – dictated which couples gained access to fertility treatment and which did not.

Locating patient perspective and experience is often difficult, with published material and medical views dominating the history. Patient files are often either censored for confidentiality purposes, or have been destroyed after the patient's death. These letters to the FPA are therefore an invaluable source for understanding how couples dealt with fertility problems, the solutions and treatment they hoped for, and how they came to

[255] In the 1940s, typical fertility testing and treatment included post-coital testing, semen testing, medication, a dilation and curettage procedure, and tubal insufflation.

understand infertility and the 'new' medical technology of artificial insemination. This correspondence is far from comprehensive, based on the small sample size, but as a source it offers a detailed look into the experience of infertility among ordinary people that is difficult to find elsewhere. While not taking the collection as a complete view, a close analysis is still useful in understanding individual experience.

**Analyzing the correspondence**

The collection of correspondence is comprised of 89 letters, written between 1945 and 1951, and is held in the Archives of the Wellcome Library. As mentioned, there were forty-six individuals who contacted the FPA about fertility problems in these years, including twenty-seven married women, ten married men, and nine professionals writing on their behalf. About half of the letters were written directly to the FPA head office, the other half to the North Kensington Sub-fertility clinic.[256] For this reason, the two sets of letters have a slightly different tone and purpose. Those written to the North Kensington (NK) clinic were largely about fertility testing and possible treatment for women, with only a few of these letters mentioning artificial insemination. Before the 1950s, the NK clinic focused on women's fertility, rather than men's, and did not offer AID, which explains the content of those letters. The letters written to the FPA head office, on the other hand, were almost entirely focused on the technological possibilities of artificial insemination, and married men penned half of the letters written to the head office.[257]

[256] From 1945 through to the early 1950s, the FPA was in the practice of giving out the names of AID practitioners when requested by ordinary people. By 1957 this had clearly ended. From this point, and likely earlier, the names of such doctors were treated as privileged information and were only discussed between medical doctors and FPA clinics. The North Kensington Family Planning Association Clinic was one of only a handful of designated 'sub-fertility' clinics in Britain and as a result the clinic received correspondence inquiring about services for infertility.

[257] It is unclear if these letters have been 'curated' before or after entering the archives, or whether this collection comprises all of the letters received during these years.

Artificial insemination was a central presence in the correspondence: 61 per cent asked directly about the procedure or expressed interest in having a so-called "test tube baby". This knowledge of AI and 'test tube babies' was a direct result of press coverage.

I have taken both a qualitative and quantitative approach to this collection of letters, whilst remaining informed by recent epistolary analysis by historians like David Gerber and Emma Jones. A single letter can tell the historian only so much, particularly when the correspondent had a sense of what the reader expected.[258] As David Gerber points out, letters "settle into patterns"; they follow conventions and "general models of writing".[259] Most importantly, letters "are based principally on the fact that the addressee is always in the consciousness of the writer" so negotiation is always taking place, if not externally than internally.[260] A letter is always written with the eventual reader in mind – in this case the FPA. As Emma Jones has argued with respect to correspondence between potential patients and the Abortion Law Reform Association in the 1960s, these types of letters cannot be taken at face value:

> …the language, form and content of letters are affected by the purpose for which they were written. The letter should not be viewed as a transparent and unmediated act of self-expression; rather it should be viewed as a 'text', and submitted to the same rigours of interrogation as we would apply to any other documentary source. The letter represents a tentative space between the writer and recipient.[261]

This tentative space described by Jones is what David Gerber refers to as negotiation. In his study of the correspondence of British immigrants to North America in the nineteenth century, Gerber describes a two-pronged process of negotiation that takes place in writing letters: the first sense refers to "bargaining between individuals", and the second refers to

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[258] Emma Jones, 'Attitudes to Abortion in the Era of Reform: evidence from the Abortion Law Reform Association correspondence', *Women's History Review*, 20(2), 2011, 282-298.
[259] David Gerber, *Authors of Their Lives: The Personal Correspondence of British Immigrants to North America in the Nineteenth Century*, (New York: New York University Press, 2006), 95.
[260] Gerber, *Authors of Their Lives*, 95.
[261] Jones, 'Attitudes to Abortion', 286.

"an internalized discussion within the consciousness of the individual correspondent".[262] Both senses of the concept of negotiation are at play in the FPA correspondence.

Of central importance to this chapter is the way in which these letters reveal the state of gender roles and marital relationships in the post-war period. From a qualitative perspective, the letters suggest that dealing with fertility problems in marriage was a shared responsibility, though this was not true of all couples. A wife would often write a joint statement for both she and her husband, but in a number of cases letters revealed marital tensions that were caused by the inability to conceive, or a husband's unwillingness to be tested or have treatment. With thirty-seven per cent of the letters from prospective patients written by husbands, the findings from this correspondence can be seen to support the studies of both Kate Fisher and Lesley Hall in showing the important role men played in negotiating reproductive decisions and family planning. This is perhaps suggestive of marital power dynamics – however, it is also often representative of the spouse seen to be "at fault". In every case but one, husbands writing to the FPA had already received a diagnosis of sterility and were searching for a solution in artificial insemination.

It is useful for the purposes of analysis to consider the profiles of correspondents. The letters show that among married couples women were more likely than men to write to the FPA, but male correspondents still represented a significant proportion (37%). Of the 46 correspondents writing to the FPA, 27 were married women, 10 were married men, 7 were doctors writing on behalf of patients, while 1 sergeant wrote on behalf of a private, and 1 nurse wrote for advice (it was unclear whether this was for personal or professional interest). Of the married women and men who were inquiring out of personal

[262] Gerber, 94.

interest, twenty-three indicated the length of their marriage – the majority of whom were married during the war. Six married before the war (1931-8); eleven married during the war (1940-5); and another six married after the war (1947-9). Of those married during the war, more than half were married in 1940. Although correspondents detailed the number of years they had been married, there is not often any mention of the circumstances surrounding the marriage or time spent apart during the war. On average, couples were married for 7 years before contacting the FPA. Plotting the available data on a chart [Figure 2.1]shows that couples who married after 1943 were more likely to contact the FPA after two or three years than their counterparts married before or early in the war, who waited an average of nine years before contacting the FPA. It is difficult to draw conclusions from this data since many married couples were separated for long stretches of time between 1939 and 1945. Thus, it is possible that fertility problems only became apparent after the war when couples were reunited. However, the clustering of letters also suggests the possibility that as 'sub-fertility' and infertility received more attention in public discourse, and as the FPA promoted their services, correspondents were spending fewer years trying to conceive before turning to the medical profession for help. Furthermore, the FPA in particular became identified as a central source for advice, testing, and treatment for all fertility-related issues.

**The 'Golden Age' of Marriage and Companionate Marriage**

To consider these letters in context, it is essential to understand marriage in the postwar period and how heterosexual couples conceptualized their relationships and the institution. Expectations and aspirations attached to the institution of marriage were critical to how both couples and individuals handled the experience of being unable to

conceive. As outlined in the Introduction, the ideal of 'companionate' marriage was particularly influential. Community studies of the family in the 1950s – including those by Young and Willmott, Newson and Newson, Gorer, and Slater and Woodside – "repeatedly examined whether or not companionate marriage was flourishing" in the postwar years.[263] For example, Young and Willmott's sociological study of working-class families in the 1950s pronounced a new marital partnership:

> In place of the old comes a new kind of companionship between man and woman…which is one of the greatest transformations of our time. There is now a nearer approach to equality between the sexes and, though each has a peculiar role, its boundaries are no longer so rigidly defined nor is it performed without consultation.[264]

However, Young and Willmott found that inequalities, reminiscent of older times, still persisted. For instance, men still often dominated decisions about childbearing: "When one husband said to us 'We wanted the baby,' his wife retorted, '*You* may have done; I know *I* didn't.'"[265] When the wife was later asked if she wanted more children, she responded: "I don't want them, but you can't tell. You ought to ask him (pointing at her husband) about that. He's the guv'nor."[266] But Young and Willmott also asserted that the gendered division of labour in the home was less rigid, and both mother and father were involved in caring for the children. As one interviewee said: "It used to be thought very undignified for men to have anything to do with children. You'd never see a man wheeling a pram or holding a baby. Of course all that's changing now."[267] John and Elizabeth Newson came to a similar conclusion in their study:

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[263] Szreter and Fisher, *Sex Before the Sexual Revolution*, 37.
[264] Segal, 3; Michael Young and Peter Willmott, *Family and Kinship in East London*, (Los Angeles: University of California Press, 1992), 30 (Originally published by Routledge in 1957).
[265] Young and Willmott, 20.
[266] Ibid.
[267] Ibid, 28.

> At a time when he has more money in his pocket, and more leisure in which to spend it, than ever before, the head of the household chooses to sit at his own fireside, a baby on his knee and a feeding-bottle in his hand.[268]

However, on the contrary, Geoffrey Gorer's 1950 study of English attitudes to marriage demonstrated the continuation of separate gendered roles. When women were asked which qualities they most desired in their husbands, the majority replied 'understanding' (with helping in the home mentioned by fewer than five per cent). When men were asked which qualities they most desired in their wives, the majority wanted 'good housekeeping' (with shared interests mentioned by only 8 per cent). In summarizing these attitudes, Gorer wrote:

> Some wives did comment upon their husbands' unwillingness to participate in any housework or childcare. A 'typical twenty-eight-year-old working-class wife', for example, complained of husbands who were 'afraid of being thought a cissy; mine hates people to know he helps at all in the house; won't push pram'.[269]

Gorer concluded: "it is marriage which is important, not, I think, love or sexual gratification; and marriage is living together, making a home together, making a life together and raising children".[270] Raising children remained central to marriage, but the lack of agreement between these studies speaks to the 1950s as a period of transition. Gender roles may have been less rigidly defined than before the war, but there was a broad spectrum on which meanings of gender were ascribed. While these surveys suggest that men took on more active roles as fathers in the post-war years, traditional markers of masculinity were often enforced. Infertility was particularly challenging in a period associated with the so-called 'golden age' of marriage, in which the social expectation to have children was so high, while at the same time information and access to fertility

[268] Segal, 3.
[269] Segal, 4; Langhamer, 'Adultery', 92.
[270] Langhamer, 'Adultery', 92

treatment was so difficult to reach. An analysis of patient agency and the role of the press in disseminating information is revealing of these challenges.

**Patient Agency and The Press**

The letters to the FPA demonstrate the influential role of the press in disseminating health information, by shaping popular understandings of reproductive science and playing unofficial liaison to the FPA. The correspondence is also reflective of the agency of individuals and couples seeking fertility solutions; artificial insemination, in particular, was primarily patient-driven and was a result – almost exclusively – of attention in the press. Many couples had dealt with infertility for years and now, with AI, had a new avenue for treatment.

The press had a significant impact on a large number of correspondents. For instance, a woman from Christchurch (Dorset) wrote in 1948, saying that she had seen in the newspaper that artificial insemination was done in England and wanted any information available.[271] As this chapter has suggested, media attention to AI was a significant influence for people writing to the FPA. Many correspondents referenced a specific news article directly – in publications like the *Leader* magazine, *News Review*, and the *Daily Mirror* – while others explained more generally that they had recently read about artificial insemination in the newspaper. This coverage did not only reach those with a personal stake in fertility treatments. Mass Observation diarists – including a clerk and an antique dealer – referenced news articles on artificial insemination in *News of the World* in 1946 and in the *Daily Telegraph* in 1947.[272] Similarly, a sergeant who was

[271] Wellcome Library, London, SA FPA/A3/2, 1948.
[272] Diarist 5122 (Male Antique Dealer) 22 April 1946 and 15 April 1947; Diarist 5447 (Female Housewife and Clerk) April 1947, Mass Observation Online, (Adam Matthew Digital Ltd., 2004), http://www.massobservation.amdigital.co.uk accessed on 28 October 2013.

writing on behalf of a private in his company referred to an article in *News Review* that had appeared in June 1945 and had started a conversation about the issues in the barracks. The letter explained that the private asked his sergeant to get in touch with the FPA to ask about the possibility of artificial insemination. The sergeant explained the private's situation:

> He is not a well to do man and would love to have children. His wife is healthy, but he can't make any children, although feeling sexually very fit, but the sperms are not moving and exist only in small numbers. Although he got injection to improve this state, he was not successful. Is there any chance his wife could receive 'Artificial Insemination' and what would be the procedure. I would be very much obliged for an early and confidential reply…[273]

That the sergeant was (apparently) writing on behalf of his private suggests the importance of both social hierarchy and class in anticipating a favourable response. However, it is also possible that the sergeant was writing about himself but disguising it as someone else. Regardless, he clearly valued the secrecy of his request and was well-informed about the private's previous testing, indicating that sperm count and motility were issues. The FPA responded by stressing how the Press had been misleading in suggesting the FPA conducted AI, but went ahead to recommend the specialist Dr Mary Barton, as well as the Association's informational booklet, *Childless Wives*.[274]

Many correspondents learned of the work done by the FPA through this type of press coverage. For example, Mrs. U. (37 years old), wrote to the NK clinic in 1949 to say that she had just read an article on the FPA clinics in *Leader* magazine (a pictorial weekly). Photos from this article featuring the range of services at the North Kensington clinic are pictured in Figure 1.6. Mrs U. and her husband were married during the war in

[273] Wellcome Library, London, SA FPA/A3/2, 1945.
[274] There is a handwritten note in the file from July 1945, which explains that Greta Graff was being difficult about AI and all future correspondence instead should recommend Mary Barton as the London specialist and Margaret Jackson in the Exeter area. The press attention directing people to the FPA was beginning, it seems, to overwhelm them and specialists would have, as a result, been receiving far more attention in these matters than previously.

1940 and very much wanted a child. In the letter she explained her medical history:

> [In 1946], after a 'D and C' operation I had a miscarriage at six months – for no apparent reason, and since then have had no further signs of pregnancy. We have both consulted a gynaecologist who after taking various tests, could find no reason for our childlessness.[275]

After reading about the work of the FPA in a magazine she had renewed hope that something could be done.

Beyond passive consumption of news content, potential patients interacted directly with the media. In March 1950, for example, Sister Clare of the *Daily Mirror* wrote an article entitled, 'Childless – but they don't DESPAIR' in which she reassured those trying to conceive and encouraged them to contact her for advice. [Figure 2.2] She told the story of 'Mrs X' who had contacted her after the last article on childlessness the previous year. Mrs X was 35, had been married for 10 years, and had largely given up on conceiving. Sister Clare explained how she had put Mrs and Mr X in touch with the appropriate specialists and that they were now expecting a baby – all without any operation by only eating a healthy diet (she stressed the importance of Vitamins A and E, particularly those found in green leafy vegetables).[276] Sister Clare concluded the article with this advice:

> If you are one of the childless, don't sit back thinking that nothing can be done. Don't hide behind a barrier of shyness. Don't resign yourself to being deprived of a baby of your own until every stone has been turned.
> Instead, write to me, like Mrs. X did, and enclose a stamped addressed envelope. I can't promise the impossible, but I can put you into touch with those who specialize in this work.[277]

One week after the publication, the Family Planning Association wrote to Sister Clare at

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[275] Wellcome Library, London, SA FPA/NK96, 'North Kensington Clinic: Sub-fertility – Correspondence re patient follow-up survey', 1949.

[276] In addition, Sister Clare recommended increasing intake of liver, soya flour, cereals, cheese, butter and eggs. Although vegetables were never rationed their variety and availability was limited, and the latter three foods (cheese, butter, eggs) were rationed until 1953, pointing to the still limited diet available in the early 1950s. One FPA correspondent who responded to Sister Clare's article took the diet and nutrition advice, explaining that she had been attending a National Health doctor for a year with no improvement so had gone to a Nature Clinic in London where she had a diet prescribed and had since experienced better health and hoped this would improve her chances of conception.
Wellcome Library, London, FPA NK/96, 1950.

[277] Sister Clare, 'Childless- but they don't despair', *The Daily Mirror*, 22 March 1950, p.4.

the *Mirror* expressing their pleasure at seeing her article. They offered detailed information regarding sub-fertility services for both men and women, particularly stressing the importance of both partners being tested, since far too often the assumption was that women were to blame. The FPA asked Sister Clare to reassure readers that if they could not reach a specialist clinic that they could go to any FPA clinic for advice.[278] As Adrian Bingham has pointed out, so-called 'agony aunt' columnists offered the "authority of doctors" combined with the "intimacy of a friend"; they "represented convenient, approachable, and knowledgeable figures to whom readers could turn at a time when many people felt it difficult to discuss sex in person".[279] It was through these columns that organizations like the FPA were increasingly brought to the public eye.[280] Reaching the medical profession in this roundabout way through the press was not entirely uncommon. When the Feversham Committee interviewed infertility specialist Dr. Bernard Sandler in 1959 about how he was contacted by patients, he explained this circuitous route. In one case, a patient from Manchester "read an article in *Reader's Digest*, and wrote to the editor in New York, who wrote to the editor in London of *Reader's Digest*, who wrote to Mary Barton, who wrote to [Sandler], and the patient lived around the corner from [Sandler's] hospital".[281] There was no clear avenue to infertility treatment in the 1940s and 1950s and, as a result, people turned to authority figures in the media.

Through such articles, the press shaped popular understandings of reproductive

[278] Wellcome Library, London, SA/FPA/A1/15, 'Model letters, arranged alphabetically by subject', 1939-1960.
[279] Bingham, *Family Newspapers*, 76.
[280] Bingham, 82.
[281] Wellcome Library, London, SA EUG/D.251, 'Tape recordings of evidence given to AID Investigation Council by Drs Barton, Bloom, Boyd, Chesser, Davidson, Jackson, Mears, Sandler, Shotton, and Wright', 1958-1960; National Archives, London, HO 342/58.

science. The language correspondents employed to describe medical procedures was directly influenced by press coverage. By and large, men and women phrased their requests to the FPA in similar ways. But there were some significant differences. For instance, 80 per cent of husbands wrote to ask explicitly about 'artificial insemination' (because they were believed to be 'at fault') while women were more open-ended in their request. One interesting difference in the language used was that it was only women who wrote of desiring a so-called 'test tube baby'. For instance, a Liverpool woman (Mrs. T.) wrote in 1945 that she had "recently heard about Test Tube babies" and "would be very pleased if you could let us have details of the necessary procedure".[282] Another, based in South Africa, said: "We have read about the clinics now in England where one may have a 'Test Tube baby' and we should very much like to know if and where this can be done."[283] Similarly, a 1951 letter from a Wolverhampton woman (Mrs. I.) read:

> I would be very much obliged, if you could furnish me with some information, in respect of conceiving [a] test tube baby, we have been reccomended[sic] to get in touch with you in regards to this matter…[284]

The use of the phrase 'test tube baby' speaks to the influential role of the press in developing popular understandings of reproductive science. It also suggests that medical knowledge of assisted conception was limited, and may also underscore how sexual passivity and naiveté remained important for women. As Kate Fisher has shown of women in this period:

> [the majority] adopted a sexual identity which prized sexual innocence and passivity. They were therefore reluctant to impose a female-led strategy which would have meant openly addressing sexual issues and would have appeared to them as sexually demeaning and immodest. [285]

Open discussion of sexual issues in this period was not only embarrassing for most

[282] Wellcome Library, SA FPA/A3/2, 1945.
[283] Wellcome Library, SA FPA/A3/2, 1945.
[284] Wellcome Library, SA FPA/A3/2.
[285] Kate Fisher, *Birth Control, Sex, and Marriage*, 201.

women, but also "challenged their sexual passivity".[286] The way in which women employed the phrase 'test tube baby' suggests that coverage in the popular press was influential – if not scientific in its language. While both male and female correspondents referenced 'artificial insemination' *only women* used the term 'test tube baby'.[287] The use of the phrase might point to a discomfort or uncertainty among these female correspondents in using medical terminology, or when thinking about conception the idea of a 'baby' was preferred to a 'procedure'. This is not to say that male correspondents were entirely comfortable with the medical terminology, as one who used the phrase 'artificial insemination' seemed tentative about it, following with "I think that is the correct term".[288] It is important to further explore the role of media and popular culture in influencing public knowledge of fertility and reproductive technologies, however these issues will be dealt with in greater detail in the next section in Chapter 4.

**The Practicalities of A.I.: Access, Cost, Class, and Locality**

While accounts in the press implied an ease of accessibility and conception with some simple advice or a procedure, the reality was another matter. In a very concrete sense, these letters reveal the restricted accessibility to fertility testing and treatment. This section looks at access to fertility treatment and A.I. and how locality, individual means, and class shaped such access.

Social class status and levels of affluence largely dictated access to fertility treatment during this period. Although the Family Planning Association catered to working and middle-class people, the private fees charged for AID were largely out of

[286] Ibid.
[287] Mothers who had conceived via AID (interviewed by the *News Chronicle* in 1958) used the term 'test tube baby' exclusively, rather than using medicalized terminology such as artificial insemination.
[288] Wellcome Library, SA FPA/A3/2, 1945.

reach for many couples. The FPA typically charged one guinea for an appointment, while private fees ranged from three guineas to twenty-six guineas per month, often with a minimum commitment of five or six months.[289] Although three guineas may have been manageable for the average married couple, the significantly higher fee certainly was not. Each doctor set their own fee scale, and they were under no obligation to accommodate potential patients of lesser means.

The class status of those who wrote to the FPA is difficult to assess as very few mentioned occupation. The North Kensington clinic would only see patients with a weekly income of under £10 – the average income in the early 1950s – suggesting that most people attending the sub-fertility FPA clinics were from the lower-middle and working classes. A 1945 survey conducted by the FPA for the Royal Commission on Population is more revealing. The FPA surveyed income and occupational class at five of their clinics during the war. Using the Registrar General's five main occupational classes[290], the study showed that in the five clinics the majority came from the 'skilled' class (71.2%) with smaller proportions from the 'professional' and 'managerial' class (17.4%), and fewer still from the 'partly skilled' and 'unskilled' demographic (11.4%). However the North Kensington clinic – where many of these letters were directed – deviated significantly from the average with an appreciably higher proportion of professionals (31.4%), and skilled workers (61.6%), and fewer partly skilled and unskilled workers (7%).[291] Kensington was one of the most affluent areas of London, however North Kensington was not, but as correspondents were often writing from across

[289] National Archives, London, HO 342/58.
[290] Class I – Professional; Class II – Managerial and Technical; Class III – Skilled; Class IV – Partly Skilled; Class V – Unskilled.
[291] For men who were still in the Armed Forces, the clinic listed their pre-war occupation. Wellcome Library, London, FPA/NK/95, 'Sub-fertility statistics', 1950-1952.

Britain we should not equate the class and occupational status of patients with those of correspondents. This breakdown serves to underline the fact that the typical FPA patient was average in terms of income and occupation.

The affordability of and proximity to a sub-fertility clinic or specialist could by itself define how a couple would build a family. Geographically, the letters came from a wide range of areas, but with sub-fertility clinics and specialists concentrated in London, with one in Exeter and another in Manchester (from 1947), the distance and cost for travel was not possible for many people. Most correspondents were from the Greater London area, but others were a distance away and were willing to travel; for example, one was in South Africa, one in Northern Ireland, one from the Isle of Wight, three in Wales, and two serving abroad. Surprisingly, there were no letters in the archives from Scotland. In their responses, the FPA warned correspondents of the financial and geographical challenges to infertility treatment.[292] For example, in their response to a man from Chester, the FPA explained that "especially for anyone in the provinces" the procedure is "neither cheap nor easy".[293] In their responses to correspondents, the North Kensington Clinic always stressed that they were not part of the National Health Service and therefore required an appointment fee of one guinea (fee in 1951). Prospective female patients were to write the clinic the day their menstrual cycle began, in order to

[292] In their responses, the North Kensington Clinic always stressed that they were not part of the National Health Service and therefore required an appointment fee of one guinea (fee in 1951). Prospective female patients were to write the clinic the day their menstrual cycle began, in order to calculate ovulation and therefore the appropriate time for an appointment. The clinic then wrote back to confirm the date and time of the appointment with the necessary details. The clinic prepared correspondents by saying that several visits may be necessary; as well, a report on the husband's exam, and a letter from their family doctor would be required. They also requested that the women have intercourse the morning of the appointment, or the night before (for a post-coital test). The patients were also asked to bring a towel – presumably to cut down on laundry fees for the examination rooms.
Wellcome Library, London, SA FPA/NK/96.
[293] Wellcome Library, London, SA FPA/A3/2, 1947.

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There was an obvious geographical disadvantage, which is stressed in several of these letters. Unless you were a family of some means, these frequent trips to London were neither practical nor possible. For example, a married woman from a small town in Wales explained that she had already seen two gynaecological specialists who told her there was nothing to prevent her from conceiving, and her husband's semen test had been normal. She explained: "I now desire a full examination and if possible to have an insufflation test…If this cannot be obtained through the Health Scheme I will gladly pay for this treatment".[295] It is clear from her letter that she was aware of available fertility testing and after trying to conceive for two years was actively seeking treatment; yet confusion still remained as to whether it was covered by the National Health Service (NHS). The FPA responded, empathizing with her difficulties, but said that due to her distance from London it would be very difficult to treat her, particularly as several visits to the clinic would be required. This underlines the geographic exclusivity of such testing and treatment. Although there were FPA clinics across the UK, only very few dealt with "sub-fertility".

[294] Wellcome Library, London, SA FPA/NK/96
[295] Wellcome Library, London, SA FPA/NK96.

The geographical barrier went hand in hand with cost as an obstacle. There was a wide range of fees – with a significant differential between FPA clinics and private specialists – from just over £1 for an appointment at a sub-fertility clinic, to upwards of £25 per month for AID at a London specialist. The fees for AIH were reasonable, and by the early 1960s it could be obtained without charge through some hospitals; by 1968 AI was available through the NHS. At the FPA Sub-fertility Clinic the charges for AIH were about 2 guineas (*c*.1961). A 1961 letter from the FPA to Dr. D. Constad of Portsmouth quotes the cost of AIH (private fees) at 5 guineas for preliminary investigations and an additional 3 guineas for each insemination. The FPA explained that there would be no charge at U.C.H. but there was a long waiting list. Similar to today, waiting time to receive such treatment free of charge at a hospital could be lengthy.[296] In addition to specialist fees, patients were expected to have the necessary fertility tests from a respected hospital, to be willing to spend one week of every month in London anywhere from three months to two years (depending on the length of treatment), and to absorb the costs of travel and accommodation.[297] FPA clinic fees were sometimes too much for a couple to bear, and based on the region, fees for sub-fertility services varied from one branch to the next. The North Kensington and Islington clinics both charged a fee of one guinea (for the first appointment).[298] But other clinics outside of central London had a significantly lower fee. For instance, the Exeter fee was a flat rate of 2/6d.; Greenwich charged a flat rate of 10/6d.; and Welwyn was free of charge. The FPA tried to be accessible to ordinary people, but as a voluntary organization they could not operate at a

[296] Wellcome Library, London, SA FPA/A3/2; Martin Richards, 'Artificial insemination and eugenics: celibate motherhood, eutelegenesis and germinal choice', *Stud. Hist. Phil. Biol. & Biomed. Sci.*, 39(2008), 211-221.
[297] Wellcome Library, London, SA FPA/A3/2, 1947.
[298] This was not a standard fee across all sub-fertility clinics. For instance, the Exeter fee was significantly lower at 2/6d. for the first visit; Greenwich charged 10/6d, and Welwyn was free.

loss. On the flip side, if couples had an average household income of more than £10 per week they would not be seen at the North Kensington clinic and were instead asked to see a specialist privately (under the assumption that that could afford the fees). The FPA clinics catered to women and families earning the national wage average of £10 or less a week. This structure is revealing of the tiered health care system discussed in Chapter 1. Infertility testing and treatment could be accessed through three different avenues with varied levels of accessibility: the FPA as a voluntary service, the NHS as a state-funded service, or through private specialists. Despite the reasonable fee charged by the FPA clinics, there were several accounts of cases where the cost was insurmountable. Mrs. M. wrote to the North Kensington Clinic in 1951 explaining that her husband was disabled as a result of the war, and after four years of marriage they had not been able to conceive. She had been referred to the sub-fertility clinic in Kensington, but she was not able to pay the full fee:

> I understand your fee is a guinea. This however is at present beyond my means. As my circumstances at the moment are unsettled. My husband who is a disabled ex-serviceman is doing very little work…should things better themselves I will pay any remaining fee due to you.[299]

The clinic responded that Mrs. M. should seek (free) advice from her own doctor under the NHS, or ask to be referred to the nearest large hospital, but they could not waive the fee. Given the limited resources available on the NHS to diagnose and treat infertility at this time, being unable to afford attendance at an FPA clinic would have been a major barrier to treatment. The ability to pay was not explicitly connected to the fitness to parent, but it was nevertheless indirectly applied. In some instances, inability to pay was a reflection of marital power dynamics rather than household income. For instance, another woman wrote to the sub-fertility clinic in 1949 to decline an appointment due to

[299] Wellcome Library, London, SA FPA/NK96, 1951.

finances:

> …my husband only allows me £4 per week, out of which I have to pay 23/- a week rent and all the other things required during the week including our food. I will not have the fee for one guinea, out of my house keeping money. I was looking forward to attending your clinic.[300]

This letter puts the cost in context, showing that for this woman one week of rent was only slightly more than the cost of attending the fertility clinic (not including any treatment). Reflecting the management of household expenses, this letter also suggests that not only was cost a barrier, but it was not always a joint effort by husband and wife to resolve fertility issues. In marriages where women lacked financial power, accessing testing and treatment was even more unlikely.

While the FPA tried to be accessible to all, couples exploring artificial insemination through a specialist faced far more prohibitive fees. For example, in the case of Mr. H. who lived outside of Birmingham and explained, "I am only an ordinary working man", the likelihood of he and his wife making frequent trips to London for AI was slim. The FPA responded to say that the legal aspects of AI are "still rather tricky", and even if it was done it would take "a great many times before it is successful", therefore it "is apt to be far too expensive for the average person". Ultimately the clinic recommended adoption as "the simpler procedure".[301] In one series of correspondence, the FPA gave quite detailed information as to what Dr Mary Barton, based in London, would expect as an AI specialist:

> In the first place Dr Barton would want to have certificates that both of you have had the necessary fertility tests and her secretary hinted that she might even require further tests done at the Royal Free Hospital in London and they would probably not be able to see you there for about six months. However, supposing the certificates you have satisfied Dr Barton it would be necessary for [Mrs W.] to come to London for one week out of every month for anywhere from three months to two years, depending on how long it takes for conception to occur. The secretary also pointed

[300] Wellcome Library, London, SA FPA/ NK96, 1949.
[301] Wellcome Library, London, SA FPA/ NK96, 1949.

> out that Dr Barton is a specialist and the fees are accordingly high on top of which there will be the travelling and arranging for accommodation in London. In fact, unless you are in a position to set aside quite a large sum of money it would really not be worth while considering the idea.[302]

Mrs. W. replied that the information was very discouraging as there was no way, owing to domestic reasons, that she could spend a week every month in London. She asked the FPA if they might advise as to how to pursue adoption. The FPA responded with the names of two adoption societies and said:

> In the circumstances I am sure the decision you have made is very wise as couples who know that no children can come to them can generally achieve much happiness by the adoption of one or two babies.[303]

The FPA refrained from building false hope. In most cases, the Association discouraged anyone pursuing AID. An alternative, as the next section suggests, was adoption.

**Adoption as an alternative**

In the post-war period, discussions of childlessness were directly linked to both adoption and assisted conception. The legislative history of adoption reflects many of the issues around artificial insemination in this period. Both adoption and assisted reproduction called into question the definitions of 'legitimacy' and family – leading to calls for legislation on inheritance rights, child welfare, and parental rights. Legal adoption had been recognized in England and Wales from January 1927, and in Scotland from January 1931.[304] The number of adoption orders ballooned after the Second World War: in 1939, the court granted 7926 orders, and by 1946 this number had grown to 23,564.[305] Yet more than three quarters of these adoptions were arranged outside of any

[302] Wellcome Library, London, SA FPA/A3/2, 1947
[303] Wellcome Library, London, SA FPA/A3/2, 1947.
[304] O.M. Stone, 'The Adoption Act, 1958'. *The Modern Law Review*, 22(5) September 1959, (pp.500-510), 500.
[305] Gretchen Miller Wrobel and Elsbeth Neil (eds), *International Advances in Adoption Research for Practice*, (Oxford: John Wiley & Sons Ltd., 2009), 30.

state supervision or adoption organization, which the Adoption of the Children Act in 1949 sought to remedy. The 1949 Act promoted state regulation, by giving power to local authorities, and secrecy in adoptions, by coding the biological parents' identities to a serial number. Yet the Act also widened the legal rights of the adopted child, by extending inheritance and succession rights.[306] The Hurst Committee of 1954 stressed the importance of "the welfare of the child" and recommended that such secrecy be tempered by allowing adopted adults the right to access the identity of their birth parent(s).[307] The Adoption Act and the Children Act of 1958 consolidated previous statutes and implemented some of the recommendations from the Hurst Committee.[308]

Slowly, there was more information becoming available on the treatment of infertility and possibilities such as AID, which presented a 'cure' to a medical problem. This marked a shift in family aspirations where people no longer looked first to adoption when they were unable to conceive, but looked to the medical profession to see what could be done to assess and treat infertility. "Childlessness" became a condition seen as treatable, and in many cases, AID was preferred to adoption because of its 'eugenic potential'. Arguments both in favour and in opposition to adoption leveraged eugenic claims. On one hand, it was thought an advantage of adoption to know a child was healthy; on the other hand, arguments were made against it due to unknown parentage and genetic inheritance.[309] The reverse arguments were applied to AID: it offered the 'benefit' of known parentage, however the risks of this relatively unknown science generated both fear and disgust. Moreover, adoption and reproductive technologies

[306] Kerry O'Halloran, *The Politics of Adoption: International Perspectives on Law, Policy and Practice*, Ebook, (Dordrecht: Springer, 2006), 19.
[307] Janette Logan and Carole Smith, *After Adoption: Direct Contact and Relationships*, (London: Routledge, 2004), 36-37; O'Halloran, *The Politics of Adoption*, 19.
[308] Stone, 'The Adoption Act, 1958', 500.
[309] See Chapter 3 for details of debates, for instance in the *British Medical Journal* correspondence.

shared the social stigma of 'illegitimacy'. Jenny Keating, an historian of adoption in Britain during the twentieth century, points out that there are shared themes between adoption and AID – particularly the importance given to the secrecy of the act, but also the stigma associated with 'illegitimacy' if that secret was revealed. Before 1950, Keating points out, those people adopting experienced embarrassment as a result of their implied infertility.[310] Even by 1960, the medical profession preferred adoption as a solution in family creation when fertility problems were present, and many infertility specialists recommended adoption instead of AI.[311] The hope for a biological 'child of one's own', made possible by science, meant that adoption increasingly became a secondary consideration to infertility treatment when a couple could not conceive. Yet, while artificial insemination remained socially taboo, adoption was broadly accepted. AI carried with it not only the label of illegitimacy, but also moral condemnation from religious authorities, including the Anglican and Catholic Church.[312]

The letters to the FPA made clear that adoption was seen as the obvious alternative when a couple's infertility could not be treated. In some cases, the clinic even offered to help couples with the adoption process. In 1950, a London woman wrote to the North Kensington Clinic thanking them for all of their kindness and help – as both she and her husband had extensive testing done which revealed that they were both "practically sterile" with no hope of conception. In delivering the news of sterility, the clinic had offered the woman help with adoption and six weeks later she wrote to the North Kensington clinic:

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[310] Jenny Keating, *A Child for Keeps: The History of Adoption in England, 1918-45*, (Basingstoke: Palgrave MacMillan, 2009), 210.
[311] National Archives, London, HO 342/58, 'Departmental Committee on Human Artificial Insemination: Doctors who have practised AID', 1959.
[312] However, as Carolyn Herbst-Lewis has pointed out, adoption was often seen as a public announcement of infertility, while artificial insemination allowed a couple to keep the husband's infertility a secret.

> My husband and I have talked the matter over seriously, and there isn't a question of doubt in our minds about what we want to do. We both adore children very much, and we definiately[sic] want to adopt a child and bring it up as our very own, which I know beyond any doubt it will not be difficult for us. Therefore I will be greatly indebted for any further help or advice on your part.[313]

For many couples, contacting the FPA was a last attempt to have a biological child. A Sussex woman wrote in 1951 explaining that after 16 years of marriage she and her husband were enquiring into child adoption, but were advised (she does not say by whom) to contact the FPA to see if there was anything more that could be done for them to have a biological child.[314] Similarly, a London woman looked to the FPA for a second opinion:

> I don't mind what I have done to me just as long as I could have a child. If you told me it was hopeless then I would give up hope and adopt a baby, but until I know for sure I am still living in hope of having one of my own. Can you please tell me if it is possible to have a child by artificial insemination…[315]

When it was obvious from the content of the letters that medical options had been exhausted, the FPA most often recommended adoption. The Association was empathetic, but was also clear about options, responding to one prospective patient:

> It seems so very sad not to be able to have a baby when you want one, but our specialist, whom I consulted, thinks you would be very much wiser to consider adopting a baby before you get very much older…She suggests that you consult your own doctor about getting a certificate which is necessary before any of the reputable adoption societys [sic] will consider looking our for a suitable child for you.[316]

Many couples described their desire for AI as a biological imperative, and it is certainly possible that this position was influenced by eugenic thought. For instance, a husband who wrote in 1945 explained that after two years of marriage he and his wife were unable to conceive. Two different hospitals and two different doctors all came to the same conclusion: "namely that the trouble is with myself (the husband) and advise us to obtain

[313] Wellcome Library, London, SA FPA/NK96, 1950.
[314] Wellcome Library, London, SA FPA/NK96, 1951.
[315] Wellcome Library, London, SA FPA/NK96.
[316] Wellcome Library, London, SA FPA/NK96, 1951.

a family by other means".[317] He stressed that it was something they were not taking lightly: "We have given this matter very serious thought and although we are not against adoption we feel it would be much more satisfactory if the child could at least by my wifes [sic]".[318] The growing practice of artificial insemination and the advancements in sub-fertility services provided couples with medical avenues that expanded reproductive choice.

**The Gendered Dynamics of Marriage in the Experience of Infertility**

The letters also poignantly reveal the gendered dynamics of marriage and the emotional experience of infertility. Although most correspondents were women, men penned thirty-seven per cent of the letters, which is in line with Lesley Hall's study of men's letters to Marie Stopes. After the publication of *Married Love* in 1918, men comprised over forty per cent of Stopes' correspondents until her death in 1958.[319] These men wrote to Stopes for advice on sex and marriage, both for individual problems and issues in an existing relationship, with questions about fertility, birth control methods, abortion, and the 'logistics' required for conception.[320] Similarly, some male correspondents who wrote to the FPA took responsibility for the couples' inability to conceive, and demonstrated support for artificial insemination – as something that would benefit the overall happiness of the marriage. Some men certainly felt the responsibility to write to the FPA. There are many possibilities as to why: that the couple wanted to show that the husband was in full support of AI; that the husband himself felt at fault for being unable to conceive; that it was seen as the husband's role to address sexual and

[317] Wellcome Library, London, SA FPA/A3/2, 1945.
[318] Wellcome Library, London, SA FPA/A3/2, 1945.
[319] Lesley Hall, *Hidden Anxieties,* 10.
[320] See Lesley Hall, *Hidden Anxieties*, Ch.4.

reproductive issues; or that the request would be taken more seriously if written by the husband rather than the wife. In most cases, it appears that the husband was the partner diagnosed as infertile and felt a personal responsibility to find a solution. Kate Fisher, in her oral history of contraceptive practices within marriage from 1920 to 1960, has shown that men typically asserted greater control than women in matters of family planning.[321]

Pregnancy avoidance and pregnancy encouragement were two sides of the same 'family planning' coin. As with birth control, negotiation around infertility testing and treatment was subject to marital power dynamics. As Fisher has argued, husbands believed it was "part of their role as men to take responsibility for their wives' fertility and to show consideration for their sexual and reproductive needs. Moreover, such consideration was not confined to newly 'companionate' husbands."[322] 'Companionate' husbands might have seen their responsibility for contraception as "part of their generation's increased respect for a wife's needs", but similarly, more 'traditional' or 'authoritarian' men believed their management of family planning was "a proper expression of a husband's natural dominance over all spheres of marriage".[323] This role of managing family planning is apparent in many of the letters from men. (Notably, the majority of male correspondents – eighty per cent – asked explicitly for artificial insemination and indicated that it was their fertility that was in question.) In one letter, this power and control over family planning was suggested through the husband's detailed knowledge of his wife's menstrual cycles. In 1945, Mr. C. wrote that he and his wife had been married for nine years and had not been able to have children because he was "certified completely sterile". He wrote that his wife had previously seen a specialist

[321] See Kate Fisher, *Birth Control, Sex and Marriage in Britain*.
[322] Fisher, 236.
[323] Ibid, 237.

in Glasgow and had artificial insemination, but it was unsuccessful. He explained his attentiveness to his wife's reproductive health by charting her monthly cycles:

> I have gone into the subject closely and have kept a record of my wife's periods, for the last two and a half years. These have always been between twenty six and thirty days and so the time when it would be necessary to visit a specialist would be easy to ascertain.[324]

This level of detail could suggest a close marital relationship, but it could also signal control. As Kate Fisher has argued, when it came to sexual matters the husband was considered the responsible party – in this case acting as fertility statistician. Plotting menstrual cycles to determine the ideal time for conception may have been seen as part of an unspoken conjugal contract, though it may also suggest male control over female reproduction.

Infertility was often viewed as a result of 'neurosis' and, as Elaine Tyler May has argued, in the postwar period women were often blamed for their own infertility. This perception that infertility was a self-inflicted condition was thought to be the result of a "subconscious rejection of their maternal instinct" as well as the "pressures of modern living" and "strains" on women in the workforce.[325] Many of these letters were therefore written with a critical judge in mind (in the form of medical professionals); conjugal harmony, cooperation, and partnership had to be proven to a medical doctor, or at least suggested, if a request for artificial insemination was to be taken seriously.[326] Expressions of emotional distance from the desire to conceive and a willingness to cooperate with the doctor were demonstrated in many of the letters. For instance, in 1945, Mr. N. requested help to have a baby by AI. Both he and his wife had been given injections, and his wife

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[324] Wellcome Library, London, SA FPA/A3/2, 1945.
[325] Davis, 'Test Tubes and Turpitude', 122; Elaine Tyler May, 'Nonmothers as Bad Mothers: Infertility and the 'Maternal Instinct'' (pp.198-219), in *'Bad' Mothers*, edited by Molly Ladd-Taylor, 198-99.
[326] National Archives, London, HO 342/58.
In *Prescription for Heterosexuality*, Carolyn Herbst Lewis has made this point in the American context.

had taken pills but to no avail. He closed his letter: "I hope it is possible for you to grant both my Wife and I our greatest wish, we give our full cooperation".[327] Historian Gayle Davis has recently stressed the importance placed on patient 'cooperation', as characterized by the medical profession.[328] Equally important to perceived 'cooperation' was maintaining an objective, scientific, and unemotional perspective when it came to conception. The general medical perception was that too much emotion attached to the desire for a child made a couple unsuitable for artificial insemination. As such, emotional expression was interpreted as a possible indicator of mental instability or neuroticism, which was most frequently applied to women.[329] It is therefore not surprising that emotional distance was often exhibited in letters to the FPA, like one from Mrs. R., who was 29 years old. She explained that she was aware of the wartime debates in the House of Lords and made clear her position: "I firmly believe that A.I. will still go on for the benefit of those unfortunate as myself and for the future generation".[330] Mrs R. made a point in her letter to appear informed and objective without raising medical concern over the expression of emotion. As Emma Jones has shown with the ALRA correspondence, letters were often written in a prescribed way, with the writer anticipating the expectations of the reader.[331] While in the ALRA letters Jones found that the majority of correspondents expressed desperation, in the FPA letters the general tone was more measured and restrained, without such inherent urgency.[332] But there were exceptions.

Many letters were overtly emotional in the expression of desire for a child, and

[327] Wellcome Library, London, SA FPA/A3/2, 1945.
[328] Davis, 'Test Tubes and Turpitude: Medical Responses to the Infertile Patient in Mid-Twentieth-Century Scotland', 124.
[329] See Davis, 'Test Tubes and Turpitude'.
[330] Wellcome Library, London, SA FPA/A3/2, 1945
[331] See Emma Jones, 'Attitudes to Abortion', *Women's History Review*, 2011.
[332] These two collections of letters cannot be closely compared as the former dealt with abortion in the 1960s and the latter dealt with infertility in the late 1940s.

some were also revealing of marital tensions. Cooperation between husbands and wives in family planning matters was not always apparent. The postwar period was one of instability in which "new models of marital intimacy and sexuality, within a shifting marital context, bred higher expectations but also great potential disappointments".[333] This expectation and resulting disappointment was sometimes communicated through these letters – reading as a type of confessional and revealing marital tensions and social pressures. For instance, in 1949 Mrs. K. wrote the following:

> I'm writing for an appointment as my Husband wishes for a daughter badly and I too want a son also I'm getting pretty desperate as I'm tired of other people keeping on about me and I want [my husband] to look at me with that look which is mine and not for the other women in this place so please do help me as I am very much in Love with my husband. I'll do anything you tell me to do…P.S. I'll never be able to thank you enough or stop thanking God for I keep praying for a miracle to happen and bring back my husband's Love.[334]

The FPA responded to Mrs. K.: "[we were] very touched to receive your letter and shall be glad to help you to the best of my ability". Mrs. K.'s response was as spontaneous and emotive as her original letter:

> I will pay the fee somehow and will do anything you say to get a daughter or son…I know my husband will fall in love with me again, he told my friend he likes things that are hard to get. Hoping that you do not mind me unburdening myself to you as it helps a great deal.[335]

It is clear from this letter that the inability to conceive was causing marital tension and perhaps an extra-marital affair. If there were any suggestions of instability in the relationship, doctors would refuse to perform AI.[336] This certainly gives the sense that beyond financial and geographical limitations, specialists acted as gatekeepers by assessing the marriage and, ultimately, deciding how a couple was to build their

[333] Langhamer, 'Adultery', 88.
[334] Wellcome Library, London, SA FPA/ NK96, 1949.
[335] Wellcome Library, London, SA FPA/NK96, 1949
[336] National Archives, London, HO 342/58 (see Chapter 5).

family.[337]

The psychological state of patients – primarily women – was also used as a medical indicator of parental suitability. There was a negative association with women who were perceived as too eager for artificial insemination or sub-fertility treatment. Some doctors explained that the ones who were 'obsessional' about having a child would not make good parents.[338] Concern with appearing overly anxious was expressed in at least one letter by a woman in Middlesex who had very irregular periods and had not been able to conceive. Writing to the North Kensington Clinic, Mrs. C. said: "I hope that you will not think I am worrying unnecessarily and will grant me an appointment … I do not mean to be any trouble but I am not sure of my way".[339] She was careful to not appear too demanding or desperate, perhaps out of fear that she would be perceived as 'neurotic' or 'obsessional'.[340] Such characterizations were applied to women, but not to men.

The epistolary approach by correspondents was gendered in several ways. Whether the letter was written as a joint or individual statement varied by gender, as did the language of the letter which was often characterized by either technical or colloquial terminology. The joint approach was characteristic of the married men who wrote to the FPA. Male correspondents almost always stressed the shared desire for children and wrote the letter as a joint statement. As mentioned, men only wrote to the FPA when they were believed to be infertile. One letter, from Mr. H. in 1949, explained that he and his wife had been happily married for 8 years – "happy that is in every respect apart from the

[337] For the role of the medical profession as gatekeepers, see Carolyn Herbst Lewis, *Prescription for Heterosexuality*.
[338] Davis, 'Test Tubes', 10, 14; National Archives HO/342/58.
[339] Wellcome Library, London, SA FPA/NK96, 1950.
[340] National Archives, London, HO 342/58.

fact that we have no children which is our hearts [sic] desire".[341] Both he and his wife had been examined:

> …with the result that I – the husband – being perfect in all other respects am proved to be not fertile. After very much consideration we have agreed that we would prefer Artificial Insemination rather than adoption and have discussed the matter with our own doctor but he does not seem very helpful.[342]

Doctors responded favourably to letters like this that demonstrated restraint, objectiveness, and measured emotions. Another correspondent, Mr N., explained that both he and his wife had been "passed as O.K."; he had 'injections' and his wife had both 'injections' and taken 'pills', but after eight years they still had not conceived.[343] The joint approach documented in the letters from married men was not always apparent in letters from married women, some of whom were pursuing fertility treatment without the support of their husbands.

Clear expressions of marital tension over infertility were only apparent in letters from female correspondents. For example, Mrs. N. (41 yrs old) wrote in 1949 that after eleven years of marriage, and three hospital visits "to have tubes blown out" which showed that everything was okay, she was still unable to conceive. It had been suggested to her that it could be "done with my Husband (artificially)". She said that her husband refused to adopt a child, but she was "getting desperate over one before my Period stops". Sometimes these letters hinted at other marital issues:

> I have tried to get my Husband to go to a London doctor. But you know what some men are, and he is very shy and does not like that sort of thing. He never seems to get real satisfaction with going with me. Said it is because I am too fat. I think it is because I have a high womb.[344]

This letter stressed the husband's reluctance to be tested, which was a common issue in

[341] Wellcome Library, London, SA FPA/NK96, 1949.
[342] Wellcome Library, London, SA FPA/ NK96, 1949.
[343] Wellcome Library, London, SA FPA/NK96, 1945.
[344] Wellcome Library, London, SA FPA/ NK/96, 1949.

fertility investigations at this time, but also emphasized the importance of 'privacy', which was an important feature of intimacy in marriage during this period.[345] The letters suggest that difficulty achieving pregnancy and/or a diagnosis of infertility affected marriages in different ways: it could bring couples closer together in their search for a solution, or push them apart in frustration. Case notes from the North Kensington Clinic revealed such marital tension and frustration. A sample of notes from these files commenting on why treatment was not being continued offers a range of conclusions, however vague:

> "Husband left her"
> "Husband won't have semen tested. Try and persuade to have further treatment"
> "Husband not yet tested – wants private appointment with Dr. D[avidson] to investigate him"
> "Illness"
> "Adopted"
> "2 dogs, 1 cat, has enough without baby!"
> "?why barren"
> "Thanks, too old for more treatment"
> "Treatment again later"
> "Husband having treatment"
> "Adopted sister's 2 children but wants own children, return for treatment later"
> "Husband, complete azospermia"[346]

The letters and case notes indicate that infertility was not only a women's or men's issue, but was a marital issue that required negotiation and agreement, between spouses as well as between doctor and patient.

The Second World War also undoubtedly affected the family planning and sexual intimacy of couples. In cases where fertility issues were present, this meant an even greater delay in starting a family. The war postponed attempts to conceive for many people, but other factors such as physical trauma, a venereal infection, or the death of a spouse also affected fertility and family planning. In some letters, the men writing were

[345] See Szreter and Fisher, *Sex Before the Sexual Revolution* (2010).
[346] Wellcome Library, London, SA FPA NK/95.

not yet demobilized, but were planning in advance to expedite the process when they returned – anticipating their long-awaited homecoming. For example, Mr. C. wrote in July 1945 enquiring about artificial insemination after receiving a diagnosis of sterility, explaining his current situation: "At present I am serving on the Continent but am expecting to be de-mobilised in early September, and we should like, if at all possible to have this matter satisfactorily dealt with as soon as possible".[347]

The timing of these letters was also reflective of wartime delays in having a family. For instance, Mr. L. wrote in 1946 inquiring about artificial insemination and wanted to know "how one would go about it and the probable cost".[348] He and his wife already had a nine year-old daughter – born before the war in 1937 – but wanted another for her company. Mr. L. explained that a recent operation had prevented him from having any more children. It was not until after the war that they tried to have another child, by which time medical complications made it impossible (no details were given on the operation). A similar case involved a Wandsworth man – Mr. B. – who contacted the clinic in early 1950. His wife of nine years had been tested and should have been able to conceive but, concerned that he was the cause, he wanted to know where he could be tested.[349] Mr. B. and his wife were married in 1941. Although the letter does not say anything to this effect, this delay in seeking help was not uncommon among war marriages – where attempts to conceive were intermittent. It was often several years after the war before a couple sought help, often spurred on by something read in the press. This delay was typical, as one interviewee told Young and Willmott of his family

[347] Wellcome Library, London, SA FPA/A3/2, 1945
[348] Wellcome Library, London, SA FPA/A3/2, 1946.
[349] The FPA advised 'Mr B.' to go to the Philip Hill Parenthood Clinic at the Royal Northern Hospital, or (if he could afford it) to go to Dr Davidson of the FPA on Sloane Street.

planning strategy: "We decided we wanted two and that's what we've got. We even planned their names, Kevin and Janice. We didn't start until after the war. Kevin (aged nine) would have been fourteen by now if it hadn't been for the war."[350] Although the war posed a delay for many people, fertility problems exacerbated the challenge of 'family planning'.

The end of the war in Europe certainly created impetus for correspondents to reach out for assistance in conceiving. In June 1945, Mr. N. wrote to the FPA requesting help for he and his wife to have a baby by artificial insemination. He was thirty-two years old and his wife was thirty-one years old. Both had been examined by doctors in London and "passed as O.K." yet they were still unable to conceive after eight years of marriage. They had been married in 1937, but it was only at the end of the war that they contacted the FPA. The letter does not tell the story of what happened during the war, how frequently they saw each other, or how long they had been actively trying to conceive. But like other letters, it suggests that the war forced the postponement of starting a family. One woman (Mrs. Q.) from Middlesex explained that she had a six year old daughter whose father was killed during the war. She remarried in 1948, but in three years had been unable to conceive and her husband's semen test was normal. She was writing to the North Kensington Clinic fearing the fault lied with her.[351] Another female correspondent (Mrs. Z.) wrote in 1946 asking about artificial insemination. She and her husband had also married during the war in 1941. They had both been examined, with the wife requiring a "slight operation", but it was her husband who was told by two hospitals

[350] Young and Willmott, 21.
[351] Wellcome Library, London, SA FPA/NK96, 1951.

that he was sterile.[352] A Sussex woman, writing in 1951, had been married for sixteen years (since 1935) and her husband was away during the war. After going for testing in 1942, she had been told that "there was nothing organically wrong" with her but was nevertheless "advised a curetting, stretching – blowing of tubes through operation".[353] But only testing and treating one half of the couple would not necessarily achieve the goal of pregnancy, as this woman explained: "My Husband was away in the Army during most of the War so possibly that was a wasted effort".[354]

These letters only scratch the surface of family planning and marriage during wartime, but it is an important reminder of postwar hope for the future – central to which was building a family. These hopes became enshrined in the pronatalist discourse and welfare reforms of the postwar years. The war created a delay for many couples in starting their family and potential fertility problems were exacerbated by war-related injuries, disease, and conceiving later in life, when infertility was more likely. The letters from married women and men only address half of the equation. Though the FPA responses were standardized in their content, it is nevertheless essential to examine the medical response to such letters.

**The response of the FPA and the medical profession**

The FPA correspondence represents the protracted path to knowledge about infertility services, which was compounded by a general lack of awareness among medical professionals. Even by the 1950s, most medical schools did not address family planning, contraception, infertility, or artificial insemination in their curricula.[355]

[352] Wellcome Library, London, SA FPA/A3/2, 1945
[353] Wellcome Library, London, SA FPA/NK96, 1951.
[354] Wellcome Library, London, SA FPA/NK96, 1951.
[355] See Chapter 1 for further details.

Therefore, there were many accounts of doctors not being able to provide patients with information as to where fertility treatment or AID was available. Thus, practitioners often knew as much about artificial insemination as their patients – which was what they read in the press or heard by word of mouth – and much of the profession believed that the practice was immoral and unethical.[356] Therefore, it was not always clear whether doctors were unwilling or unable to provide patients with a referral.

A number of doctors wrote to the FPA for information regarding artificial insemination, most often at the request of their patient. For example, after a television programme on AI in November 1957, a general practitioner explained that he had several enquiries from patients interested in the practice and wanted to have the names of doctors to whom he could refer patients. The FPA suggested Reynold Boyd, Edward Griffith and Mary Barton – all private specialists located in London.[357] Similarly, in 1948, the gynaecologist Linton Snaith wrote to the FPA inquiring about AIH on behalf of one of his patients. He said that they could not afford heavy fees, but were prepared to pay a moderate amount (though no specifics were mentioned). He described them as a most *"deserving"* couple [original emphasis]. The intention here was not exactly clear, but it was implied to mean that they were working class. The FPA wrote back to say that Dr. Joan Malleson – the abortion advocate – who they used as "a general 'sorting house'" in such cases, was willing to help the couple herself and treat them as economically as possible.[358] Class and eugenic undertones were sometimes, though not always, present in these discussions.

The motives of medical practitioners were not always obvious, and some letters

[356] See Letters to the Editor of the *British Medical Journal* from 1943 to 1945, as referenced in Chapter 3.
[357] Wellcome Library, London, SA FPA/A3/2
[358] Wellcome Library, London, SA FPA/A3/2, Linton Snaith, 1948.

suggest that practitioners could act as obstacles to reproductive health information and 'gatekeepers' to infertility treatment.[359] For example, Mrs. R. (age twenty-nine) wrote to the FPA in May 1945 asking for artificial insemination, explaining that although she was quite healthy, her husband was sterile. Her doctor had apparently attempted for nine months to find where AI was performed but had been unable to supply any information. That her doctor was unable to direct the request seems suspect, particularly since the FPA supplied Mrs. R. directly with the name of Dr. Margaret Jackson in Exeter. Perhaps Mrs. R.'s doctor was embarrassed to make requests on a controversial subject, or perhaps did not consider them a 'suitable' couple. Couples' suitability as parents – the deciding factor in whether they should be given access to AI – was based on a combination of factors tied to financial, psychological, and marital health. The criteria for selection often aligned with the aims of 'positive' eugenics – and later 'crypto-eugenics'. Therefore, restricting access to fertility treatment for some, and opening it to others, can be viewed as 'positive' eugenics in practice.

Clarifying the distinction between sub-fertility services and artificial insemination remained a battle for the FPA, particularly as several doctors were holding private clinics for AI at FPA facilities. With 61 per cent of correspondents requesting artificial insemination, the FPA received much unwanted attention after the Press had conflated 'sub-fertility' with AID. It became a standard response from the FPA that the Association did not undertake AI: "articles in the Press were rather misleading for this Association does not itself undertake cases for Artificial Insemination".[360] But (early on) they did go

[359] On physicians as 'gatekeepers', see Carolyn Herbst Lewis, *Prescription for Heterosexuality*.
[360] Wellcome Library, London, SA FPA/A3/2, 1945

on to offer the names of doctors who could be contacted to perform AI.[361] The FPA warned of "special fees" for consultation and that the actual process of insemination "would probably run into some guineas".[362] The FPA also stressed that it was not a procedure that would be rushed into: the "doctor would have to be completely convinced that there was no chance of a naturally conceived baby".[363] From 1945, the FPA began to formally distance itself from AID by, for instance, writing corrective letters to the press. In April 1945, an FPA spokesperson told readers of the *Daily Mail* that "it is unfortunate that the Association should have become linked with such a controversial subject, simply bristling with legal and psychological difficulties".[364] This continued through the next decade. When, in November 1957, the *Sunday Pictorial* published an article suggesting that FPA clinics performed AI, the Association responded with a clarification of the practice and their role in it. By the late 1950s, the FPA undertook AIH (by husband) at their sub-fertility clinic on Sloane Street, London but AID (by donor) was outside of their scope.[365] Furthermore, to correct the frequent implication in the press that a so-called 'test tube baby' was easily achieved by artificial insemination, the FPA explained in their statement to the *Sunday Pictorial*:

> The process is expensive and patients may need to attend twice a month for insemination. It often takes several months before conception is achieved. It is not available under the National Health Service. Recognising these difficulties, we, as an Association, regard the couples' intense desire to have a child as the important factor, and when it has been proved that pregnancy by normal means, or by A.I.H. is unattainable, we suggest that the couple should consider Adoption or A.I.D. and refer them either to the appropriate society or specialist[366]

But more often than not, the FPA would discourage couples from pursuing AID. Despite

[361] This practice changed as the referral process became more common place in the 1950s.
[362] Wellcome Library, London SA FPA/A3/2, 1945
[363] Wellcome Library, London, SA FPA/A3/2, 1945.
[364] Naomi Pfeffer, *The Stork and the Syringe*, 118.
[365] Wellcome Library, London, SA FPA/A3/2.
[366] Wellcome Library, London, SA FPA/A3/2.

the medical possibility for assisted reproduction, most doctors and FPA clinics continued recommending adoption to couples, rather than encouraging fertility treatment. Success rates for artificial insemination in the immediate post-war years remained relatively low, with frequent instances of miscarriage and stillbirth.[367] But press coverage dealing with infertility and artificial insemination did not address any of the associated difficulties, and recommended prospective patients contact the FPA.

**Conclusion**

Although these letters are not a comprehensive account of the experience of infertility, they offer a context for discussion – and they ground the issue in the experiential and emotional. They demonstrate that despite much public criticism of 'new' reproductive technologies in the postwar years, many couples were open and willing to try artificial insemination – and any number of other treatments.

The discrete time frame represented in this collection of correspondence is not explained in the archival material. After 1951, patient letters were no longer included in the files, which perhaps suggests that as media attention grew through the 1950s there were too many requests with which to keep up. From 1945 through to the early 1950s, the FPA was in the practice of giving out the names of AID practitioners when requested by ordinary people. By 1957, and likely earlier, this had ended. From this point, the names of such doctors were treated as privileged information and were only discussed between medical doctors and FPA clinics. This shift happened in tandem with the standardization of the referrals process. As press coverage of AID increased, the FPA found itself the

[367] See, for example, Wellcome Library, London SA FPA NK/95

subject of such articles, and specialists in particular were receiving unwanted attention.[368] This shift from patient request to medical referral changed the route to infertility treatment. Although it should have improved the efficiency in directing patients, it also reduced the power and agency of prospective patients – particularly if they came up against an NHS doctor who was morally opposed to the requested procedure.

There are many silences in these letters, particularly in offering a clear picture of marital relationships. An important absence in these letters is the cause of the fertility problems, primarily in relation to the husbands, which is never defined. For example, while some female correspondents explain the blockage of fallopian tubes as a causal factor, and detail treatments received, male correspondents (and wives writing on their behalf) only allude to 'tests', 'treatments' and 'operations' without defining them, and concentrate exclusively on the diagnosis. For instance, one man who was writing from Northern Ireland married his wife in China in early 1940 and had subsequently lived in Japanese internment for three years. He explained his diagnosis in 1946:

> [the doctor] examined both my wife and myself and attributes the trouble to me. He assures me it will always be impossible for me to produce children, and has recommended that I get in touch with some London (or first class doctor) who might be able to advise us on the possibility of artificial insemination.[369]

Again, it is unclear whether his infertility was a result of internment, or was related to something else entirely. This is perhaps a result of the diagnostic practice in this period – where men were often diagnosed as 'sterile' even if in reality the results were more nuanced; whereas with women, there were a number of possible treatments. When the issue of infertility was seen as related to the woman, more invasive procedures were standard.

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[368] For example, Greta Graff requested that her name no longer be given out to the public.
[369] Wellcome Library, London, SA FPA/A3/2, 1946.

Although artificial insemination offered a solution to a sub-fertile husband and his wife, the medical standards for assessing seminal quality were inconsistent, at best, and inaccurate, at worst. When approached for AI, most specialists would not accept the semen test results of hospitals – unless recognized as reputable or 'first class' – as they were apt to be inaccurate and less thorough in their testing. During the interwar period, the "four parameters of seminal quality – volume of semen, sperm numbers, morphology and motility – had been delineated" but doctors largely still relied on whether sperm *appeared* 'manly'.[370] If sperm were deemed to *look* healthy, they would report test results as 'satisfactory' or 'within normal limits'.[371] There was also a belief that morphology was crucial to have a 'normal' baby:

> Until the 1950s, men with large numbers of irregularly shaped sperm were discouraged from having children on the grounds that they might produce a malformed child or one deficient in some way which would put their wife at risk of miscarriage.[372]

Even by the mid-1950s, there was no standardization for the minimum number of sperm considered necessary for fertility: "some doctors maintained it was 60 million per ml, others 20 million per ml."[373] Therefore, depending on the definition used, some men faced a diagnosis of sterility by one doctor, while another would diagnosis sub-fertility. Although the practice of AIHD remained controversial among practitioners, it did serve to provide cover for a possible misdiagnosis of sterility.

With the host of difficulties in attaining not only information on, but also treatment for infertility, press coverage empowered prospective patients with knowledge that was not available from any other source. Media coverage characterized the FPA as

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[370] Pfeffer, 124.
[371] Ibid, 124.
[372] Ibid, 125.
[373] Today, a low sperm count is considered fewer than 15 million per millimeter.
Pfeffer, 124; 'Low Sperm Count', Mayo Clinic, http://www.mayoclinic.org/diseases-conditions/low-sperm-count/basics/definition/con-20033441

the authority on this issue, which proved to be both a blessing and a nuisance for the organization. The press was incredibly influential on this matter, and it is reflected in a learning curve on the subject of infertility that is shown in the way people wrote about their medical history. Those who asked about artificial insemination after September 1949 appear to be more informed on the issue. For example, several women prefaced their request for AI with the explanation that they had previous testing or operations and that all other options had been exhausted. These types of letters were concentrated after 1949, perhaps indicating a growing understanding of infertility from that period; a knowledge that AI was not the only option, but was a 'last resort' or one method of treatment. These later letters suggest that by 1950 there was relatively more information available as a result of press coverage – particularly the Archbishop of Canterbury's 1948 investigation, a House of Lords debate, the Royal Commission on Population, and references in popular culture – which will be explored in the next section.

## *Chapter 3*

### *Medicine, Morality and Politics: Debating Artificial Insemination, 1943–48*

As the FPA established sub-fertility services and ordinary people sought out fertility treatments, official opinion debated the practice of artificial insemination. This chapter analyzes three discursive sites in which artificial insemination, and its possible social consequences, were discussed: the House of Lords, the *British Medical Journal*, and the Archbishop of Canterbury's Commission. Between 1943 and 1948, the controversy over AI established a narrative that guided discussion of the issue until the publication of the Feversham Report in 1960. The Archbishop of Canterbury's Commission Report stated in 1948 that artificial insemination was a 'breach of marriage', that should be made a criminal offense, and it was this emotive image that was carried forward through the 1950s. The chapter will explore why the debate over AI emerged during the Second World War and what aspects of this clinical procedure provoked such controversy. This five year period frames an early debate among official bodies over the practice of AI, and demonstrates how this became a hot-button issue for its implications for family life, social structure, and medical practice.

The central issues in this debate were the social value of biological kinship, the fear of scientific intervention, and the ambiguous legal boundaries of donor insemination. The strongest point of contention was centred on the biological bond of the family, and how paternity, child legitimacy, marital integrity, and population concerns were implicated when assisted conception was practiced. This debate challenged the way that family roles were defined, both socially and legally. The increasing fragmentation of the

family unit – evidenced by the rising divorce rate, declining birth rate, and growing numbers of women in the workforce – focused commentators in on the last fixture holding it together: biological kinship. Without that, they thought, the grounds on which the whole of society was based would fall away.

This chapter begins by examining a discussion in the House of Lords, which came on the heels of the passing of the Agriculture Bill of 1943 that made provision for the artificial insemination of livestock to increase wartime food production. As such, the chapter will also consider the broader context of AI in its application to animal husbandry and the role of both the veterinary and medical professions in developing the field of reproductive medicine. Debate in the *BMJ* that followed from the House of Lords discussion was directed at both the insemination technique itself and the animal association, but most of the letters published in the *Journal* were concerned with how the practice of AI implicated the hetero-normative family, particularly the institution of marriage, and the legal definition of the parent and child. Finally, the chapter will close with an analysis of the Archbishop of Canterbury's Commission on Artificial Insemination, which reported in 1948.

These debates highlight a moment during the war when concerns over food production and animal husbandry became linked to anxieties about Britain's population, fertility, and family life. The catalyst for this debate over AI was the Agriculture Act of 1943, which included policy for the artificial insemination of livestock in order to increase meat and dairy production during wartime. The discussion of this Bill in Parliament, perhaps unsurprisingly, shifted from livestock insemination to the potential applications for humans. This parliamentary discussion precipitated the lively debate in

the correspondence pages of the *BMJ* – drawing in sixty-five doctors – and the Archbishop of Canterbury's Commission, which recommended that AID be made a criminal offense. This discourse raised foundational questions: who bears the social and legal responsibility for assisted conception? How is 'the family' defined? And what are the legal rights of both parent and child?

This chapter offers a new view on this period of debate, which has received limited historical attention. In *Reproduction by Design* (2012), Angus McLaren has examined this debate in the *BMJ* from 1943 to 1945, from which he observed:

> …the conversation about artificial insemination was not so much about the concerns for a basic medical procedure but for the ways in which it might have an impact on the medical profession, morality, marriage, paternity, and population.[1]

This chapter is aligned with McLaren and suggests that artificial insemination was a symbolic threat, rather than a real threat, to the idealized post-war family. Although the present chapter addresses some of the same themes of McLaren's work, it takes the *BMJ* correspondence as the beginning of a longer debate, rather than a conclusion. Outside of McLaren's work, this debate in the *BMJ* has not been closely examined elsewhere, and neither the House of Lords discussion nor the Archbishop of Canterbury's Report have been analyzed, save for passing mention.[2] The Archbishop of Canterbury's Report marked the first official publication to guide public opinion on the subject in Britain, and is therefore worth a comprehensive exploration. It influenced both official and public sentiment and remained a key reference point in future discussions. This chapter suggests

[1] Angus McLaren, *Reproduction by Design*, 124.
[2] For a work that addresses the issue but does not analyze the debate see, for example, Norman St John-Stevas, *Life, Death and the Law: Law and Christian Morals in the English and American legal systems*, (Bloomington: Indiana University Press, 1961).

that the debates over artificial insemination in the 1940s laid the framework for discussions in the following decades.

**Debating AI in the House of Lords**

The impetus for the debate over artificial insemination that sprawled in the years following the war began with a discussion in the House of Lords on 28 July 1943. In the aftermath of the passing of the Agriculture (Miscellaneous Provisions) Act in April 1943, Lord Brabazon of Tara initiated a discussion on "Insemination" in its broadest sense – considering both animals and humans – and in so doing he sparked an ongoing debate beyond the political realm. Lord Brabazon stressed the importance of a cautious approach to the issue, since in his life he had "seen science run ahead of human wisdom", and this was of particular concern when scientific advancements were to affect human life.[3] The concern was less over the application of AI in the animal world, but rather was focused on the impact of the human application. The fear of scientific intervention – particularly in reproduction – was a prominent theme throughout this period. He pointed to the "danger of very grave abuses arising" with "very great care and surveillance" needed for "this particular development". He explained that "[t]here are women who would like to have children without marrying and without sinning", and that the Church would (in the future) need to determine whether or not this was a sin.[4] This prospect of 'unmarried' motherhood was perceived as a threat to family stability, and this concern was echoed in both the *BMJ* correspondence and the Archbishop of Canterbury's Report. Brabazon also pointed to the ethics of the practice of AI, in particular the potential for insemination after

[3] 'Insemination', House of Lords Debate, 28 July 1943, Vol 129, cc.818-36. Accessed online through Hansard.
[4] 'Insemination', House of Lords Debate, 28 July 1943.

a man had died.[5] Brabazon concluded in saying: "I do not think we should live in a fool's paradise and ignore this subject on the ground that it is, as it is, unpleasant".[6] Lord Glentanar also advised caution in moving forward with this practice:

> It is very easy to follow along a path which may eventually bring us to committing ourselves in a manner in which it will be very difficult for the human race to retrace its steps. Little is known about the ultimate results of these unnatural practices which are now being experimented with.[7]

Conceptualizing the practice of AI as 'unnatural' and as a form of human experimentation persisted throughout the 1950s. This discussion in the House of Lords also anticipated future concerns, as Glentanar raised the issues of sex determination and surrogacy. He mentioned that other "experiments" were being made in this area with the ovum of one female being transplanted into the uterus of another, and studies being made in the process of sex determination. He cautioned against the practice of sex determination which, if it was to come into practice, could have "profound sociological and political results".[8] In 1943, such concern for surrogacy capabilities and prenatal screening to determine the sex of a fetus were decades away from their practical application, however it is notable and fascinating that these practices were anticipated and feared during the war.

Several peers expressed fears that AI would disrupt family life. Viscount Bledisloe opposed the practice of AI for humans: "I most earnestly hope that at any rate we in this country will do everything in our power to discourage a process which can only, in the long run, tend most seriously to break up family life".[9] The Bishop of

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[5] 'Medical Notes in Parliament: Artificial Insemination', *British Medical Journal*, 14 August 1943, 219; 'Insemination', House of Lords Debate, 28 July 1943, Vol 128, cc.818-36. Accessed online through Hansard.
[6] 'Insemination', Lords Debate.
[7] Lords Debate, 28 July 1943.
[8] Lords Debate, 28 July 1943.
[9] Ibid.

Chichester's concern focused on the marital relationship, and how 'disastrous' the practice would be to family life. The Bishop closed his speech by referencing Aldous Huxley's *Brave New World*, "where he sets before us the fearful calamity of a purely mechanical world".[10] The Duke of Norfolk reassured the House of Lords that the Ministry of Health would monitor the human aspect of AI. At the close of the discussion, Lord Brabazon's Motion for Papers was withdrawn. Despite these fears of reproductive science breaking up family life, for the next fifteen years the government continued to put the issue on the back burner.

**The role of agriculture, farming and animal husbandry**

Discussions of human reproduction had long been connected to animal husbandry. The Agriculture Bill, which provoked the discussion of AI in the House of Lords, demonstrated that wartime concern over the birth rate and pronatalist thought applied not only to humans, but also to livestock. During the war, farming became critical to maintaining "the health, strength and fighting capacity of the nation", and reproduction of livestock was central to this aim.[11] This resulted in a shift to 'farming from Whitehall' as the County War Agricultural Executive Committees (CWAECs) became surveyor, buyer and distributor of goods. For farmers, this ensured fixed prices and stable markets, but meant they in return had to "plough up permanent pasture, plant arable crops, mechanise, and adopt new methods of livestock husbandry".[12] These changes led to gross agricultural output increasing by two-thirds from 1939 to 1942 alone. Milk production was central to this as developments in nutritional health during the interwar years had

[10] Ibid.
[11] Abigail Woods, 'The farm as clinic: veterinary expertise and the transformation of dairy farming, 1930 – 1950', *Studies in History and Philosophy of Biological and Biomedical Sciences*, 38 (2007), (pp. 462 – 487), 463.
[12] Woods, 'The farm as clinic', 463.

"designated milk a 'protective food' essential for health", and the Milk Marketing Board, established in 1933, had fixed its price.[13] AI became essential to maintaining milk output, ensuring "the regular birth of live calves, since yields peak soon after calving and then gradually decline".[14]

The wartime agricultural developments relied largely on the veterinary profession, which was catapulted into an important position that included not only disease control but also reproductive medicine. As Sarah Wilmot has argued, "historians have hardly begun to explore reproductive research in agriculture and its relations to medicine".[15] Artificial insemination completely changed agricultural breeding in the first half of the twentieth century, moving from 100% of cows mating naturally at the beginning of the century to 60% being conceived by artificial insemination by the end of the 1950s.[16] Wilmot has also stressed the institutional connection between reproductive research on animals and humans. Edinburgh's Institute of Animal Genetics developed links with medical research institutions and, with aid from the Medical Research Council, "produced products for the clinics, including standardised hormone preparations for clinical trials and a lucrative pregnancy diagnosis service".[17] In addition to the work done in Edinburgh, breeding centres in Cambridge and Reading were set up early in the war to expedite the reproduction of cattle through artificial insemination. What ultimately developed was a collaborative professional relationship between practitioners of animal reproductive

[13] Ibid.
[14] Ibid, 465.
[15] Sarah Wilmot, 'Between the farm and the clinic: agriculture and reproductive technology in the twentieth century', *Studies in History and Philosophy of Biological and Biomedical Sciences*, 38 (2007), (pp. 303 – 315), 304.
[16] Sarah Wilmot, 'From 'public service' to artificial insemination: animal breeding science and reproductive research in early twentieth-century Britain', *Studies in History and Philosophy of Biological and Biomedical Sciences*, 38 (2007), (pp. 411 – 441), 411.
[17] Wilmot, 'From 'public service' to artificial insemination', 433.

sciences, and specialists in human infertility. For example, in both 1947 and 1948 conferences on infertility were held in Oxford and Exeter, respectively, which brought together "eminent gynaecologists and Veterinary surgeons".[18] These conferences tied together interests in "zoology, physiology, histology, human clinical medicine, agricultural science, veterinary practice and sociology" with the common goal of improving "the diagnosis, prevention and cure of impaired infertility".[19] However, this collaborative intellectual ground involved a small section of the medical profession, and when the practice of AI was brought to the attention of the wider profession, controversy erupted.

**Debating AI in the *British Medical Journal*, 1943 – 1945**

Between September 1943 and March 1945, sixty-nine letters concerning artificial insemination (AI) written by sixty-five different doctors were published in the *British Medical Journal* (*BMJ*).[20] This correspondence produced a heated debate within the medical profession, which only drew to a close when the *Journal* insisted that it would stop publishing letters on the subject "before the antagonists have torn each other to pieces and all the quieter people are bored to death".[21] However, the response to AI was not at all commensurate with the practice. In the *BMJ* correspondence, there is a distinct separation between clinical observation and moral outrage. [Figure 3.1]

Artificial insemination divided the correspondents to the *BMJ*, with some seeing the procedure as a means to bring happiness to a childless marriage and support population growth, while others saw it as a destructive force that would hasten the

[18] Wellcome Library, London, FPA/A6/4, 'Conference on Infertility, Exeter', 1948; See also SA FPA/A6/3 on the Conference on Infertility in Oxford, 1947 and FPA/A6/2 on the 1944-46 conferences on infertility.
[19] Wellcome Library, London, FPA/A6/3, 'Foreward to conference proceedings, written by Arthur Walton', 1947.
[20] Unless otherwise stated, all correspondents to the *BMJ* were medical doctors.
[21] 'Doctors in Hot Print', *British Medical Journal*, 10 March 1945, 339.

breakdown of marriage as an institution, psychologically damage both children and parents, and lead society even further into a mechanized and commodified world. Central to this debate are questions over reproductive rights and the freedom to choose assisted conception to build a family. There was a tension between the desire for an authoritative pronouncement on the ethics of the practice, and a laissez-faire approach that would leave the decision in the hands of doctors and patients. On 14 August 1943, the *BMJ* reported on the House of Lords discussion (July 28), which had raised the question of human insemination. It was a straightforward report of the issues including legitimacy, unmarried motherhood, post-humous conception, transplanting of an ovum, and sex determination; while it also stressed the agricultural side of the debate.[22] Three weeks later, the *Journal* published a letter in its correspondence pages from Dr. Mary Barton, who introduced herself as "a worker in this specific branch of sterility and infertility".[23] Barton argued that the House of Lords discussion had been "one-sided" as there was no suggestion that there were any favourable aspects to AI. She called for the medical profession to protect the practice from interference from the lay public in "methods of treatment which are in their infancy and might if reasonably suppressed postpone the alleviation and happiness of many thousands of individuals".[24] Barton proceeded to present the facts of the practice, from her perspective: infertility was on the rise; the birth rate was falling; the vast majority of cases used AIH; donor insemination required the consent of both husband and wife; and in AIH the method is "not so artificial", by which she referred to post-coital insemination. Barton disagreed with the Bishop of Chichester's statement that AI would make home life anxious and unhappy, and asserted that adoption

[22] 'Medical Notes in Parliament', *British Medical Journal* 14 August 1943.
[23] Mary Barton, 'Correspondence', *British Medical Journal*, 4 September 1943.
[24] Mary Barton, 'Correspondence', *British Medical Journal*, 4 September 1943.

was not the answer as "[n]o woman who has chosen to bear her own child would exchange this greater joy for anything less".[25] Thus, AI was positioned as a more satisfactory option than adoption. Barton said the "greatest psychological obstacle" in these cases is knowledge of the husband's infertility and she believed that the marriage would be strengthened by "the mutual responsibility for the wife's child granted her by her husband's generosity".[26] Barton also drew attention to the gender dynamics at work: "For centuries, woman has borne the blame and burden of the barren marriage, and surely it is time man accepted his part of the responsibility".[27] She further suggested that if a wife was denied a good solution to the "intolerable situation" of a "barren marriage", "she is often tempted to a bad one".[28] In other words, AI was an antidote to adultery in a childless marriage. In the United States, Dr Sophia Kleegman made a similar argument in favour of AID, which was that it "might serve to protect a frustrated and desperate wife from seeking an extra marital sexual partner".[29] She positioned male infertility as leaving a wife to make a choice between a medical procedure and adultery. This became a point of argument over the next eighteen months, with AI being labelled as a "pseudo-adulterous practice" and "extra-marital artificial insemination". The desirability of adoption compared with AID also became a point of contention. Barton concluded her letter by urging the profession to fairly weigh all the evidence "and decide the question for themselves".[30] It was this letter from Mary Barton that initiated what was, at the time, the most comprehensive discussion of the clinical practice and ethical questioning of assisted conception.

[25] Barton, *British Medical Journal*, 4 Sept 1943.
[26] Ibid.
[27] Ibid.
[28] Ibid.
[29] Herbst-Lewis, *Prescription for Heterosexuality*, 127.
[30] Mary Barton, *British Medical Journal*, 4 Sept 1943.

Immediate concern was expressed in the *BMJ* over the emotional and psychological implications for the child. L.J. Bendit turned the argument to the welfare of the child and the potential for "deep scars left on the mind of a child" as a result of "the sex relation between cultured people [being] tampered with".[31] Ultimately, he said, "when a psychologically damaged child grows up, society suffers too".[32] Similarly, Alex Leitch raised a number of questions about the psychological consequences for the family dynamic, including the child being "extremely prone to develop an Oedipus or mother-fixation complex".[33] He believed that it would "lead to a constant struggle, obvious or repressed, between the child and the husband for the woman's love and affection".[34]

To counter criticisms, and as a show of support for the practice, sixteen clinicians specializing in the treatment of involuntary sterility signed a letter published in the *BMJ* on 16 October 1943, which offered a clinical assessment and called for more comprehensive services. The report presented eight key points about diagnostic and demographic facts of infertility, including that infertility was blind to class – it was as common among the working classes as it was among any other. It also stressed that "childlessness is rarely deliberate", and that a small family of one or two children was often a result of low fecundity with sixty to ninety per cent of all 'barren' or one-child families experiencing fertility problems. Infertility was common among both men and women, but most women did not seek advice and those who did were more frequently middle class. There had been an increase in attendance at speciality fertility clinics in recent years. The letter concluded by saying:

[31] L.J. Bendit, 'Correspondence', *British Medical Journal*, 25 September 1943.
[32] L.J. Bendit, 'Correspondence', *British Medical Journal*, 25 September 1943.
[33] Alex Leitch, *British Medical Journal*, 2 October 1943.
[34] Alex Leitch, *British Medical Journal*, 2 October 1943.

> …no effort to solve the problem of the decline in the population can be considered satisfactory unless it recognizes the necessity for providing facilities for the skilled diagnosis and treatment of all grades of infecundity.[35]

Practitioners with experience in AI stressed the medical aspects of the treatment. For instance, M. Moore White explained the various clinical investigations for sub-fertility for women: testing patency of fallopian tubes by injecting lipiodol and taking an x-ray, by utero-tubal insufflation, an endometrial biopsy, or cervical secretions tested after coitus. She stressed that on several occasions she had been approached by a husband requesting AI "because he can't bear the fact that he is the cause of his wife's disappointment".[36] She believed in cases like this there should be no concern about psychological trauma.[37]

## Questioning the role of the medical profession

The medical profession experienced significant change during the war, which perhaps heightened tensions around the subject of AI. In the 1930s, there was a growing gap between general practitioners and technical specialists and the war underlined the need for reform in regional hospital planning in order to link and focus specialist services.[38] Between 1939 and 1949, 'new' specialties grew quickly: specialists in anaesthesiology increased from 4.7% to 8.6% of the medical profession, those in pathology from 4% to 8.5% and those in psychiatry from 2.3% to 7.6%.[39] Over the same period, the total number of specialists more than tripled from 1,620 to 5,316.[40] The Medical Planning Commission published a report in 1942, which described "the sense of

[35] Barton, Jackson, Sharman, Moore White, Walker, Wiesner, et al., *British Medical Journal*, 16 October 1943.
[36] M. Moore White, *British Medical Journal*, 6 November 1943.
[37] M. Moore White, *British Medical Journal* 6 November 1943.
[38] Rosemary Stevens, *Medical Practice in Modern England. The Impact of Specialization and State Medicine*, (New Brunswick, New Jersey: Transaction Publishers, 2003), 63.
[39] Stevens, 111.
[40] Ibid.

isolation of the general practitioner, the rift between the general practitioner and both voluntary and municipal hospital authorities, [and] the need for a unified health plan".[41] The Second World War came at a critical time for it interrupted the further division of the profession into autonomous specialties.[42] Rosemary Stevens argues that the war acted as a catalyst in forcing a solution – culminating in the establishment of the NHS – to problems that had already existed: "the split between consultants and general practitioners, increased specialization within the hospitals and in the professional bodies, and the need to redefine the purpose of postgraduate diplomas".[43] Of course, the establishment of the NHS was not a panacea for tensions in the profession, but it provided a clearer structure of services and made health care available to all.

The AI debate in the *BMJ* must be considered in the context of the complex and fractured organization of the medical profession during the war. Rather than take responsibility for AI and work in association with voluntary bodies like the FPA, many doctors felt the profession should be distanced as far as possible from the practice. J.S.M. Connell viewed the practice of AI as the profession advertising the idea of a "physical Utopia" and neglecting the fundamentals of medicine.[44] Taking this sentiment further, A.J. Brock believed that AI threatened the standing of the medical profession, which already had competition from faith healers and patent-medicine makers.[45] Others, such as P.P. McKinney felt it was an issue in which the medical profession should play only a minor role. In his view, it was "not a mere obstetric matter", but a sociological one that

[41] Ibid, 70.
[42] Ibid, 106.
[43] Ibid, 124.
[44] J.S.M. Connell, *British Medical Journal*, 15 January 1944, 95.
[45] A.J. Brock, *British Medical Journal*, 9 December 1944, 772.

calls upon the Church to pronounce its views.[46] F.M.R. Walshe warned that if the profession did not follow the Christian ethic it would "become the servant of hedonism".[47] He also speculated that a new medical speciality would likely develop from the practice of AI. Less than a month later Walshe extended his criticism further to pronounce that, "medicine now is being invaded by this evil".[48] G.L. Davies drew a direct comparison between feelings towards AI and the war: "One imagines that the stomachs of the average medical man and woman, in spite of nearly six years of war and Nazi horrors, still retain sufficient sensitivity to experience some feelings of antiperislalsis [vomiting] when discussing this subject".[49]

How doctors understood their medical duty differed quite substantially. F.J. Wilfrid Sass insisted that "the care of the health of the people is the doctor's job, not the production of artificial babies," while others felt that assisting a couple through the practice of artificial insemination was absolutely within their remit.[50] M. Grace Eggleton viewed the role of the medical profession as altruistic:

> Our aim should be to aid the establishment of stable, healthy populations in all the countries of the world, and to this end the possible use of artificial insemination no less than that of birth control should be judged not on grounds of narrow-minded puritanism or bigoted Catholicism…but with a view to the greater security and happiness of the ordinary man.[51]

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[46] P.P. McKinney, *British Medical Journal*, 16 December 1944, 801.
[47] F.M.R. Walshe, *British Medical Journal*, 3 February 1945, 165.
[48] F.M.R. Walshe, *British Medical Journal*, 24 February 1945, 276-77.
[49] G.L. Davies, *British Medical Journal*, 24 February 1945, 277.
Davies' comment was made one month after the Soviet liberation of Auschwitz, however public knowledge of Nazi crimes remained very limited. Soviet press *Pravda* was the first paper to report on Auschwitz on 2 February 1945. It was not until April and May 1945 when the Western press reported widely on the atrocities of the death camps. For early reports on the liberation of Buchenwald see, for instance, 'Camp of Death and Misery', *The Times*, 16 April 1945, p.3.
For press coverage of liberation see Dan Stone, *The Liberation of the Camps: The End of the Holocaust and Its Aftermath*, (New Haven: Yale University Press, 2015), 68-69.
Stone suggests that the Allies focused on camps they had liberated – Belsen, Buchenwald and Dachau – and distrusted Soviet reports, including those about Auschwitz and Majdanek. However, the *Illustrated London News* reported on Majdanek on 14 October 1944, and the *Daily Mail* on 4 September 1944, yet the BBC refused to report on it believing it was 'a Russian propaganda stunt'.
[50] F.J. Wilfrid Sass, *British Medical Journal*, 3 February 1945, 165.
[51] M. Grace Eggleton, *British Medical Journal*, 17 February 1945, 236.

Those doctors who advocated (or at least did not oppose AI) insisted that the practitioner should not impose personal or religious beliefs on the patient, and supported the individual couple's freedom to choose. [52] It was felt by Ian G. Wickes that patients should be considered first, "rather than spout at them our own, often distorted, ideas, that are frequently legacies of the unenlightened doctrines of the Victorian era".[53] While numerous doctors advocated the couple's freedom to choose, they also supported the implementation of regulation and legislation, if only to protect the profession.[54] However, despite calls for regulation by medical authorities, both the Medical Defence Union and the Royal College of Obstetricians and Gynaecologists explained in the *BMJ* that the subject was under discussion but offered no explicit view in support or opposition, underlining the ambiguity over what body was responsible for ruling on the ethical and legal aspects of the practice.[55]

## A threat to the family

The controversy over AI emerged at a time of crisis when wartime fears were sensitized by yet another perceived threat to the 'moral family'. The anxiety over a declining population led to the establishment of the Royal Commission on Population in 1944, that was concerned with the "ultimate threat of a fading-out of the British

[52] Keith Duff, *British Medical Journal*, 30 December 1944, 868.
[53] Ian G. Wickes, *British Medical Journal*, 16 December 1944, 802.
[54] Edward J.R. Primrose, *British Medical Journal*, 30 December 1944, 868.
[55] Robert Forces, Secretary, Medical Defense Union, *British Medical Journal*, 18 November 1944; W. Gilliatt, Deputy Honorary Secretary, Royal College of Obstetricians and Gynaecologists, *British Medical Journal*, 3 March 1945.
The Medical Defence Union was founded in 1885 "as the world's first organisation to defend the reputations of doctors" and continues to function today, providing indemnity and advice to its members. For the history of the Union see 'Medical Defence Union: Our Heritage', Medical Defence Union, http://www.themdu.com/sitecore/content/corporate/ddu/home/about-ddu/our-heritage

people".[56] It was feared that if population patterns remained as they were, there would be a continuous decline by "twenty per cent in each successive generation," which gave rise to the generally agreed target of four children per family, and pronatalist social thought.[57] The 1944 Mass Observation report on the birth rate estimated that if fertility continued to decline at the same rate as it did during the 1930s, by 2015 Britain's population would be 10,456,000 – nearly one quarter of its wartime population – with an annual decrease of 3%.[58] Such fears were to prove unfounded, as the current population of Britain is upwards of sixty million. Despite this anxiety about the falling birth rate, the number of live births in England and Wales continued to grow, increasing by 1.15% from 1940 to 1945.[59] However, as John Costello has pointed out, this growth was uneven as the rate declined between 1939 and 1941 and showed growth only in 1943. These birth rate statistics are reflective of the early apprehension about the war, and a growing confidence following the Allied victories in 1943 and 1944.[60] Denise Riley has argued that during and after the Second World War "the reproductive woman at the heart of family policy was surrounded by the language of pronatalism", which she defines as the encouragement of women to have more children as a response to the apprehension over the low birth rate.[61] Pronatalism had been growing through the 1930s as a solution to population concerns, but it had become "more generally diffused towards the end of the war".[62]

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[56] Stephen Jackson, *Britain's Population, Demographic Issues in Contemporary Society*, (London: Routledge, 1998), 59.
[57] Denise Riley, *War in the Nursery*, 158.
[58] *Britain and Her Birth Rate*, A Report prepared by Mass Observation, (London: John Murray, 1945), 24. In the 1940s Britain's total population was over 40 million.
[59] Jane Lewis and John Welshman, 'The Issue of Never-Married Motherhood in Britain, 1920 – 70', *Social History of Medicine*, 10(3) 1997, (pp. 401 – 418), 402.
[60] John Costello, *Love, Sex and War. Changing Values 1939 – 45*, (London: Collins and Sons Co. Ltd, 1985), 270.
[61] Riley, *War in the Nursery*, 151.
[62] Ibid.

However, Riley says this alone cannot account for women's decisions over reproduction: "Rhetoric doesn't make women have more children through the sheer power of the word…Its presence matters, though."[63] Both the 1945 Family Allowances Act and the 1944 Royal Commission of Equal Pay were "shaded with pronatalist thought".[64] And yet, there were fears that equal pay would have a " 'dysgenic effect' on the birth rate", while the Family Allowances Act was seen as an attempt to encourage reproduction through financial incentive by giving mothers 5s. per week for a second child. In these ways, the State intervened in the lives of its citizens through welfare reforms aimed to support families, but this in itself did not make people have more children. Although the Family Allowances Act was initially perceived as a success, as it had long been fought for by Eleanor Rathbone[65], most Mass-Observation respondents did not feel that 5s. a week was enough to encourage them to have another child.[66] At the same time, the Eugenics Society opposed family allowances as it was seen to encourage the less-well-off to have more children. The State was perhaps more concerned with the population than were the general public. In a random street sample, done by Mass-Observation in June 1944, 25 per cent of people thought an increasing birth rate was a 'bad thing', 26 per cent thought it was 'unimportant' and 49 per cent thought it was a 'good thing'.[67]

There was an obvious but often unspoken potential for AI to remedy such population concerns, while at the same time supporting 'positive' eugenic aims. C.O. Carter, a war-service doctor and Eugenics Society member, saw such potential in AID. He referenced the high death rate of the 'country's best' and the consequent shortage of

[63] Ibid.
[64] Ibid, 167.
[65] Eleanor Rathbone was also a proponent of eugenics.
[66] Ibid, 163.
[67] *Britain and Her Birth Rate*, 31.

men that was anticipated. In his view, the future of Britain depended on "the rapid provision of new children both with high genetic potential for intelligence and other desirable qualities".[68] The Prime Minister himself, Winston Churchill, had suggested a replacement level of four children for the average couple, and Carter therefore believed that "above average" married couples must plan for six to eight children. In this context, AI offered "a useful supplementary method" for children of "high genetic potential".[69] Carter saw two instances in which AI should be used: firstly, for sterile or genetically disadvantaged husbands, and secondly, for 'surplus' women who could not find a husband after the war or young widows "of a good type".[70] Carter did not appear to have any qualms about unmarried motherhood if it benefitted the nation's eugenic potential. Carter was alone in overtly advocating the eugenic benefit of AI. Most medical correspondents were focused on the effects it could have on family structures.

For some correspondents, artificial insemination was seen as having the ability to save a marriage, while for others it marked the breakdown of the institution. It clearly struck at anxieties over family life and social structure. Alex Leitch believed AID was "likely to worsen rather than improve the marital relationship", attributing this largely to the perceived psychological damage it would cause.[71] H.P. Newsholme stated that AID would break the pledge of marriage and any medical practitioner who performed the procedure was aiding and abetting this breakdown. "Call it adultery or what you will", Newsholme wrote, but no doctor should "be party to such an offense against marriage".[72] He said that unmarried motherhood would 'degrade marriage' because it would no longer

[68] C.O. Carter, *British Medical Journal*, 27 January 1945, 130.
[69] Ibid.
[70] Ibid.
[71] Alex Leitch, *British Medical Journal,* 2 October 1943, 434.
[72] H.P. Newsholme, *British Medical Journal*, 11 November 1944, 641-2.

be seen as a prerequisite for having children.[73] A.J. Brock referred to AI as a "practice of social disintegration"[74] while E.H. Strange suggested that just because something is desired it should not be gratified, comparing maternal desires to the spoiled infantile desires of a child.[75] McKinney argued that artificial insemination "strikes at the very foundation of the family".[76] These critiques would be echoed in debates over AI for the next fifteen years.

At the same time, a number of doctors advocated for patient agency and called for a more flexible approach. For instance, J. Hobart Nixon, a practitioner of AI, reported a case in which insemination saved a marriage on the verge of collapse.[77] Margaret Jackson explained that most requests for the procedure came from the infertile husband, and Joan Malleson agreed that it was not uncommon for the request to come from the husband.[78] Malleson suggested that it was a personal choice that is often a great benefit to the couple.[79] Children were seen as central to marriage and, for some people, AI offered the only opportunity of biological conception. R. MacDonald Ladell also supported the freedom of couples to choose AI.[80] R.F. Stronge advocated a more open, long-term approach to the subject: "This is a changing world and the things which appear to us most stable, such as human nature and morals, must change inevitably".[81] He said it was "futile to fight against [change]".[82] On 30 December 1944, Keith Duff commented

[73] H.P. Newsholme, 11 Nov 1944.
[74] A.J. Brock, *British Medical Journal*, 9 December 1944.
[75] E.H. Strange, *British Medical Journal*, 9 December 1944.
[76] P.P. McKinney, *British Medical Journal*, 16 December 1944.
[77] J. Hobart Nixon, *British Medical Journal*, 16 December 1944, 801.
[78] Margaret Jackson, *British Medical Journal*, 28 October 1944; Joan Malleson, *British Medical Journal*, 25 November 1944, 706-7.
[79] Joan Malleson, *British Medical Journal*, 25 November 1944.
[80] R. MacDonald Ladell, *British Medical Journal*, 25 November 1944.
[81] R.F. Stronge, *British Medical Journal*, 9 December 1944.
[82] R.F. Stronge, 9 December 1944.

on the exaggerated reaction from medical professionals. He said personal morals and emotion should stay out of it – and instead the focus should be on the medical application of AI as effective treatment. He suggested that the profession would do what was best if they were left to their own devices, and remarked sarcastically that perhaps the critics might prefer divorce or remarriage to a fertile partner.[83] Edward J.R. Primrose also advocated freedom of choice. He saw legislation as useful, in part to protect medical practitioners.[84]

Following concerns around marital relations, fears of adultery and divorce also became associated with AI. Mary Barton suggested that if women were denied a 'good' solution to infertility, they may be 'tempted' to a bad solution – implying a turn to adulterous relations in order to conceive.[85] J.A. Forrest echoed this, recommending that if a couple wanted AI it should be permitted, as it was better than the alternative of adultery.[86] However, others argued that AI was not an alternative but rather was akin to adultery. J.R.A. Todhunter warned that if moral and aesthetic standards were loosened for medical reasons it was easy to go down a dangerous path.[87] Joseph Phelan argued that AI was "closely akin to adultery in that the semen in her uterus is not that of her husband".[88] Similarly, J.A. Rooth believed that if a third party was to be involved, he could see no moral difference between AI and doing it "in the natural way".[89] C. Gordon-Watson felt that those involved with AI were accessories "to pseudo-adulterous practices" resulting in

[83] Keith Duff, *British Medical Journal*, 30 December 1944, 868.
[84] Edward J.R. Primrose, *British Medical Journal*, 30 December 1944.
[85] Mary Barton, *British Medical Journal*, 4 September 1943, 312-13.
[86] J.A. Forrest, *British Medical Journal, 24* February 1945, 277.
[87] J.R.A. Todhunter, *British Medical Journal*, 1 January 1944, 25.
[88] Joseph Phelan, *British Medical Journal*, 16 December 1944, 802.
[89] J.A. Rooth, *British Medical Journal*, 3 February 1945, 165.

illegitimate children" and hoped the General Medical Council would regard AI as "unprofessional conduct".[90]

## The Meaning of Parenthood

Assisted conception called for a more flexible definition of parenthood, and challenged the heteronormative family ideal of biological kinship. It also created the possibility that single women could become mothers through AID – which became another point of argument in the *Journal*. The general perception in the *BMJ* was that AI was only acceptable for married couples, and even then it was a highly questionable practice. Yet some doctors advocated that AI be opened to unmarried women during the war. However, this was often based on the assumption that a woman could not be fulfilled without the experience of motherhood. For instance, Anne Ethel McCandless suggested that it should be considered for unmarried women, as they would be "far less likely to develop into embittered spinsters".[91] As she saw it, immorality was removed from the practice and therefore the Church could not denounce it, though she called on the government to consider the question of whether or not the children born of AI would be deemed illegitimate.[92] McCandless' comment invoked a pronatalist stance by implying that motherhood was critical to a woman's happiness. However, her position also advocated individual choice for women, regardless of marital status. Pearse Williams agreed with McCandless, though on a eugenic principle, that it was a "tragedy" for both women and the State that "professional women, highly intelligent and physically fit"

[90] C. Gordon-Watson, *British Medical Journal*, 17 February 1945, 236.
[91] Anne Ethel McCandless, *British Medical Journal*, 2 October 1943, 434.
[92] Ibid.

(presumed to be unmarried) were unable to have children.[93] Such pronouncements caused a backlash, as A.S. Hannay was outraged by the suggestion that unmarried women would have access to AI, asking, "would it not be at least as ethical to legalize polygamy"?[94]

Social sensitivities around unmarried motherhood were certainly not new, but were heightened during the war as illegitimate births increased. The illegitimacy rate rose through the war from 4.34% of all live births in 1940 to 9.33% in 1945.[95] Yet rather than an increase in extra-marital sex, the Registrar-General's calculations suggested that, "during the war fewer extramarital conceptions were legitimized by marriage".[96] The illegitimacy rate declined rapidly after the war, from 9.3 per cent in 1945 to 6.6 percent in 1946, and with it government concern also declined. Lewis and Welshman have argued that, "there was a shift in attitudes towards unmarried mothers during the Second World War but this did not mean that they were integrated into the mainstream of welfare state provision".[97] In this instance, population concerns and eugenically motivated aims, came up against traditional family ideals and gender roles. Whether marriage was a prerequisite for parenthood was debated alongside biological and social parenthood, by way of adoption.

Artificial insemination became a counterpoint to adoption and the medical profession was divided over which 'remedy' to childlessness was preferable. The

[93] Pearse Williams, *British Medical Journal*, 16 October 1943, 496.
[94] A.S. Hannay, *British Medical Journal*, 17 February 1945, 236.
[95] As pointed out by Lewis and Welshman, the term illegitimacy has not been used in official statistics since the Family Law Reform Act of 1987, which "abolished the status of illegitimacy while retaining a distinction between the father of legitimate and illegitimate children".
Lewis and Welshman, 'Never Married Motherhood', 402.
[96] June Purvis, *Women's History: Britain 1850 – 1945 an introduction*, (New York: St Martin's Press, 1995), 315.
[97] Lewis and Welshman, 407.

ambiguity of what AI meant in terms of parenthood and the legal status of the child, in the absence of any legislation, led many in the medical profession to insist that adoption was a preferred solution to infertility. For others AI offered a more maternally and biologically satisfying option. Mary Barton initially advocated AI over adoption, in terms of biological fulfilment for the mother, though later relaxed this view to say that it was about the preference of the couple.[98] Margaret Jackson offered a balanced view, stating that adoption was an option but many people felt strongly about passing on their 'genes'.[99] Supporting this, M. Moore White explained that several men had approached her requesting a donor as they would rather a child have fifty per cent of one of them than nothing of either of them through adoption.[100] Reynold H. Boyd also saw AIH and AID as better options than adoption.[101] Boyd said that in most cases AID provides "a child far more an integral member of the family than any adopted child would have been, and also satisfied a woman's yearning to have a child of her own".[102] He stressed that AI was positive for the marriage.[103] Conversely, Alex Leitch believed that adoption provided a "better chance" for "mutual happiness", suggesting that AI was only for the benefit of the woman.[104] He implied that giving birth was an indulgence, referring to "the thrill of the physical act of motherhood".[105] Barton presented AI and adoption as two possibilities and underscored a woman's right to make this choice:

> The value of the physical act of motherhood varies greatly from woman to woman, and none but the individual can decide how much she is prepared to sacrifice in this

[98] Mary Barton, *British Medical Journal*, 4 September 1943, 312-3; Mary Barton, *British Medical Journal*, 4 December 1943, 727-8.
[99] Margaret Hadley Jackson, *British Medical Journal*, 28 October 1944, 577.
[100] M.Moore White, *British Medical Journal*, 6 November 1943, 588.
[101] Reynold H. Boyd, *British Medical Journal*, 2 October 1943, 434.
[102] Reynold Boyd, *British Medical Journal*, 2 October 1943.
[103] Reynold Boyd, *British Medical Journal*, 2 October 1943.
[104] Alex Leitch, *British Medical Journal*, 2 October 1943, 434.
[105] Leitch, *British Medical Journal*, 2 October 1943, 434.

> life and what for. In any case adoption is an ever-present solution should she prefer it.[106]

The pages of the *BMJ* provided a stage for debate over the family – from marriage to motherhood, adultery to adoption – as moral values were assigned to artificial insemination.

## A Clinical Guide to AI

In early 1945, a more heated debate was provoked when a clinical article laid bare the practice of artificial insemination. On 13 January 1945, the *BMJ* published a report on artificial insemination written by clinicians Mary Barton, Kenneth Walker, and B.P. Wiesner.[107] The four-page report covered the clinical practice of artificial insemination, presenting some conclusions on the "developing field" with the aim of "dispel[ling] certain misconceptions that are constantly arising".[108] The article addressed the scope of the practice with advice on the procedure for cases involving impotence, painful intercourse, 'failure to ejaculate', 'inadequate cervical invasion', and sterility.[109] They provided detailed descriptions of the procedure and various techniques that had been used

[106] Barton also states that the child should never know how he or she was conceived. Barton believed that unmarried women having AID raised questions about 'the status of the child' and 'the quality of its upbringing' and decisions about the application for married people should be settled first. She also suggested that 'the desire for fatherhood is rarer than the desire for motherhood'.
Mary Barton, *British Medical Journal*, 4 December 1943.
[107] There are questions surrounding the integrity of B.P. Wiesner's practice of AI. Wiesner and Barton were married, and in 2012 a popular media story reported that he had fathered 600 children at their fertility clinic. DNA tests done on 18 people conceived at the clinic between 1943 and 1962, showed that Wiesner was the sperm donor for two-thirds of them. This number was extrapolated, based on the average number of patients during this period to reach 600. There are suggestions of his integrity being under question in the archives. For example, both Barton and Wiesner were not invited to the infertility conferences organized by the FPA from 1944 to 1946. Bernard Sandler also criticized the practices of a 'London surgeon' when speaking with the Eugenics Society about AI in advance of the Feversham Committee. See, for example, Rebecca Smith, 'British man 'fathered 600 children' at own fertility clinic', *The Telegraph*, 8 April 2012; Wellcome Library, London, SA FPA/A6/2; Wellcome Library, London, EUG/D.251.
[108] Barton, Walker, Wiesner, 'Artificial Insemination', *British Medical Journal*, 13 January 1945.
[109] Barton, Walker, Wiesner, 40.

with success, creating a basic guidebook for medical practitioners who had little knowledge of the practice beyond the moral opposition.

The report provided readers with the knowledge to advise patients on self-insemination.[110] The authors explained that "[m]any impotent husbands are capable of producing fecund semen by masturbation" and the report followed by providing step-by-step instructions for the couple to conduct a self-insemination at home, with the wife being taught the procedure during the fecund phase of her cycle:

> The technique is as follows: She first douches with warm water (1 pint); half an hour later the husband passes semen into a cold dry glass container and allows it to liquefy at room temperature (about 10 minutes). The wife then draws up the semen into a clean dry urogenital glass syringe, and, lying on her back with knees drawn up, she passes the syringe into the vagina and very slowly expels the semen. The prone position should be retained for about half an hour.[111]

Women undergoing AI were also instructed on how to read their rectal temperature on waking in order to determine the occurrence of ovulation. While the report advised that "conception should occur readily", if after four or five cycles a pregnancy has not occurred the case should be reviewed. Of eleven cases of self-insemination treated by the doctors, eight pregnancies had resulted with one miscarriage.[112] Of course, in most cases a medical practitioner performed AI in a similar format as described above. In these cases, the procedure would be repeated monthly for up to two years.

The report outlined the indications for AID, and how to assess the marital relationship in such cases. They said that indications for AID included sterility, as well as other biological concerns like genetic "deafness" and a "transmissible nervous

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[110] In the late 1970s, self-insemination became a feminist initiative in London (see Conclusion) and, in 1952, Marie Stopes advocated self-insemination to couples wanting to avoid steep medical fees. For Marie Stopes' advice to correspondents see Wellcome Library, London, SA/EUG/K.32, 'Artificial Insemination Letters', 1952 [open prior to February 2013; now closed until 2037].
[111] 'Artificial Insemination', *British Medical Journal*, 13 January 1945, 40.
[112] Ibid.

disease".[113] They echoed other physicians in stating that "quite often the husband is unwilling to undergo treatment, and the suggestion of A.I.D. comes from him", however, "[s]ome women demand A.I.D. without the knowledge of the infecund husband, claiming that paternity would save his self-esteem".[114] They qualified this point, explaining that "such women are usually good and devoted wives who…have rejected other ways of becoming pregnant".[115] Yet, they suggested that others had more "dubious reasons" like forcing a marriage with an AID pregnancy. In practice, the only cases they accepted were based on biological and medical factors, as well as "the suitability of the couple for parenthood".[116] Such assessments and speculation about marital dynamics were vented by practitioners during the Feversham Committee investigation fifteen years later and will be explored in Chapter 5.

Further clinical recommendations were given for treatment. They outlined the details of the procedure and technique, including charting temperatures for ovulation. The authors of the report provided clear instructions of the technique for both AIH and AID: "A glass syringe fitted with an intra-uterine cannula" was used "and a small quantity of semen (0.1-0.2 c.cm.) is drawn up into this syringe, which must be dry".[117] Following this, "[t]he tip of the cannula is passed into the cervical canal (1/4 – 1/3 in. of the external os). The semen is then injected *very slowly* into the canal…The patient may be allowed to leave a few minutes after insemination".[118] It was often the case that the procedure would need to be repeated monthly for up to two years.

[113] Ibid.
[114] Ibid.
[115] Ibid.
[116] Ibid.
[117] Ibid.
[118] Ibid.

Finding an appropriate anonymous donor was the most difficult aspect of the procedure. In the case of AID, the physician was entirely responsible for procuring the donor. They stressed the importance of anonymity: 'the prospective parents should never be aware of the identity of the donor'.[119] Barton, Walker and Wiesner warned readers of the importance of anonymity:

> …the husband's brother might be regarded as the first choice because of genotypical resemblance…experience shows that this choice is usually incompatible with secrecy, and that it is conducive to emotional disturbances involving both husband and wife.[120]

They advised against a couple choosing a donor who was known to them. In this sense, AI practitioners were self-regulating in their insistence upon standards of anonymity for the benefit of both donor and recipient. In choosing a donor, 'biological dangers' were avoided, which included transmissible disease, and "adverse characteristics of possible genetical significance, such as alcoholism, criminality, or tuberculosis". Moreover, "[e]xcessive pronounced physical features" were avoided because they might lead to the identification of the donor.[121] The eugenic implications were also outlined: "Positive considerations concerning the eugenic quality of the donor's stock will largely be governed by the scientific views and perhaps the individuals preferences of the physician concerned". The authors of the report favoured intelligent men, with a family history of "good capacity for social adjustment". Other practitioners, they suggested, might prioritize physical characteristics or athletics. The prospective parents often desired to match particular characteristics or qualities, however this was not always possible. In practice, they required that the donor have at least two 'legitimate' children, be of a 'mature age' recommended as 30 to 45 years, be in good health, with a certificate from

[119] Ibid, 41.
[120] Ibid.
[121] Ibid.

his physician, the completion of a Wassermann test for syphilis, a sperm count exceeding 30 million per c.cm., and a matching blood group to at least one parent to "minimize the possibility of bastardization".[122] At this time, paternity could only be tested through blood type, and matching types was therefore seen as a defense against the questioning of biological parenthood. Although most parents desired "donors of like race – e.g., Jewish couples usually ask for a Jewish donor" – the report pointed out that, "it is a curious reflection on the present epoch that some have specifically asked for non-Jewish donors, since they want to safeguard the child so far as is possible against anti-Semitism".[123] Interfaith insemination was not common, but even in donor selection, fears associated with the war were evident. The report explained that though the donor panel was small and the samples were only usable for a few hours, each emission could be used for 20 inseminations during that period and therefore, in theory, a donor that submitted two specimens per week could produce 400 children weekly, and 20,000 annually.[124] As far-fetched a possibility as this was, opponents of AI quickly exploited these details imagining visions of 'a brave new world'. In order to regulate inseminations, Barton, Walker and Wiesner had set a limit of 100 children per donor, which had not yet been reached by any individual. In the absence of professional or governmental regulations, those practicing AI established guidelines that are not dissimilar to those of today.

Barton, Walker and Wiesner's report acted as a handbook for the practice of artificial insemination, which was, as shown by correspondence, little understood and

[122] Ibid.
[123] Ibid.
[124] Ibid, 42.

minimally practiced. Even information on birth control was not yet being taught in most medical schools and the Ministry of Health continued to treat contraception as taboo.[125]

## The Legal Status of the Child

In the two months following the publication of this clinical report, a spate of letters appeared each week in the *BMJ*, until the *Journal* ultimately put an end to the discussion. These letters continued to debate 'legitimate' means of family formation, focusing on the legal consequences of AI. They were particularly focused on questions of the legal implications for both the child and the father, to which the issue of legitimacy was central. Leonard Parsons insisted that "extramarital artificial insemination" was breaking the law and the child of AI would be illegitimate and the doctor involved in the procedure an "accessory to the misdemeanour".[126] G.J. Finch corrected Parsons on the issue of illegitimacy and crime explaining that the doctor "is in no way an accessory to any misdemeanour" as any child born to a married woman during the marriage is considered legitimate. Finch explained that there was the risk of the third party "taking action to bastardize the child", but it would be very difficult for this to be legally sanctioned.[127] Kenneth McFadyean concurred that the child "would be born in wedlock and would therefore be legal in every sense of the word".[128] Though Reynold Boyd, an advocate of AI, advised that when registering an AI birth all information regarding the father should be left blank.[129] AID raised the question of the child's legal status: which

[125] Leathard, *Fight for Family Planning*, 74.
[126] Leonard Parsons, *British Medical Journal*, 20 January 1945, 96.
[127] G.J. Finch, *British Medical Journal*, 10 February 1945, 199.
[128] Kenneth McFadyean, *British Medical Journal,* 3 March 1945.
[129] Reynold H. Boyd, *British Medical Journal*, 27 January 1945, 130.

'father's' name should be given and registered, and what did this say about legitimacy?[130] The question of whether the child should be told of their origins was raised, as well as whether it was a felony to keep this information from the child. Some doctors saw it to be quite obvious that the child was illegitimate and concealing this would make the doctor criminally liable. J.A. Rooth questioned the child's reaction to discovering they were "the offspring of a test-tube supplied by some unknown man," adding "what would they think of their mother?"[131]

The legal grey area of AI also meant that these later letters were concerned with adoption. Leonard Parsons believed that adoption was the better choice for a couple dealing with infertility.[132] A.S. Hannay agreed with Parsons that "the parental longing of the childless" can be fulfilled through adoption, though employing 'positive eugenics' to argue that adoption was the better option as the parents could select the child and "disease" and "weakness" can be almost "completely eliminated".[133] Mary Jeffries saw the disadvantages of AID outweighing the advantages of satisfying the mother; she advocated adoption, where there was 'no less maternal instinct aroused in the mother'.[134] In contrast, F.E.S. Hatfield believed that adoption should be discouraged on a eugenic basis: "the frequently poor genetic quality of the material presented for adoption" was a disadvantage.[135] Although, the biological lineage of AID could also be seen as a problem: G.L. Davies suggested women desiring a child conceived by AI might have a 'neuropathic tendency' that might be passed on to their children.[136] Even on the question

[130] Robert Anderson, *British Medical Journal*, 15 January 1944, 96.
[131] J.A. Rooth, *British Medical Journal*, 3 February 1945, 165.
[132] Leonard G. Parsons, *British Medical Journal*, 20 January 1945, 96.
[133] A.S. Hannay, *British Medical Journal*, 17 February 1945, 236.
[134] Mary C. Jeffries, *British Medical Journal,* 17 Feb 1945.
[135] F.E.S. Hatfield, *British Medical Journal*, 10 March 1945, 347.
[136] G.L. Davies, *British Medical Journal,* 24 Feb 1945.

of adoption, medical opinion was far from unanimous and was, moreover, saturated with eugenic thought.

In the final weeks of debate in the *Journal* some doctors called for a more tolerant approach, empowering couples to make the choice for themselves. J.A. Forrest said the debate had become overly emotional, and that the question is for those involved: "if a couple wish to resort to this method to obtain a child they should be allowed to do so".[137] He advocated that freedom of choice be provided to families. Similarly, F.E.S. Hatfield called for 'reasonable toleration', and advocated the couples' freedom to make the choice for themselves: "Can we not allow each couple to decide for themselves and allow them the privilege of decent motives in the seeking of a solution to their very tragic dilemma?".[138]

By early March 1945, the debate devolved into personal attacks on colleagues. In the last of such letters permitted by the *BMJ*, Barton, Walker, and Wiesner wrote that they could not offer a response since "many of these letters contain nothing but abuse".[139] They were disappointed with the lack of interest in the scientific aspects. As they pointed out, those doctors with the most exaggerated speculations and hostile criticism had "no first-hand experience of this subject" and had given "free rein to their imaginations".[140] In that same issue, the *BMJ* brought an end to the debate. They explained that many letters were not even published, though they attempted to provide a balanced view: "A time always comes when it is plain that a heated and inconclusive correspondence has run its

[137] J.A. Forrest, *British Medical Journal,* 24 Feb 1945.
[138] F.E.S. Hatfield, *British Medical Journal,* 10 March 1945.
[139] Barton, Walker, Wiesner, *British Medical Journal*, 10 March 1945.
[140] Mary Barton, Kenneth Walker, B.P. Wiesner, *British Medical Journal*, 10 March 1945, 346-7.

full course and ought to be wound up".[141] The debate through the correspondence pages of the *Journal* challenges ideas of the family, marriage, and parenthood, and called into question the legal status of a child conceived in this way, as well as the ethical role of doctors in this area of medicine.

The medical debate in the *BMJ* did not escape the attention of Parliament. On 29 March 1945, in the House of Commons, MP Tom Driberg asked Minister of Health Henry Willink about the extent of the "experiments now being conducted in the artificial insemination of women".[142] Willink explained that he had no information on the practice beyond what had been published in the medical press. Willink was questioned further by other members of parliament, including Ivor Bulmer-Thomas who suggested that AI be added to the terms of reference of the Royal Commission on Population. Willink was criticized for his lack of knowledge in the field and seeming indifference to act on the matter, and the discussion was concluded when he told the House he would endeavour to "obtain fuller information".[143]

## Exposing the horrors of the Nazi regime

In the broader context of the Second World War, this debate over artificial insemination was not a terribly significant event. In the months that followed the *BMJ* debate, the Allies celebrated the victory in Europe with the surrender of Nazi Germany (8 May 1945), and victory in the Pacific was declared (14 August 1945), following the atomic bombing of Hiroshima and Nagasaki. Yet within these victories were reports of the horrors of the war. The dark side of AI was exposed in reports of medical

[141] 'Doctors in Hot Print', *British Medical Journal*, 10 March 1945.
[142] 'Artificial Insemination (Experiments)', House of Commons Debate, Hansard, 29 March 1945, vol 409 cc1525-6. Accessed http://hansard.millbanksystems.com/commons/1945/mar/29/artificial-insemination-experiments
[143] Ibid.

experimentation in Nazi camps, as survivors gave evidence at war crime trials. From April 1945, with the Allied liberation of concentration camps in Europe, there was a growing number of reports in the press about the horrors and genocide of the Nazi death camps, the details of which were developed further in reports of the war crime trials. It was in this coverage that the medical experimentation conducted in the camps was brought to light. In September 1945, *The Times* reported on the Belsen trial of Nazi war criminals during which experimentation in the camps – including artificial insemination – was discussed by witnesses. On September 21, Dr Ada Binko – a Polish-Jewish medical doctor whose family had all died in Auschwitz – gave evidence to the Belsen military court which included discussion of medical experimentation on prisoners: Binko explained that "one woman who had been subjected to artificial insemination tried to commit suicide because she believed she was no longer capable of bearing a child".[144] Similarly, a few days later on September 25, Helena Hamermarz – a 25-year old Polish-Jewish women, who had been a medical student before the war – provided evidence of her experiences in Belsen and Auschwitz, where she worked in the hospital. She described the experiments of artificial insemination that had been conducted on young girls: "They were hung up by their legs and injected. A little later they were in great pain, and 'quite often died'".[145] These important and powerful reports received limited press coverage, but they presented a horrific image of medical abuse that perhaps informed opposing arguments to the practice as a voluntary medical treatment for infertility. Thus, in the aftermath of the war, two opposing images of AI emerged: on the one hand, it brought happiness to heterosexual married couples who could not conceive naturally,

[144] 'Gas Chamber at Auschwitz', *The Times*, 22 September 1945, p.3.
[145] 'Nazi Beatings of Women, Evidence at Belsen Trial', *The Times*, 26 September 1945, p.3.

while on the other hand, it provoked images of family disintegration, and ghastly scientific experimentation, eugenics, and abuse of medical authority.

## The Archbishop of Canterbury's Commission, 1945 – 1948

As the debate over AI became more public, the Archbishop of Canterbury appointed a Commission to investigate and report on the practice. The Commission on Artificial Insemination, appointed by the Archbishop of Canterbury in December 1945, reported on its findings in 1948. The Commission had been set up in order "to consider the practice of human artificial insemination with special reference to its theological, moral, social, psychological, and legal implications".[146] The 1948 report laid out the history of artificial insemination, the psychological aspects, the sociological and eugenic implications, the legal aspects, and a theological statement. Most significantly, it called AI a 'breach of marriage' and recommended legislation to make donor insemination a criminal offence.[147]

It is perhaps surprising that the Archbishop of Canterbury, Geoffrey Fisher, commissioned a Report on human artificial insemination in December 1945. This was not the only report commissioned during his tenure (from 1945-61), but it was an obvious outlier to the others that were largely focused on promoting unity among Christian churches: these included a report on Evangelism (1945), The Church of South India (1950), and Relations between the Church of England and the Church of Scotland (1951).[148] Without the intervention of a government body, the Archbishop initiated a

[146] 'Artificial Insemination', *The Times*, 2 August 1943.
[147] 'Artificial Insemination: Report by Archbishop's Commission', *The Times*, 2 August 1948.
[148] Other reports commissioned by the Archbishop of Canterbury include: Evangelism (1945); The Church of South India (1950); Relations between the Church of England the Church of Scotland (1951); the Church of England and the Churches of Norway, Denmark, Iceland (1952); Relations with the Church of Sweden

Commission to enquire into the subject of human artificial insemination. The Commission's thorough investigation raised a number of doubts about AID. Key among them was the lack of available data, and the unknown consequences of the practice, both psychological and sociological. The murky legal turf on which AI sat bred further doubts, raising questions of professional liability for doctors and criminal acts punishable by law for all parties involved.

The membership of the inquiry was typical of such Commissions, including experts in matters of religion, medicine, law and society, and an unequal gender balance of male members outnumbering female members with a ratio of more than 3:1. The Commission was comprised of thirteen members, with three women and ten men.[149] These members represented theologians (5 members), medical practitioners (4), lawyers (2), and social organizations (2).

The Archbishop of Canterbury stressed that the report was "not a Church document, nor [was] it addressed to the general public", but was rather to act as a guide for professionals involved: doctors, lawyers, and theologians.[150] The Report, which was addressed to professionals rather than the lay person, stressed the threat that science and technology posed to both society and the family. In the Preface of the Report, the Archbishop cautioned that society was moving too quickly:

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(1954); Commemoration of Saints and Heroes in the Faith of the Anglican Communion (1957); Christian Doctrine (1957); Music in Church (1961).

[149] *Artificial Human Insemination. The Report of a Commission appointed by His Grace the Archbishop of Canterbury* (1948).
The Bishop of London chaired the Commission, which also included E.A. Bennet (Psychotherapist and Psychiatrist); Miss M.L. Harford (Chief Woman Officer, National Council of Social Service); Reverend E.O. James (Professor in Philosophy of Religion); W.P. Kraemer (Doctor); Miss L. Martindale (Surgeon); Reverend W.R. Matthews (Dean of St. Paul's); Alan Moncrieff (Doctor and Professor of Child Health); Reverend R.C. Mortimer (Professor of Moral and Pastoral Theology); Mrs. B.C. Roberts (Secretary of Mother's Union); Sir H.B. Vaisey (Judge); Right Honourable H.U. Willink (previously Minister of Health, 1943-45); Reverend G.L. Russell (Secretary to Commission).

[150] *Times*, 2 August 1948.

> The growth of natural science and of technical skill has vastly increased the extent to which man can control natural processes and direct them to his own self-chosen ends. But the fact that man can now do certain things which before he could not do in no way settles the question whether he ought to do them. Man is always only too ready to say 'What I can do, I may do', without further enquiry. The discovery of the atom bomb has gone a long way to convince him that in fact further enquiry is most necessary. Man's use of his powers must be subordinated to a moral law of some kind. The Christian knows that it must be obedient to the moral law of God. But some of man's recently acquired powers raise so many complex issues and often for the first time in man's history, that expert thought is necessary to discover their precise significance.[151]

Particularly in the aftermath of war, approaching this subject with caution was paramount. The Report was informed by the debates in the *British Medical Journal*, and some of the *BMJ* correspondents also acted as witnesses to the Commission, including Mary Barton and Margaret Jackson. The report's description of the technique of AIH and AID was based on the 1945 medical report in the *BMJ* by Barton, Walker and Wiesner. The Report included a lengthy quote from this medical report on the question of donor selection, stressing the importance of anonymity and the potential reproductive rate of 400 weekly or 20,000 annually per donor.[152] The Report also outlined a historic narrative of the practice, beginning with animal husbandry in the fourteenth century, followed by the human application by John Hunter in the late-eighteenth century and by Marion Sims in 1866.[153] It explained the efficiency of AI in animal husbandry and agriculture, referencing practices in Russia and the 1943 Agriculture Act which made provision for the artificial insemination of livestock as well as "the distribution and sale of semen".[154] The Report also pointed to Marie Stopes' claim that she "popularized the notion of human artificial insemination as early as 1918", and it further referenced reported cases

[151] *The Report of a Commission appointed by His Grace the Archbishop of Canterbury*, 6.
[152] *The Report of a Commission appointed by His Grace the Archbishop of Canterbury*, 10.
[153] *The Report of a Commission appointed by His Grace the Archbishop of Canterbury*, 11.
[154] Three years later, the Agriculture (Artificial Insemination) Act of 1946 made provisions for "the establishment of research centres and for financial aid for a limited period to authorized bodies" like the Milk Marketing Board.
*The Report of a Commission appointed by His Grace the Archbishop of Canterbury*, 11-12.

in the USA of nearly 10,000 AID babies. It was explained that in Britain the practice had existed in "a limited circle for at least 25 years". In Exeter, the proportion of patients attending for sub-fertility increased from one per cent in 1935 to more than twenty-five per cent in 1944, though of all sub-fertility cases AID was "used in just over 1%".[155] Margaret Jackson said of thirty-four AI cases, seventeen were successfully inseminated, thirteen had live births, one still birth, one miscarriage, and two were still pregnant. In her evidence to the Commission, Jackson emphasized the happiness these successful inseminations brought to both husband and wife.

Although the Report included a section entitled 'The Case for AID', it was clear that the Commission was opposed to the practice. The Commission had heard and read reports from "a number of doctors with first-hand knowledge of artificial insemination", who are people with 'sincerity', 'compassion', and a 'deep desire' to help their patients. However, the report raised concerns around secrecy and the possibility that blood tests could establish false paternity claims; and suggested that it was too early on in the practice to know the full consequences – psychological and otherwise – on the child. Jackson had provided extracts from letters written by her patients, with glowing reviews, but this did not seem to sway the Commission.[156] C.P. Blacker also provided testimony to the Commission – Blacker explained that in the cases of which he had first-hand knowledge, the decision was mutual. He had knowledge of eight cases of AID – on the basis of heredity disease. He described the children as having above average mental qualities and being equally attached to their parents.[157] The Report explained that donors received no financial compensation, and the couples inquiring about AID were above-

[155] *The Report of a Commission appointed by His Grace the Archbishop of Canterbury*, 13.
[156] Ibid, 15.
[157] Ibid, 17.

average: "the couples who desire A.I.D. are of more than average intelligence, thoughtfulness and responsibility".[158] Such commentary was suggestive of the 'positive' eugenic application. Most testimony provided to the Commission suggested that it was the husband rather than the wife who first inquired about AID – it was suggested that this was out of a sense of inferiority, guilt and/or disappointment to his wife and a "passionate desire for children".[159] Despite the opposition to the practice, the Report presented an argument favouring AID over adoption, which was based on the biological experience of maternity, the *genetic benefit* of known parentage with a *carefully selected* donor, and the expectation that fewer children would be available for adoption if the pre-war birth rate trajectory continued.[160]

At the centre of the report was a fear for the destruction of the family if biological bonds became less certain. The Report underscored the importance of maintaining unity within the family despite the many threats to its stability:

> The family which has, as a matter of history, been the basic unit of Western society, has suffered during the last two centuries and especially in our own time from numerous assaults from without and increasing stress within. Its economic unity is now largely disintegrated, its moral authority invaded, its cultural functions absorbed by other agencies. Outside the home members of the family are divided by the various occupational and social demands made upon each of them. What remains to unite them is something which cannot be destroyed by the changing patterns of society – their physical kinship…Once the physical basis of these bonds is in doubt and the family's essential kinship called into question, there can be no certainty that the moral obligations erected upon it will survive unshaken.[161]

There was a fixation on the physical bonds, and the uncertainty and potential chaos if this was lost. The Commission also made the point that society had a right to know the 'identity' of an individual – the secrecy of AID went against this. The Commission emphasized the threat AID posed to the basic social structure of British society:

[158] Ibid, 17.
[159] Ibid, 18.
[160] Ibid, 18.
[161] Ibid, 31.

> Our whole social system, as well as our system of law, is based upon the principle that the individual is a member of a family. It presupposes the institution of monogamous marriage.[162]

The Report asserted that advocates of AID had "fallen into the error of regarding the matter as the concern of the husband and wife only".[163] If the assurance of biological kinship was lost – through the practice of AID "[i]t would change the whole basis of society".[164] The legal advisors to the Committee recommended that the law prohibit AID entirely: "In our view, the evils necessarily involved in A.I.D. are so grave that early consideration should be given to the framing of legislation to make the practice a criminal offence".[165]

AID was seen to question "the true ends of sexual activity, or marriage and family life".[166] Marriage was seen as an "exclusive union" and to introduce "any third party by such means" breaches that union.[167] The three purposes of marriage described by the report were "closely related and mutually dependent": procreation; union; and "society, help and comfort".[168] The practice of AID raised the question of "whether such a procedure is, of its nature, adultery". Based on the law, the Commission concluded, "there seems no doubt it is – whatever the motives, circumstances, or consequences may be".[169] However, the report pointed out, there were other considerations: "anything novel and unaccustomed, especially (it would seem) in the sexual sphere, gives rise to

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[162] Moreoever, unmarried motherhood was opposed on the basis of economic considerations (that there was no male parent to provide financially), the welfare of the child (that children should have 'two parents to look to', and donor liability (that he would be liable to maintain the child).
Ibid, 41-42.
[163] Ibid, 42.
[164] Ibid.
[165] Ibid.
[166] Ibid, 43.
[167] Ibid, 45.
[168] Ibid.
[169] Ibid, 47.

spontaneous repugnance and tends to provoke opposition which, though intense and sincere, is rather emotional than rational".[170]

On the question of the eugenic implications, the Commission seemed unclear. The Report outlined the three principal uses for AID: first, in cases of male sterility, second, in cases of hereditary disease of the husband, and third "[i]n cases where…the paternity of a man endowed with outstanding qualities is desired".[171] However, the role of eugenics in practice and in the views of the Commission members is ambiguous. The report referenced the possible use of AID "For Eugenic Ends", in cases where "[t]he eugenic argument has been carried forward". This was followed by a lengthy quote by Julian Huxley on "the opportunity of eugenics" in artificial insemination.[172] However, as far as the Commission was aware, such eugenic applications remained hypothetical.[173]

The members compiled the majority of the Report in a collaborative fashion yet, interestingly, two Commission members wrote the legal section of the report independently. Justice Harry Vaisey and Henry Willink, previously the Minister of Health, were emphatic in their opposition to AID on legal grounds. They pointed out that the issues so far had not appeared in English courts, however it had been dealt with by the Ontario Supreme Court in *Orford v Orford* in 1921. They were absolute in their position: "We entertain no doubt at all that the act of both a married 'donor' and a married recipient constitutes adultery".[174] Further, they supported the view that a child conceived

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[170] The report also speculated about the possible impact of the application of AID in sex determination – namely that marriage might not survive as an institution if sex determination led to a severe gender imbalance.
Ibid, 33, 49.
[171] Ibid, 7.
[172] Ibid, 8.
The report's reference to the eugenic application referred to *The Uniqueness of Man* by Julian Huxley.
[173] Ibid, 32.
[174] Ibid, 37.

by AID was illegitimate, and warned that the false registration of birth would be considered a criminal act under the 1911 Perjury Act, which carried a seven year sentence.[175]

While the Commission demonstrated a certain level of compassion towards couples experiencing infertility, they were still adamant that AID was morally wrong. They posed the question: "On what rational ground is it urged that while *sexual* desires ought not to be indulged at will, *parental* desires may be?"[176] It also described AID as an unnecessary human gratification: the practice presupposes "that because we want a thing so much it might be right for us to have it" but it rejects "the very idea of limitation, acceptance, of a given natural order, and social frame".[177] By introducing a medical means to assist conception, the Commission believed that AID eliminated the personal nature of marriage and commodified reproduction:

> The suppression of the full personal character of sexual activity is a most significant and ominous feature of our time. Its effect is the prostitution, not of a class of women, but of womanhood itself – which is thenceforth valued less for personal than for explicitly sexual qualities.[178]

Ultimately, the Commission concluded that AID did not fulfil the ends of marriage.[179] The Report further said that having a child does not ensure the success of a marriage, therefore this was not a valid argument in favour of AID. It recommended people have a medical exam before they get married to avoid learning of infertility later on. The Commission raised other concerns: donors running wild, fathering 'excessive numbers of children' which could lead, unknowingly, to 'the intermarriage of children of the same

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[175] Ibid, 39.
[176] Ibid, 50.
[177] Ibid, 50.
[178] Ibid, 51.
Interestingly, this point about reproductive technologies as a transaction that exploits women has something in common with the feminist positions from the 1980s in opposition to reproductive technologies.
[179] Ibid, 55.

father'.[180] Their final recommendations accepted AIH, but asserted that AID 'involves a breach of the marriage', is 'wrong in principle', and legislation to make AID a criminal offence should be considered.

The only dissenting voice in the Commission's Report came from Walter Robert Matthews, who was the Dean of St. Paul's Cathedral (1934-67) and an active writer of religious philosophy.[181] Matthews was not a proponent of AID, but rather disagreed with the Commission's assessment as too impulsive. He believed the members were too eager to reach an "absolute judgement" on an "imperfectly understood" issue: "[a]fter all, one should be cautious in adding to the list of deadly sins".[182] He agreed that under the current legal system, AID appeared to be illegal. He did not agree with the suggestion that AID be made a criminal offence for two reasons: first, if AID was already illegal any legislation would be unnecessary; and second, that any law would be difficult to enforce. He stated a repugnance to the concept of AI broadly speaking, less on a superficial level and more because it "tends to reduce life to mechanism and…would degrade our conception of personality".[183] He further pointed out that much of the psychological implications were purely speculative, as there was no evidence of the effects of the practice. In fact, he was of the belief that the evidence given to the Commission pointed to the welfare of the woman being improved by AID, when "the marriage itself is happier

[180] Ibid, 56.
[181] Matthews also spoke out in favour of voluntary euthanasia, giving an address at the Voluntary Euthanasia Society on the ethical aspect in 1950. In 1961 Matthews became an Honorary Fellow of the Eugenics Society, and that year he gave the Herbert Gray Lecture on 'Eugenics and the Family' in which he "address the 'population explosion' and the threat it posed to the welfare state".
For additional biographical information see H.P. Owen, 'Matthews, Walter Robert Matthews', *Oxford Dictionary of National Biography*, (Oxford University Press, 2004). On Matthews' involvement in the voluntary euthanasia movement see Norman St John-Stevas, *Life, Death and the Law*, 269. For Matthews' involvement in the Eugenics Society see Alan P.F. Sell, *Four Philosophical Anglicans*, (Eugene, OR: Wipf & Stock Publishers, 2010), 137-138.
[182] *The Report of a Commission appointed by His Grace the Archbishop of Canterbury*, 59.
[183] Ibid, 60.

and the husband consequently benefits".[184] He saw no evidence of psychological suffering on the part of the child since AID created "[a] real home which consists of parents and child".[185] Matthews was pro-family, though not pro-AID.

Matthews' key opposition was that the Commission had ruled on an issue without thought for the future. Matthews disagreed with two main points in the Theological section of the Report. First, that it assumed "a static view of nature and of man…It might have been written by men who had never heard of evolution". His second criticism was that the Report took a "static view of society" presuming that the family will not change its form. Matthews stressed the naturalness of change, and that it should be anticipated. It was not about holding strong to things as they were, but rather being open and unafraid of change, so long as it was within the ethic of the Christian law of love.[186] Matthews emphasized that "Christians ought not to identify their religion with things as they are, even in the case of the family. Like all human things, it will change".[187] He cautioned against such an extreme position as making the practice a criminal offence: "If we are to condemn A.I.D. absolutely, we must hold that, under no conditions, could it ever be right."[188]

Without any existing recommendations for best practice, the Report set out to provide some basic regulatory suggestions. The Appendix laid out measures for medical practitioners to follow, prepared by the Medical Defence Union. It advised that doctors obtain a written request from husband and wife, stating who the donor would be. The couple should be over 21 years of age, and it should be explained to them that there are

[184] Ibid.
[185] Ibid, 62.
[186] Ibid, 63.
[187] Ibid, 63.
[188] Ibid, 61.

no guarantees. Fears of scientific intervention in human affairs were apparent in the language of this report, as the Commission recommended that in the case of AID, an "alien donor" should sign a consent form. Furthermore, the practitioner risked being charged with negligence, being complicit in the dissolution of marriage, and/or conspiracy.[189]

## Conclusion

The double-edged sword of scientific advancement was illuminated in official discourse on artificial insemination during, and immediately after the Second World War. On the one hand, reproductive technology opened new doors for family building, while on the other, it played into existing fears of an increasingly mechanized world and the dehumanization of reproduction. The House of Lords discussion, the *BMJ* correspondence debate, and the Archbishop of Canterbury's Report frame the key concerns that persisted through the 1940s and 1950s: the potential consequences of scientific advancement, the legal definitions of parent and child, and the role of biological

[189] Consent form templates were included in the appendix, both for the husband and wife, and for the donor.Thus, the Report established a set of guidelines and also a framework that would guide discussion on the subject of A.I.D. over the following decades. The document outlined three main concerns in the practice:

1. Negligence – the following precautions should be observed: the donor should not be related to either spouse; the donor's medical and personal history should be closely investigated (including "such tests as a Wasserman, a complete blood count, compatible Rh factor and full general examination to eliminate T.B., diabetes, epilepsy, endocrine dysfunction, psychosis"); the donor's fertility should be examined; he should be no more than 40 years old; the "characteristics and race" should be similar to the husband; before using semen from a 'bank' the medical practitioner should be confident of its professional standing.
2. Possible proceedings of dissolution of marriage – the recommendation that everything be done to ensure that both the patient and her spouse, and the donor and his spouse fully understand and give consent to the procedure to avoid divorce in future.
3. Alleged conspiracy – there was the chance that a medical practitioner could be sued for falsifying legitimacy for a child born by AID (who wouldn't be a rightful heir to an estate, etc). It was suggested that the medical practitioner obtain "an assurance in writing that the birth of a child by the wife would not defeat the claims of any persons contingently interested in default of their having issue".

kinship in conceiving the family. These three sites of official discourse constructed a framework that defined the parameters for debate around assisted conception until 1960.

This narrative has followed commentators in the House of Lords, to the *British Medical Journal*, in the House of Commons, and through a social investigation spearheaded by the Archbishop of Canterbury. Discussion in the House of Lords over the 1943 Agriculture Bill, which approved artificial insemination for livestock in order to increase domestic produce, also raised the implications of human AI. The debate in the correspondence pages of the *British Medical Journal* vented the range of concerns implicated in the procedure, at the centre of which was family life and the extent to which science should insert itself into conception. It also, naturally, became a discussion of the role of the medical profession itself and the potential legal liability of participating in assisted conception and falsifying a birth certificate to grant legitimacy. Fears that took hold during the war over a declining population and birth rate, and increasing rates of illegitimacy and divorce, heightened concerns around artificial insemination. For some doctors, AI was seen in a pronatalist and eugenic context, while for others it was condemned on moral grounds and as a threat to the family. Without an explicit description of the procedure published until 1945 in the *BMJ*, most opposition to the practice was based solely on speculation. Medical opponents to AI focused on its threat to marriage, and the ambiguous legal status of both parent and child through donor insemination. Among both its advocates and opponents, eugenic principles were an undercurrent in the discussion over assisted reproduction. In a House of Commons discussion in March 1945, it became clear that Parliament and the Minister of Health were unaware of the scope of the practice and, following evidence implicating Nazi

experimentation, in December 1945 the Archbishop of Canterbury commissioned a report on the subject. The Archbishop's Report of 1948 presented a thorough survey of the practice, yet its ultimate conclusion that artificial insemination was a 'breach of marriage' and should be made a criminal offence was largely informed by a fear of science and its potential destruction of family life. The Report was used as an authoritative marker until the Feversham Report was published twelve years later in 1960. These debates over artificial insemination therefore shed light on a critical period in the development of reproductive medicine.

When set in context, it is hardly surprising that this seemingly 'disruptive' technology provoked such exaggerated concerns. The family was central to reconstruction in Britain from 1943 onwards, and after the bombing of Hiroshima and Nagasaki in 1945 there was a greater wariness around the prospects of scientific 'advancement'. The potential of AI also disrupted assumptions of traditional gender roles, by suggesting the possibility of upsetting the delicate domestic power balance if men's reproductive value could be commodified. What did it mean for the future of Britain if women were both economically independent and less physically reliant on men to reproduce? Following the recommendation from the Archbishop of Canterbury's Commission that AID was a 'breach of marriage', the next chapter will examine AID and the idea of the 'test tube baby' within the context of marriage by tracking legal cases, political discourse, and popular culture.

# *Chapter 4*

## *Breach of Marriage? Legal, Political, and Popular Discourses of 'Test Tube Babies', 1948–58*

Between 1948 and 1958, 'test-tube babies' and their effect on marriage became a subject of intense debate in the courts, in Parliament, and in popular culture.[190] Two *Daily Mirror* headlines, published nearly a decade apart, are representative of this preoccupation with artificial insemination, triggered by legal cases of marriage dissolution:

> 'Nullity Makes a Test-Tube Baby Illegitimate'
> *The Daily Mirror*, 1 December 1948
>
> 'Test-Tube Babies and Divorce, Not Adultery Rules a Judge'
> *The Daily Mirror*, 11 January 1958

The first case, in December 1948, involved thirty-one-year old Mrs 'L', who was granted a decree of nullity in a London court. This ruling rendered her two-month old son – conceived via artificial insemination by husband – illegitimate. After five years of marriage, she had petitioned for an annulment on the grounds that her thirty-seven-year old husband was unable to consummate the marriage.[191] The wife and husband had discussed artificial insemination as a solution to their problem, and in December 1947, sought AIH by an expert. She left her husband in January 1948, not knowing she was pregnant. Judge Pearce, presiding over the *R.E.L. v E.L.* case, said:

> The wife seemed to me to try hard under very trying conditions to make a success of the marriage which reflected considerable strain and humiliation on a

[190] The latter section of this chapter is included in a forthcoming publication. See Hayley Andrew, ''Phantom Fathers' and 'Test Tube Babies': Debates on Marriage, Infertility, and Artificial Insemination in the British Media, c.1957-60', in Tracey Loughran and Gayle Davis (eds), *A Handbook of Infertility in History: Approaches, Contexts and Perspectives*, (London: Palgrave MacMillan, 2016).
[191] 'Medical Notes in Parliament', *British Medical Journal*, 18 December 1948.

> woman…She left because the sex side of her married life was intolerable to her – and for no other reason".[192]

The Judge explained that it would be better for the child to become illegitimate than to be brought up by an "embittered mother tied to a marriage that had never been a *real marriage* and which only through the *unnatural aid* of science had produced the fruit of marriage" [emphasis added].[193] The second case began nine years later, in December 1957. Ronald MacLennan of Glasgow sued his wife, Margaret MacLennan, for adultery on the basis that she had given birth to a child as a result of artificial insemination by donor without his consent. Margaret was Australian and had been a professional figure skater, but since the birth of her daughter in 1956 had been living in Brooklyn, New York working as a nurse. The question under consideration in *MacLennan v MacLennan* was whether a wife who had a child as a result of AID could be said to have committed adultery.[194] Lord Wheatley, who presided over the case, said that as AID did not come within the definition of intercourse it therefore could not legally be ruled adultery. Yet he did go on to say that it was nevertheless a "grave breach of the marriage contract" and ultimately granted Ronald MacLennan a divorce.[195] Both cases were focused on the means of conception, and the parameters of the marriage contract.

These two controversial judicial rulings – one, concerned with nullity and illegitimacy, and the other with adultery and divorce – were the first of their kind in Britain, and led to heightened media attention around AI and spurred political debate. In both 1949 and 1958, the Cabinet Ministers and the House of Lords responded to these legal cases and discussed artificial insemination with the aim of establishing a

[192] *Daily Mirror*, 1 Dec 1948, p.5.
[193] 'Unusual Ground for Nullity Decree', *The West Australian*, 1 December 1948, p.4.
[194] 'Question of Adultery', *The Times*, 6 December 1957.
[195] 'Test Tube Baby Ruling', *Daily Mirror*, 11 January 1958, p.20.

governmental inquiry into the practice, with the latter session achieving its goal with the creation of the Feversham Committee. Bookended by these two legal cases involving marital breakdown, this chapter will analyze the discourse around artificial insemination during this period and suggest that through the lens of AI we can see the ways in which attitudes to marriage and illegitimacy changed by the late 1950s.

Artificial insemination represented the junction of science and marriage. But when science interfered with the family, as artificial insemination did, this intersection became a public concern. The manipulation of human reproduction in an era of dramatic scientific advancements, combined with a cultural preoccupation with marriage (and its apparent decline), provided ripe ground for speculation about a 'brave new world'. Scientific discovery, changing gender roles, and pronatalism converged over the issue of artificial insemination, sparking social anxieties. Although on the surface the 1950s appeared to be a period of stability, there were a number of destabilizing forces at work that threatened the security of the family. There was a moral panic over adultery and homosexuality, increased immigration and concern over 'dark strangers', growing numbers of married women in the workforce, and increasing divorce and illegitimacy rates – all of which appeared to threaten the British family unit.[196] At a time of exponential media growth, this instability resulted in a decade-long media preoccupation with marriage and divorce, which often included reference to artificial insemination. 1958 marked a critical moment in this history. The chapter will examine the way in which the courts, government, and media framed artificial insemination as a 'new' medical

[196] See, for example, Chris Waters, 'Dark Strangers in Our Midst: Discourses of Race and Nation in Britain, 1947 – 1963', *Journal of British Studies*, 36 (April 1997); Pat Thane, *Unequal Britain*; Chris Waters, 'Disorders of the Mind, Disorders of the Body Social: Peter Wildeblood and the Making of the Modern Homosexual'; Frank Mort, 'Cityscapes, Consumption, Masculinities and the Mapping of London since 1950'; Claire Langhamer, 'Adultery in Postwar Britain'.

technology, and it will consider how the idea of the 'test-tube baby' reflected anxieties over the state of marriage, and the prospects of science, in the postwar period. It will look at different mediums including theatre, film, television, and print media; and by considering the political and legal context it will address the threat assisted conception was seen to pose to the social unit of 'The Family'. Discourse around artificial insemination in the 1950s is revealing of acute social anxieties over marriage, family, gender roles, and the future. I will argue that popular culture and the media acted as agents of change in framing perspectives on artificial insemination for public consumption. This chapter also questions how and if this media influence shaped the law. Sensational legal cases drew public attention to AI – which was played out through the media – and the state was reluctantly drawn into the discussion. By 1958, interest in AI had reached a fever pitch and the government was thus forced to convene an official inquiry into the practice.

This chapter uses political discourse and popular culture as a lens through which to examine a particular historical moment, when the rise of assisted reproductive technology intersected with social anxieties. AI seemed to present a particular threat to hetero-normative marriage, to the extent that it was recommended as a new ground for divorce. These social concerns were not new; AID became part of a discussion about marriage and gender roles that was already underway. Social anxieties of the 1940s and 1950s disproportionately magnified the practice of AID – and the media and popular culture gave rise to a false belief of its pervasiveness.

The heightened social sensitivity around marriage and gender roles created a ground ripe for debate over donor insemination – with its implication of adultery,

illegitimacy, and male sexual incompetence. AID was seen to mirror an extra-marital affair – the donor posing as the 'lover' causing a breakdown in the marriage of husband and wife. The norm of heterosexual marital sex –whether for pleasure or reproduction – was challenged by a syringe. Heightened concern over divorce, illegitimacy and sexuality found a welcome landing site on the issue of donor insemination, as a place to moralize and reassert 'family values'. In the 1950s, reproductive technologies increasingly became a platform for public debate, a contrast from being confined to the medical community and government in the previous decades. But with growing public consciousness and awareness came fears of a technology that threatened to unhinge 'normal' family life.

**The Law and Politics of Artificial Insemination, 1948-49**

Following closely on the heels of both the Archbishop of Canterbury's Commission Report and the ruling on *R.E.L. v E.L.*, in late 1948 artificial insemination once again became the subject of political debate. In the House of Commons in December 1948, MP Tom Driberg (Labour) asked Prime Minister Clement Attlee to consider the appointment of a Royal Commission to examine both the legal and social implications of artificial insemination, particularly AID, with attention to the problems of legitimacy and inheritance. The Prime Minister responded that he wanted to first see the Report on the Royal Commission on Population. Shortly after this initial discussion on 17 January 1949, the Cabinet discussed the possibility of a Royal Commission on divorce law. MP G.W. Odey (Conservative) was to address the Prime Minister on 18 January to request the Government set up a Commission to examine the divorce laws, including the place of AI.[197] The Lord Chancellor said that sooner or later there would need to be a

[197] National Archives, London, CAB/128/15, C.M. (49), 17 January 1949.

commission to deal with issues such as artificial insemination, but the preference was to postpone such discussion until after the election.[198] The Prime Minister agreed that postponement was the best 'solution', and at "some later date it might be right to institute some form of enquiry".[199] This delay tactic became a common feature of political strategy on the subjects of reproductive technologies.

Parliamentary discussion was followed by debate in the House of Lords on 16 March 1949, addressing the problems of legitimacy and artificial insemination.[200] The Marquess of Reading and Lord Brabazon called attention to the recent judicial decision, ruling on the legitimacy of children in cases of nullity. They focused on the case of *R.E.L. v E.L.* in which the child was made illegitimate because in law the marriage had never existed. The law of nullity presented a number of problems, one of which was in cases of artificial insemination. The Motion introduced in the House of Lords had the well-being of children at its heart. The Marquess of Reading, who was the key figure in leading discussion on the subject in 1949 and 1958, introduced the issue.[201] He presented the opposing views on the practice and drew attention to the increased public interest in the matter:

> The question of artificial insemination practised among human beings is, I realise, one which some people may regard as beneficient and advantageous, and as a scientific development for which humanity ought to be grateful. On the other hand, there will be many people who will view it with horror and repugnance, and devoutly wish that it had never been devised. But the fact remains, and has to be faced, that it does exist, and is, I believe, increasingly practised. It is a question which is nowadays not infrequently discussed in the Press. It is a question which

[198] There was some agitation from the Marriage Reform League, but they were mainly lobbying to make separation grounds for divorce.
[199] National Archives, London, CAB/195/7, C.M.4(49), 17 January 1949.
[200] 'Problems of Legitimacy and Artificial Insemination', House of Lords Debate, 16 March 1949, vol 161 cc386-429. Accessed http://hansard.millbanksystems.com/lords/1949/mar/16/problems-of-legitimacy-and-artificial
[201] Gerald Isaacs, 2nd Marquess of Reading (1889-1960) succeeded his father in 1935.

> forms the subject, objectively and sincerely treated, of a play running at this moment in London.[202] [this play was *Breach of Marriage*]

The press was little interested in this Lords' debate, with only the *Times* and *Guardian* publishing matter-of-fact reports of the proceedings.[203] Three other peers took part in the debate, and diverged on the key issue of whether a government inquiry should be made. The Lords' debate considered the consequences of legislation that would make AID a criminal offence, as recommended by the Archbishop of Canterbury's 1948 Report. The Marquess of Reading was firmly against the suggestion that AI be made a criminal offence, for fear of "driving it underground and forcing it into clandestine and uncontrolled use".[204] Lord Chorley concurred that making it a criminal offence would drive it underground, and he did not believe such legislation would be in line with public opinion: "To make that sort of thing a criminal offence would undoubtedly shock a large number of people".[205] This particular point underlines the importance of public opinion in drawing conclusions pertaining to family law. Primarily though, the debate drew attention to legal inconsistencies. Lord Merriman, Lord Brabazon, and the Marquess of Reading pointed to the lack of coherence in the law as it pertained to legitimacy, nullity, and adultery. The Marquess of Reading highlighted the irony in legal decisions about AI: "in the case of artificial insemination by husband, the marriage can be annulled because there has been no consummation of the marriage…whereas on the other side [with AID]

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[202] 'Problems of Legitimacy and Artificial Insemination', House of Lords Debate, 16 March 1949, vol 161 cc386-429. Accessed http://hansard.millbanksystems.com/lords/1949/mar/16/problems-of-legitimacy-and-artificial

[203] On the limited reporting see, for example, 'Lords Debate on Artificial Insemination: Call to Government on Inquiry', *Times*, 17 March 1949; 'Artificial Human Insemination: Government urged to set up a Royal Commission', *Guardian*, 17 March 1949. The Lords' Debate also appeared in the Canadian press: 'Artificial Insemination Scored by Canterbury', *Globe and Mail*, 17 March 1949.

[204] 'Problems of Legitimacy and Artificial Insemination', House of Lords Debate, 16 March 1949.

[205] Ibid.

Robert Chorley (1895-1978) served in the House of Lords from 1945 to 1978 – the title was newly created in 1945.

it can be put forward as an instance of adultery, because for that purpose it is regarded as extra-marital intercourse".[206] Therefore, he stressed, the same medical procedure can result in two vastly different legal conclusions when a marriage was dissolved. Lord Brabazon pointed to the same problem:

> It would seem to me that there again the law has got to 'get into step'. Actions of a man relative to a woman to whom he is not married constitute adultery, whereas the same actions of a man relative to a wife can be used as ground for pleading non-consummation of marriage. These two things must be brought together from the point of view of the law; otherwise the situation is nothing short of ridiculous.[207]

When sex was separated from reproduction, it demanded new legal interpretations. Lord Merriman weighed in saying the notion that AID was adultery was 'absolute nonsense': "So far as I know, it has always been accepted that sexual intercourse, in the ordinary sense of the word, is necessary to constitute adultery…the man and the woman must be, as it were, personally concerned". [208]

The tone of the debate was not sympathetic to artificial insemination, but criticized its practice and, above all, called for an investigation and legal ruling on its position in Britain. Criticism was directed at donors, and concern was expressed over false registration, inheritance, incestuous marriage, and the possibility of unmarried women becoming mothers via AID. Lord Merriman stressed the importance of some kind of registration to avoid half-brothers and half-sisters marrying and reproducing a generation on. Lord Brabazon was particularly critical of the unknown donors:

> Now I would like to say a word about these curious people called 'donors'…anyone who wished to be a donor must be a megalomaniac of the first order, and consequently not sound in mind…[and] on the way to a lunatic asylum. Be that as it may, I do not believe that in any country of advanced social type such as ours there will be found many people who will consent to be donors. I sincerely hope that if they are ever discovered, they will be ostracised by society.[209]

[206] Ibid.
[207] Ibid.
[208] Ibid.
[209] Ibid.

The purpose of the debate was to raise the question of an official investigation into the matter – however, following so closely on the Archbishop of Canterbury's Commission, neither the Lords nor the Ministers were particularly interested in pushing it forward. The Marquess of Reading stressed the urgency for a decision to be made on the matter, in part to guide public opinion:

> It is admittedly a subject of very acute controversy and divergence of opinion, and one which raises any number of problems…I think it is a subject upon which public opinion in general is asking for a lead, whatever that lead may be and in whatever direction it may tend.[210]

He went on to call for the appointment of a Royal Commission or Departmental Committee to investigate the issues: "…this matter has now reached the stage in its development at which it can no longer be conveniently shelved or ignored. It is essential that the public should know without delay where they stand". [211] Lord Brabazon (1884-1964), who originally brought the subject to the House of Lords in 1943, explained the importance of an inquiry, quoting his original 1943 speech:

> …in my life I have seen science run ahead of human wisdom, with the result that in the aeroplane we produced out of our technical skill something which has very nearly destroyed civilisation itself. If that is true in the mechanical world, surely it is even more important that we should know all about other advances in other walks of science which are sure to have the most tremendous repercussions.[212]

This statement should not be characterized as an unthinking or throw-away comment. Brabazon himself was a pioneer aviator, and served as Minister of Transport and Minister of Aircraft Production during the Second World War, until he was forced to resign and entered the Peerage in 1942.[213] Certainly, his observation about the negative potential of

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[210] Ibid.
[211] Ibid.
[212] Ibid.
[213] In February 1942, Brabazon was reported in the press as hoping the "German and Russian armies would annihilate each other" after which Churchill requested his resignation and offering him a peerage. Kenneth Rose, 'Brabazon, John Theodore Cuthbert Moore', *Oxford Dictionary of National Biography*, (Oxford University Press, 2004), Online edition, January 2011.

airplanes was informed by the bombing campaigns in Britain and, of course, later in Japan. To a twenty-first century reader, it may seem a poor comparison – airplane bombing during the war leading to the deaths of hundreds of thousands of people, and the practice of artificial insemination by a few hundred people per year – however, such commentary underscores this fear of science and its potential applications.

The majority opinion of the Lords' was that no action needed to be taken at that point in time. Although Merriman said he supported an inquiry and called for action sooner rather than later, Lord Chorley argued that until the Royal Commission on Population reported, there should not be an investigation (whether by Commission or Committee) into artificial insemination. He concluded this on the basis that the question of AI "is to a considerable extent governed by the question of fertility, which is one of the important matters into which the Commission are going". [214] The Archbishop of Canterbury responded that he did not see fertility as having anything whatsoever to do with AI. Lord Chorley was of the opinion that the problems that would arise from AI – such as legitimacy and inheritance – should be dealt with by the courts on a case by case basis through Common Law – and did not immediately demand a formal investigation. The Marquess of Reading criticized the lack of action on the part of the Government:

> …all the Government say is that they are going to give it consideration. Well, one knows perfectly well what that means. It means that they are going to give it refrigeration and nothing else, and that is what they will continue to do…I am very reluctant to withdraw this Motion, but with the consent of the House I suppose I shall have to do so." [215]

[214] 'Problems of Legitimacy and Artificial Insemination', House of Lords Debate, 16 March 1949.
[215] Ibid

The Motion was withdrawn because there was no consensus to have an inquiry until after the Royal Commission on Population had reported, which followed three months later in June 1949.[216]

## Popular Culture and Politics converge

While politicians and legislators waited for a more suitable time to tackle artificial insemination, popular culture took the reigns in guiding public opinion. At the time of the House of Lords debate, public opinion was already being shaped by a stage play in London's West End. The play, mentioned by the Marquess of Reading in the debate, was called *Breach of Marriage*, which opened at the Duke of York's Theatre in January 1949.[217] Even before it opened, the Press anticipated the effect the play might have on public opinion, and even legislation:

> A play about to take the West End stage may well… awaken the sort of public opinion that forces legal changes…It brings the problem of AID into fine focus. It shows not only the tragedy of the childless couple but also the tragedy which AID might bring – one worse than any it sets out to alleviate.[218]

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[216] The Royal Commission on Population "promoted pro-natalist policies that would help maintain the 'Britishness' of the United Kingdom", and discouraged the immigration of non-white Commonwealth citizens.
John E. Roemer, Woojin Lee, Karine Van Der Straeten, *Racism, Xenophobia and Distribution: Multi-Issue Politics in Advanced Democracies*, (Cambridge, Mass.: Harvard University Press, 2007), 136.

[217] *Breach of Marriage* was first shown from Oct-Dec 1948 at the Torch in London (off Knightsbride). The Torch was a private theatre and the play was therefore not subject to censorship by the Lord Chamberlain's Office. It opened in a public West End theatre in January 1949. *The Cambridge History of 20th C English Literature* groups it with other postwar plays at "non-commercial theatres that attempted to break away from the formulas of West End theatre with works by unestablished writers [which] played a vital role in compensating for the lack of opportunities elsewhere, but these 'fringe' ventures were short-lived as they succumbed to the adverse economic climate"
Laura Marcus and Peter Nicholls (eds), *The Cambridge History of twentieth-century English Literature*, (Cambridge: Cambridge University Press, 2004), 497.
*Breach of Marriage*, unlike many other private ventures, turned out to be a trans-Atlantic success. It was surprising that the Lord Chamberlain's Office approved the play, when "many previous plays dealing honestly and sincerely with the problem of sexual relationships have been vetoed". Interesting, the play was publicized in a number of different Australian newspapers in the Winter of 1948, despite the play never travelling there.
See: *Observer*, Oct 1948; 'Controversy Dogs this A.1. Play', *Mirror* (Perth, Australia), 13 November 1948, p.14; 'Test Tube Drama', *Morning Bulletin* (Rockhampton, Australia), 27 Nov 1948, p.5; 'Breach of Marriage', *The Spectator*, 4 February 1949, 150.

[218] *The Star*, 24 November 1948.

Written by Dan Sutherland, a 45-year-old ex-soldier, the play followed a husband and wife who were unable to conceive naturally and, as a result, turn to artificial insemination. The couple visits Dr Erasmus Baring at his research centre, and explain that their marriage is threatened because the husband's war injuries have made it impossible for him to biologically father a child.[219] The wife wanted to postpone childbearing until after the war when her husband was no longer in service, and is wracked with guilt believing that the delay in starting their family is her fault. After examining the husband, who is in a wheelchair, the doctor concludes that he is 'tubercularly diseased'.[220] The wife begs the doctor not to reveal the diagnosis to the husband, and to perform AID without her husband's knowledge.[221] The 'anonymous donor' is Dr Baring's medical assistant – who is about to leave for Africa. The 'tragedy' of the play strikes when the husband finds a letter that reveals his medical condition, and realizes that a donor had been used to impregnate his wife – he deduces that the donor could have only been the young doctor, who is now back from Africa. The husband is so upset by the implicit deceit that "he wheels himself off to the nearest railway station and throws himself under a train", driven to suicide after discovering the donor's identity he meets a tragic death.[222] The play was shut down after only a four-week run, despite relatively good reviews[223] and receiving the required approval from the Lord Chamberlain's Office (that

[219] W.J. Igoe, 'Breach of drama', *Catholic Herald*, 22 June 1951, 4.
[220] Igoe, *Catholic Herald*.
[221] Ibid.
[222] 'Breach of Marriage', *The Spectator*, 4 February 1949, 150.
[223] The play received mixed reviews. Although the *Catholic Herald* gave it a scathing review – describing it as "sentimentality crudely whipped into melodrama" – *The Spectator* offered a lukewarm review saying that "it is not at all bad", and the *Daily Mail* described the play as "a very good one". The *Daily Express* described it as "a play well worth seeing". The *New York Times* summarized the positive critical reviews from the *Daily Mail* and the *Times.*
For reviews of the play see W.J. Igoe, *Catholic Herald*, 1951; 'Breach of Marriage', *The Spectator*, 4 February 1949, 150; Louis Calta, 'Drama Humming on Rustic Circuit', *New York Times*, 9 June 1951, p.13; 'This plot is shattering', *Daily Express,* Jan 26 1949,p.5; 'London Sees New Play', *New York Times*, 27 January 1949.

surprisingly only deleted two words from the original script).[224] The public interest in the play was obvious: even before it opened in the West End, there were eight bids, all from different countries, for the film rights.[225] Despite its short run, it was nevertheless revived in London in 1951 and went on to tour across the UK and North America with showings in Toronto, Boston, New York, Edinburgh, and closing in Dunfermline, Scotland in early 1952.[226] The husband's tragic suicide, preventing any possible marital reconciliation, was likely shocking to the original audience and it was therefore decided that before touring, the London audience would be shown three different conclusions to the sensational plot – one happy, one tragic, and one dramatic. It was intended that whichever received the most applause would be used for the performances in North America.[227] It is unclear which ending was deemed a success, however a teleplay revival in 1958 – addressed later in this chapter – suggests a preference for a 'happy' ending.

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[224] 'Wrote and Tore up 30 Plays: 31st is a Hit', *The Sydney Morning Herald*, 1 Dec 1948, p.3.; Louis Calta, 'Drama Humming on Rustic Circuit', *New York Times*, 9 June 1951, p.13.

[225] '8 Lands Bid for New U.K. Play on Artificial Insemination', *Globe and Mail*, 2 December 1948.

[226] Later stagings of the play included the following:
Summer 1949: London -- Palace Theatre in Watford
June 1951: London -- Scala Theatre
July 1951: Toronto – Royal Alexandra Theatre **it was announced to be opening in Toronto, but the *Globe* did not follow this up with a review
August 1951: Boston
August 1951: New York – Ziegfeld Theatre
November 1951: Edinburgh -- Gateway Theatre
December 1951: London -- Theatre Royal
May 1952: Dumfernline, Scotland – Opera House
1957: Bristol.
For reports on these showings see: 'Palace Theatre, Watford – Full list of productions'. Yumpu. https://www.yumpu.com/en/document/view/8377773/palace-theatre-watford-full-list-of-productions-doolleecom/43 accessed on 10 March 2016; 'Breach of Marriage'. Scottish Theatre Archive. University of Glasgow, Special Collections. http://special.lib.gla.ac.uk/sta/search/resultsda.cfm?AID=1; 'Scala Theatre, Breach of Marriage', *The Times*, 15 June 1951; 'Audience to Rule on Play's Ending', *The Globe and Mail*, 12 June 1951, p.10; Louis Calta, 'Drama Humming on Rustic Circuit', *New York Times*, 9 June 1951, p.13.

[227] 'Audience to Rule on Play's Ending', *The Globe and Mail*, 12 June 1951, p.10.

**Popular Representations of Marriage and Divorce**

Popular representations of artificial insemination reflected the period's preoccupation with marriage, and the risk of divorce. The implication of adultery through donor insemination became the undertone in much of the public discourse, as did concerns over secrecy, jealousy, and donor identity. Reflective of the instability of the 1950s, these concerns played into ideas about gender roles, and marriage. In the wake of the Second World War, divorce rates climbed to unprecedented levels.[228] There were a number of factors that may have contributed to the rising divorce rate: wartime separations; loosening of the divorce laws in 1937; the implementation of Legal Aid in 1950 that enabled ordinary people to use divorce courts at a reduced cost; and/or the demographic fact that people were living longer and thus marriage was a longer life commitment than it had been previously.[229] With a particularly high number of men filing suits after the war, more attention was paid to wifely infidelity. Statistics recorded after the war seemed to suggest that more wives were having extra-marital relationships than at any time before. In the peak divorce year of 1946, husbands initiated two-thirds of petitions.[230] In 1949, a Mass Observation survey showed that one wife in every five and one husband in every four admitted to extra-marital relations.[231] This trend appeared to continue since between 1950 and 1970 "the proportion of divorces granted to men which cited wifely adultery as grounds rose significantly".[232] As Claire Langhamer has argued,

[228] The average annual number of divorce petitions grew from 4785 in the early 1930s, to 16,075 in wartime, to 41,704 in 1946, and only going back down to 38,382 in 1951. To put it another way, the proportion of marriages ending in divorce had climbed from 1.6% in 1937 to 7.1% by 1950, declining only slightly to 6.7% in 1954.
See Thane, 'Family Life and Normality', 198.
[229] Thane, 'Family Life and Normality', 198.
[230] Langhamer, 'Adultery', 94.
[231] Ibid, 87.
[232] Ibid, 97.

the pressure and expectation embedded in companionate marriage made marital infidelity more, rather than less, likely in this period.[233]

The media was active in constructing social boundaries for marital relationships. Newspaper quizzes and questionnaires in the popular press attempted to define successful marriage and acceptable gender roles, and by engaging readers in this way demonstrated "a move to more explicitly and boldly create norms and ideals amongst readers".[234] These newspaper quizzes constructed standards for marriage: on one hand, reinforcing the ideal of companionate marriage, while on the other hand suggesting that things had gone too far in equalizing gender roles. For example, in October 1949, the quiz 'Am I a Good Husband?' appeared in the *Daily Mirror*. The 'right' answers encouraged men to give their wives a "domestic holiday" once per week, and for those men who *agreed* to their wives working full-time, the quiz suggested that husbands should "set the table and have the kettle boiling if you're the first home".[235] But there was a backlash to the growing number of women entering the workforce. In 1955, the *Daily Mirror* asked readers, "How do YOU rate as a mate?"[236] The parameters of the quiz implied that a married woman's place was in the home – with the responsibility of maintaining a clean and tidy appearance, keeping the household budget, keeping the house in good order, and being able to entertain a dinner party at short notice with limited ingredients. Later that year, the *Mirror* highlighted the 'fact' that nearly one quarter of British men regretted marrying their wives, asking 'Would You Marry Your Wife Again?' This survey, given to 110,000 husbands in fourteen countries, concluded with the result that one in five British

[233] Ibid, 93.
[234] King, 31.
This section draws inspiration from Laura King's analysis of fatherhood in popular newspaper quizzes during this period.
[235] 'Am I a Good Husband?', *Daily Mirror*, 4 Oct 1949.
[236] 'How do you rate as a mate', *Daily Mirror*, 5 May 1955.

husbands said 'No', they would not marry their wives again. The article issued a list of "principle faults for which men blame[d] their wives", including infidelity, financial problems, conflicts of temperament, poor housekeeping, selfishness, jealousy, and excessive drinking. Other critiques leveled at wives in this 1955 'study' were that they hogged the bathroom, took up too much space in bed, smoked before breakfast, talked too much, hogged the radio, and consistently ran late. At the end of this article was a 'Happy Marriage Test', for wives who were "wondering whether their husbands are secretly regretting their marriage".[237] The 'test' questions, drawn up by American psychologist Dr. R.F. Hertz, implied that wives should meet the following expectations: take a "genuine interest" in your husband's job, be generous with "praise and admiration", make yourself "as pretty for your husband" as during the first few months of marriage, ask your husband to help choose a new dress, share a common leisure hobby, and still be "your husband's best friend".[238] If wives did not meet four of these criteria, they had failed.[239] Once again, this quiz celebrated and promoted the idea of companionate marriage, however, traditional gender roles were embedded in this understanding. Similarly, in 1957, the *Mirror* asked readers: Have You Got That Ten-Year Itch? Jane Dexter, reporting for the *Mirror*, explained that adultery was not the *real* reason that marriages break up, but was the result "that come at the end of years of neglect":

> It is the everyday thoughtless action that starts the hate that ends in the break-up of a home. A husband or wife can forgive an unfaithful act and still live happily ever after.[240]

The *Mirror* also pointed to women's independence in 1957 as an explanation for marital breakdown:

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[237] 'Would You Marry Your Wife Again?', *Daily Mirror*, 15 December 1955.
[238] 'Would You Marry Your Wife Again?', *Daily Mirror*, 15 December 1955.
[239] 'Would You Marry Your Wife Again?', *Daily Mirror*, 15 December 1955.
[240] Jane Dexter, 'Have you got that ten-year itch?', *Daily Mirror*, 27 June 1957.

> The fact that women are now more independent also helps towards a split. At one time, a couple kept together for security and economic reasons, even when they were no longer in love. Now that so many women go out to business they are less dependent on their husbands.[241]

Traditional gender roles were celebrated in these quizzes – which placed the male breadwinner/female housewife model as the ideal, and explicitly attributed marital breakdown to female independence. While in 1949, men were encouraged to put the kettle on and set the table if their wives were at work, by 1958 women's increased economic power was explained as a key feature of marital breakdown. Although children and parenthood were not the focus of these particular quizzes, there were others that were specifically targeted at fathers and 'family men'.[242] Therefore, the pro-family message sent by such quizzes in the popular press was that while men could offer more help around the house, women's place was in the home, and they had best follow the traditional gender code.

This promotion of traditional gender roles in marriage continued into 1959. From April to May 1959, another series of marital quizzes appeared in the *Daily Mirror* that sought to create a picture of 'Mr. and Mrs. Average'. Fifteen thousand wives responded, reporting that Mr. Average is good-tempered at breakfast, nice to his in-laws, provides a steady house-keeping allowance, does not mind if his wife dyes her hair, but does not like her in slacks. He helps around the house – but not too much – he makes his wife a 'cuppa' in the morning and pushes the baby pram, when asked. The article concludes: "None of them is perfect. But who would want a perfect husband?"[243] These quizzes allowed readers to assess their marriage against the norm, which still underlined the continued importance of traditional gender roles and power dynamics. Women were

[241] Jane Dexter, 'Have you got that ten-year itch?', *Daily Mirror*, 27 June 1957.
[242] See Laura King, 'Hidden Fathers?', 2012.
[243] 'Mr. Average', *Daily Mirror*, 13 May 1959.

expected to wear dresses or skirts, be the primary parents and housekeeper, and be dependent on their husband financially. These articles and 'quizzes' aimed to temper expectations, encourage marital longevity – despite a wife's dissatisfaction – and reassert traditional behaviour and divisions of labour. Indirectly, these quizzes and articles pointed to the wife as the partner whose behaviour would determine marital success or failure. This preoccupation with marriage and divorce in the press was, in part, a response to the Royal Commission on Marriage and Divorce (RCMD). Formed in 1951, the Commission reported its findings in 1956. The Commission was comprised of 13 men and 6 women. Ultimately, the members were split on the issue of divorce after a seven-year separation, which was one of the key issues on which Parliament asked for guidance. What is notable is that artificial insemination, which was seen as a new cause for marital breakdown, became part of the Commission's discussion. MP Reginald Maudling, who wrote in *The Observer* about the Royal Commission, described the importance of AI to its broad remit:

> Some of the legal problems have been brought into prominence by recent developments and decisions.… The development of artificial insemination has produced problems of a quite novel character, and of very great importance, which particularly call for consideration by a body of the highest standing.[244]

The Commission also examined laws relating to non-consummation, nullity, and long-term separations.

Treating infertility was positioned as a potential solution to the marriage crisis, but also heightened concerns about adultery. Whilst the RCMD was underway, more attention was paid to divorce rates, and particular attention was paid to the connection between family size and the likelihood of divorce. The *Daily Mirror* published a report stating that three-quarters of divorces were childless or one-child couples, arguing that

[244] Marriage and the Law, *The Observer*, 15 July 1951, p.4.

the rate of divorce was much lower among larger families. If divorce was largely blamed on wives, such reports therefore positioned motherhood as women's fulfillment. Furthermore, in a broader sense, population and birth rates were still a concern but it was reframed to be less about the 'nation' and more about the state of marriage. In 'The Danger Ages for Husband and Wife' the *Mirror* explained that most wives involved in divorces were between twenty-five and thirty years old, and the men involved were between thirty and thirty-five (based on the Registrar General's annual review analyzing the 30,870 divorce decrees in 1950). Almost half of the marriages ending in divorce in 1950 had lasted for between 7 and 15 years. The article reassured readers that the divorce rate seemed to be dropping: in 1952, "[t]he year's total of divorces was nearly 4000 fewer than in the previous year, when the figure was 34,856. And during 1950 only 29,729 new petitions were filed, compared with 35,191 the year before".[245] The message seemed to be that while the crisis was subsiding, couples should stay vigilant lest their marriage should fall apart.

The RCMD requested that various organizational bodies give evidence, and they were largely split on the issue of AI. The British Medical Association made a recommendation regarding AI that "a husband should be deemed the legal father of children born after artificial insemination with his consent".[246] The Archbishop of Canterbury's report, on the other hand, argued in favour of legislation to criminalize the practice: "The evils necessarily involved in artificial insemination (donor) are so grave

[245] 'The Danger Ages for a Husband and Wife', *The Daily Mirror*, 30 June 1952, p.1.
[246] 'B.M.A. Proposals on Divorce', *The Times*, 18 April 1952.

that early consideration should be given to the framing of legislation to make the practice a criminal offence".[247]

When, in 1956, the Royal Commission on Marriage and Divorce reported their findings, it became clear that the nineteen members disagreed on the major proposals. What they did unanimously agree upon was suggesting three new grounds for divorce: first, "Wilful refusal to consummate a marriage"; second, "Artificial insemination by a donor without the husband's consent"; and, finally, "Detention as a dangerous mental defective".[248] That AID was included as one of the key recommendations for divorce legislation, highlights the social anxiety and concern over the practice – particularly its effect on marriage in the post-war period.

During the Commission's investigation (1951-56), artificial insemination complicated the legal grounds of marriage and divorce outside of Britain too. In 1953, both Denmark and Norway made official recommendations on AI. Norway's Royal Commission on Artificial Insemination recommended that a husband be allowed a divorce if the procedure was done without his knowledge; that only approved doctors be allowed to perform AI, that husbands give consent, and that wives and donors not know the other's name.[249] Addressing unmarried women and children's rights, the article 'Test-tube babies for unwed' in the *Daily Mirror* reported that a proposal was made to Denmark's Ministry of Justice to allow unmarried women access to insemination – though if made law it would "only be allowed in exceptional cases, as when a woman of 'high moral standards' desires to have a child by that method".[250] Concern was shown for the rights of the child

[247] 'Social Effects of Divorce', *The Times*, 27 May 1952.
[248] 'The Great Marriage Muddle', *Daily Mirror*, 21 March 1956, p.1.
[249] 'Laws on Artificial Insemination', *The Times*, 14 April 1953.
[250] 'Test-tube babies for unwed', *The Daily Mirror*, 14 April 1953, p.3.

in Denmark, as there would be no record that children were conceived by artificial insemination, and "they will enjoy rights equal to those of others".[251] This was a much different scenario than in Britain, where registries of 'test-tube children' were suggested, along with being deemed 'illegitimate' and cut off from any right to inheritance. *The Mirror* further explained that in Norway a proposal suggested "strict rules to protect the legal position of test-tube children": the Norwegian committee agreed that a child conceived by AI "would have the same legal status as any other child".[252] Reporting on this ruling, *The Times* reassured readers that if AI was given to unmarried women in Norway, doctors would need to give authorization and it would not be performed on any woman under 25 years of age. This approach taken in Denmark and Norway is reflective of older views about illegitimacy and children's rights in Scandinavian countries. For instance, Norway's 1915 Castbergian Laws on Children gave equal rights to children who were born outside of marriage.[253]

The British press continued looking beyond national borders at how AI was being dealt with in other countries. More publicity was given to the subject in 1954 when two custody cases in Chicago sparked attention. Publicized while the RCMD was underway, these cases perhaps influenced the Commission's recommendation that AI be made grounds for divorce. Two mothers in Chicago contended that their children were conceived by artificial insemination, and therefore illegitimate, in order to deny custody to their respective husbands; this underlined the legal power of women as mothers. In the first case, instigated by Mrs Arline Ohlson (30 yrs old), Judge Elmer N. Holmgren ruled

[251] 'Test-tube babies for unwed', *The Daily Mirror*, 14 April 1953, p.3.
[252] Ibid.
[253] *The Emergence of Human Rights in Europe: An Anthology*, (Strasbourg: Council of Europe Publishing, 2002), 115.

that the alleged 'test tube baby' was the legal son of the husband – confirming the child's 'legitimate' status. The judge further instructed Mrs Ohlson (on Mr Ohlson's request) to halt her allegations that their three-year-old son was a "test tube baby".[254] Mrs Ohlson appeared to be invoking the 'test tube baby' label to utilize the legal definitions of illegitimacy in an attempt to cut the father out of the child's life. What the article does not tell us is what the family circumstances were. For instance, what were Mrs Ohlson's reasons for bringing the case to court? Only one month later, another Chicago mother – Mary Doornbos – petitioned for divorce on grounds of drunkenness and requested sole custody of her five year old son on the basis that he was conceived by artificial insemination by donor, reported *The Times*.[255] From the mother's perspective, a label of illegitimacy must have seemed the lesser evil, compared to the father remaining in their child's life. Once again, the mother attempted to gain sole parental rights based on the child being considered 'illegitimate' under law. The husband in turn filed suit asking that AI be declared adultery.[256] Although custody was granted to the mother, it was done so by vilifying Mary Doornbos: Judge Gibson Gorman ruled that artificial insemination by donor (AID) was illegal and constituted adultery by the mother. The judge also ruled that children conceived by AID were illegitimate. Judge Gorman said: "A child so conceived is not a child born in wedlock, and therefore illegitimate. As such, it is the child of the mother, and the father has no right or interest in said child".[257] Despite being given the ruling that AID was equivalent to adultery, and being blamed for what was perceived as sexual promiscuity, Mrs Doornbos left the court with the outcome she had hoped for:

[254] 'Test Tube Baby Ruled Dad's Son', *Toronto Star*, 5 November 1954.
[255] 'Legality of Artificial Insemination', *The Times*, 14 December 1954; Carolyn Herbst-Lewis, *Prescription for Heterosexuality*, 127.
[256] 'Test Tube Baby Ruled Dad's Son', *Toronto Star*, 5 November 1954.
[257] 'Artificial Insemination Adulterous, Judge Rules', *Globe and Mail*, 14 December 1954.

cutting her husband out of the child's life.[258] After the ruling, Mr Doornbos announced his plan to sue his wife for adultery. In these cases, a plea of artificial insemination by donor provided a potential loophole to expedite divorce and secure custody, but the mother put at risk both her reputation and that of her child. The details of these cases and the marriages involved were not made entirely clear in the press reports, however they are useful examples in demonstrating the murky legal landscape of donor insemination. Dramatic court cases involving AI made for great press, but so too did scientific discoveries and possibilities in reproduction.

**Science, Technology, and Speculation**

The discourse on reproductive technologies in the 1950s had much in common with popular science and speculative fiction. As reproduction converged with science fiction, the press frequently referenced *Brave New World*; invoking its vision of the assembly-line reproduction of test-tube babies designed with their social destination already decided. Even contemporary science fiction film reflected social anxieties concerning reproduction.

Science offered both fear and hope for the future. A 1958 Gallup Poll revealed that one half of those interviewed believed that scientific advancements were beneficial for 'man', while one quarter thought such advancements were harmful, and the remaining quarter were not yet sure.[259] Technology now seemed to have the capacity to restructure human relations. In the case of reproductive technologies this could mean the reshaping of the meaning of 'family'. Much of the media emphasis on AI turned to dramatizations

[258] As Carolyn Herbst-Lewis has pointed out, American physicians criticized Gorman's ruling as 'biased' because he was a Roman Catholic and argued that "artificial insemination was not adultery". Herbst-Lewis, *Prescription for Heterosexuality*, 127.
[259] Gallup, *The Gallup International Public Opinion Polls*, p.458.

and science fiction fantasy, where concerns over the family converged with fears about science and technology. Throughout the 1950s, the press covered stories on designer babies, celebrity sperm donors, cryopreservation, and surrogacy. For example, in 1953, *The Daily Mirror* reported that the first 'frozen' test-tube baby was to be born in the United States to a "young American housewife" - one of three women who were inseminated with "life-giving contents of test-tubes stored on ice".[260] Dr. R.C. Bunge of the Iowa University Medical School explained that the insemination was "purely exploratory" and admitted that "we are not absolutely sure that normal healthy infants will be born, although prenatal tests on the mothers have been perfectly satisfactory".[261] He further explained that although "X-rays have shown that the babies are growing normally", they would not know more "until the first baby is born and thoroughly examined".[262] Similarly, in September 1958, the *Times* ran the headline 'Fatherhood Centuries After Death', explaining that a female biologist in France had successfully preserved some of her husband's semen and "given birth to two children by him through artificial insemination after he was killed in a road accident".[263] The biologist who made the announcement – Professor Jean Rostand – believed the next step in this science was the preservation of the whole human at low temperatures.[264] The fascination and experimentation with cryopreservation was growing during this period. But these articles in the British press were outward looking, and largely based on practices that still fell within the realm of science fiction. Extending these reports to a speculative level, the *Woman's Sunday Mirror* reported in 1957 on a sensational new plan:

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[260] 'She Will Have First 'Frozen' Test-Tube Baby', *Daily Mirror*, 6 December 1953, p.3.
[261] Ibid.
[262] Ibid.
[263] 'Fatherhood Centuries After Death', *The Times*, 24 September 1958.
[264] Ibid.

> …women would be able to bear the child of their favourite male celebrity…Famous statesmen, sportsmen, musicians, writers and artists would supply specimens of their seed to a special 'bank'.[265]

The article explained that the specimens would be preserved in deep freeze, with women paying for their father of choice. Although there would certainly be objections to a "fee-paying celebrity bank", the *Sunday Mirror* said that there were many doctors who believed "a bank of healthy male seed, stored by deep freeze, is a vital necessity in case of atomic war" since exposure to nuclear radiation could render a man sterile.[266] Thus, speculation about cryopreservation was tied up with concern over radiation and the possibility of nuclear war. The concept of a radiation-proof underground sperm bank was raised numerous times by the Eugenics Society – whose members believed it was an important initiative for the preservation of the British population.[267] For example, in April 1958 C.P. Blacker argued that "underground seminal banks" should be constructed that would be protected from radiation.[268] Since the first atomic bomb was dropped in 1945, he argued, there had been a growing "awareness of the effects of radiation on human genes" and coupled with the establishment of blood banks, the public had been familiarized "with the idea of accumulating for general use supplies of fluids from the human body".[269] Eugenic implications were inherent in such suggestions, like improving the nation's children with the 'seed' of famous and successful men. The other subtext was a fear of science and technology. During the Cold War, atomic and nuclear risks were a very real concern and a protected sperm bank seemed a realistic solution to a decimated population.

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[265] Amy Landreth, 'Amazing 'Artificial' Baby Plan', *Woman's Sunday Mirror*, 13 October 1957.
[266] Landreth, *Woman's Sunday Mirror*, 13 October 1957.
[267] C.P. Blacker, *Eugenics Review*, Vol.50 April 1958, pp.51-54.
Blacker was General Secretary of the Eugenics Society from 1931 to 1952.
[268] Ibid.
[269] C.P. Blacker, 'Artificial Insemination: The Society's Position', *Eugenics Review* (50), April 1958, p.51.

This discourse was exemplified by Aldous Huxley's 1932 science fiction novel, *Brave New World*. The press drew on ideas and imagery referenced in the book. The concept of the 'test tube baby' was popularized by *Brave New World* and the press frequently referenced Huxley's novel, which was still in the public's consciousness. As is suggested in Figures 4.1 and 4.2, the term 'test-tube babies' did not come into usage until the late 1920s.[270] Well known in Britain since its publication in 1932, by the early 1960s *Brave New World* was considered one of the most influential dystopian novels of the twentieth century. [271] *Brave New World* was set in a future London in the year of 2540. It extended mass production and commercialism to human reproduction, where embryos were raised in 'hatcheries', 'conditioning centres', and 'fertilizing rooms'. After being incubated in 'test-tubes' they were divided into five castes: Alpha, Beta, Gamma, Delta and Episolon. The lower castes were conditioned and chemically treated to reduce intelligence and physical stature.[272] A 1958 *News Chronicle* article explored the eugenic possibilities of artificial insemination, referencing *Brave New World*. The headline read 'Your Child Made to Measure', and explained that Britain had reached "a Brave New World stage of being able to breed human beings to order – from Alpha Plus supermen to Delta Minus morons".[273] Readers were confronted with this distant fiction becoming a scientific reality.

Of course, Huxley was not the first to suggest this type of scientific reproduction in speculative literature. J.B.S. Haldane's 1924 work, *Daedalus*, predicted that 'ectogenesis'

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[270] See figures 4.1 and 4.2, Google Ngram Viewer, 1920 to 1980.
[271] *Brave New World* sold 23,000 copies in Britain in its first two years. Although literary crtics did not celebrate the work in its early years, it received later accolades and has been reconized as "arguably the Western world's most famous science fiction novel".
Raychel Haugrud Reiff, *Aldous Huxley: Brave New World*, (Tarrytown, NY: Marshall Cavendish, 2010), 96-98.
[272] Aldous Huxley, *Brave New World*, (London: Chatto & Windus, 1932).
[273] 'Fathers Anonymous: Your Child Made to Measure', *News Chronicle*, 6 February 1958.

would be achieved by 1951 with the growth of an embryo outside of the mother's body.[274] This prophesy, it turned out, was only two decades off. Another science fiction novel, *The World In 2030* (1930), written by the Earl of Birkenhead, generated controversy with Haldane, who argued that Birkenhead had pirated many of his ideas.[275] Both Haldane and Birkenhead "predicted that the separation of sexual love from reproduction would characterize the human reproduction of the future".[276] These examples of speculative fiction during the interwar period, particularly *Brave New World*, became a point of reference in popular discourse around assisted reproductive technologies.

Science fiction-inspired speculation about the possibilities of reproductive technology was particularly timely in the 1950s, when science fiction film became a popular genre in the West; in part as a response to fears of nuclear war, communism, and the power of science.[277] The 'atomic age', an obsession with 'outer space', and ideas of the 'other' influenced British sci fi cinema in the 1950s.[278] Science fiction film also reflected social anxieties concerning reproduction. One such film that is suggestive of these preoccupations was *Devil Girl From Mars* (1954), a British film directed by David Macdonald, which became a cult classic.[279] The low-budget, camp film told the story of a Martian woman and her robot, who descend in their spacecraft to rural Scotland in order

[274] Leon Surette, *Dreams of a Totalitarian Utopia: literary modernism and politics*, (Montreal: McGill-Queen's University Press, 2011), 113.
[275] *Western Argus*, 24 June 1930, p.1-2.
[276] Arlene Judith Klotzko, *A Clone of Your Own? The science and ethics of cloning*, (New York: Cambridge University Press, 2006), 7.
[277] I.Q. Hunter, *British Science Fiction Cinema*, (London: Routledge, 1999), 7.
[278] Tony Shaw, *British Cinema and the Cold War*: *the state, propaganda and consensus*, (London: I.B. Tauris, 2001), 126.
[279] See Tom Weaver, *Science Fiction Stars and Horror Heroes: interviews with actors, directors and writers of the 1940s though 1960s*, (Jefferson, NC: McFarland, 1991), 40-41; Eric Rabkin, *Mars: A Tour of the Human Imagination*, (Westport, Conn.: Praeger Publishers, 2005), 154.

to collect healthy male specimens to repopulate Mars after a war of the sexes [Figure 4.3; 4.4]. Martian Nyah – clad in a second-skin bodysuit, black leather cap and cape – descends from her spacecraft and vaporizes the first man she sees with a laser gun. Nyah is accompanied by Charlie, a 'mechanical man'. She enters a small Scottish inn and explains that she has travelled to Earth in order to collect male stock to help repopulate Mars. Nyah explains the history of Mars and the condition of its present population:

> Nyah: "Many of your Earth years ago, our women were similar to yours today. Our emancipation took several hundred years and ended in a bitter devastating war between the sexes. The last war we ever had. After the war of the sexes, women became the rulers of Mars but now the male has fallen into a decline. The birth rate is dropping tremendously, for despite our advanced science we have still found no way of creating life.
> Woman: "So you've come here for new blood?"
> Nyah: "In a way…I will select some of your strongest men to return with me to Mars"
> Man: "And if they don't want to go with you?"
> Nyah: "There is no 'if'"[280]

Although women had won the Martian war, it had left the male population decimated. The film touched on anxieties of shifting gender roles, and highlighted eugenic arguments in support of the benefits of scientific breeding. Aside from Nyah's 'mechanical man', men are easily disposable in the film, and useful only for breeding purposes. In his analysis of sexual politics in British sci-fi film, Steve Chibnall summarized the importance of the film: "The arrival of Nyah is a revelation, not simply of extraterrestrial life, but of the quiet revolution of morals, mores and gender relations in Britain".[281] *Devil Girl From Mars* offered "literal examples of inter-planetary miscegenation".[282] Perhaps unknowingly, the film referenced a suggestion made in 1943 by an American eugenicist, Frances Seymour, to repopulate Europe after the war by way of artificial insemination

[280] *Devil Girl From Mars*. Online. Directed by David MacDonald. UK: Spartan Productions, 1954. Accessed online: https://vimeo.com/20281651 on 9 March 2016
[281] Steve Chibnall, 'The politics of sexual difference in British sf pulp cinema', *British Science Fiction Cinema*, I.Q. Hunter, ed., (London: Routledge, 1999), 62-64.
[282] Ibid, 62-64.

with the sperm of American men, by transporting semen from America by airplane to the rest of Europe. She intended to call the scheme 'The Seymour Plan for Racial Betterment'.[283] The British Eugenics Society, in particular C.P. Blacker and Lord Horder, dismissed Seymour's idea as ludicrous, but both the fictional scheme in *Devil Girl From Mars* and Seymour's unfulfilled plan emphasized men's potential for breeding. *Devil Girl from Mars* played out an interplanetary power struggle between men and women. It can be interpreted as an expression of anxiety about the changing nature of family life, and the gender roles that shaped it. The way in which this story was told is also revealing of the concerns of the society in which it was produced.[284] Therefore, questions about the possible existence of 'aliens' from Mars also referenced "fears of global conflict and social disintegration".[285] This film represents a literal expression of fears associated with artificial insemination, while at the same time, it fits comfortably within the British sci-fi cinema narratives of the 1950s. Like marriage quizzes, divorce court reporting, and speculative literature, films can tell us a great deal about the cultural preoccupations of a society. Although these anxieties did not lead to any political action – even after the 1956 Report from the RCMD – a sensational divorce case in 1958 forced the government into action.

**A sensational divorce case: *MacLennan v MacLennan***

The quantity and intensity of interest in AI reached unprecedented heights in early 1958 when Lord Wheatley ruled on the MacLennan divorce case that began in December 1957. Artificial insemination, Wheatley said, did not constitute adultery. Challenging

[283] Wellcome Library, London, SA/EUG/D.6, 'AID (Artificial Insemination by Donor)', 1934-1956.
[284] Stephen Brooke, 'Cinema, crime, and the city in the 20th century', *Streetlife: The Culture and History of European Cities*. York University, Toronto, 26 January 2016.
[285] Shaw, *British Cinema and the Cold War*, 127.

previous legal rulings and feeding anxiety over the high divorce rate, the result of *MacLennan v MacLennan* – like *R.E.L. v E.L.* in 1948 – made waves in the government, church, and media. In the following weeks and months, the House of Lords debated the validity of artificial insemination (AID); the Archbishop of Canterbury condemned the practice; a film and TV show dramatized its effects on marriage; a TV documentary and radio programme explored the medical aspects, and hundreds of news articles discussed the ethical, moral and legal issues of conceiving children by AID – popularly deemed 'test-tube babies'.[286] This response was due, in part, to the media growth that by the late 1950s had reached unprecedented heights. Appealing to both sexual curiosity and moral voyeurism, the MacLennan divorce case presented a unique opportunity for the media to engage in a debate over the ethics of conception and the boundaries of marriage.

When Lord Wheatley made his ruling on the case in early January 1958, splashed across the front page of the *Mirror* was the headline: 'TEST-TUBE BABIES AND DIVORCE - Not adultery rules a judge'.[287] The divorce involved Ronald MacLennan of Glasgow who (in December 1957) took his wife, Margaret MacLennan, to court, claiming adultery because she had apparently had a child by artificial insemination without his consent. [288] The legal representation for Mr MacLennan suggested that AI

[286] Notably, this media coverage was international in scope with coverage in the *New York Times*, *Globe & Mail*, and *Toronto Star* among others. Canadian publication *Justice Weekly* devoted several articles in 1958 to tracing the legal history of AI to Toronto in 1920/21 - the *Orford v Orford* case. Drawing on this, the *Globe*'s columnist J.V. McAree wrote an editorial examining the 1920 and 1958 cases, insisting on the importance of both "in view of the fact that there is a great increase in England, on the Continent, and in the United States, in the use of artificial insemination. Indeed, according to Justice Weekly, one London hospital is said to be specializing in such cases". McAree distanced Canada from the practice - citing only the US, Britain and Europe as areas where the technique was practiced.

[287] Although the ruling was unprecedented, the case itself was not. There had been a number of cases elsewhere over the previous decades, including Orford v. Orford in Toronto (1921), Ohlson v. Ohlson in Chicago (1954) and Doornbos v. Doornbos also in Chicago (1954).
'Test-Tube Babies and Divorce', *Daily Mirror*, 11 January 1958, p.1.

[288] The MacLennan case sparked other similar cases in the US and Europe. Another case in the US gained attention in the press in February 1958. This time a New York woman was arguing that her ex-husband was

gave women the power to have extra-marital affairs without consequence. While Mrs MacLennan's legal representative alluded to recent developments in deep-freezing by arguing that if "a woman could be artificially inseminated by a dead man" it surely could not be considered adultery.[289] Inherent in this argument were power dynamics and shifting gender norms.

The ultimate legal ruling from Lord Wheatley was that since AID did not come within the definition of intercourse it could not be ruled adultery. Yet Wheatley did go on to say that it was nevertheless a "grave breach of the marriage contract", and ultimately granted Ronald a divorce when Margaret refused to provide details of the alleged treatment.[290] Wheatley said that "artificial insemination removed the link of human relationship from procreation".[291] This case was particularly important in clearly identifying that reproduction without sex was not only possible, but that it was perhaps more common than most people assumed. But the language still maintained a level of reservation in not being explicit in its reference to sex. The press coverage of the case failed to reveal the details of the MacLennan's relationship and whether a claim of AID

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not entitled to custody of their two children because they were "born by artificial insemination by donor". The ruling fell in the husband's favour. Supreme Court Justice Vincent Lupiano said: "Determination of children's custody and visitation must rest solely on their welfare". AI as a claim for custody acted as a possible legal loophole - whether the claims were true or false, there was a period in the 1950s where these rulings could have gone either way, but the MacLennan case set a precedent and generated a significant amount of attention. Later in 1958, the *Toronto Star* reported that an Italian court had echoed the MacLennan case ruling. The decision in a Padova court was the first Italian case dealing with AI. On 12 February 1958, the *Times* reported that the German Federation of Women Doctors had submitted a statement to the Minister of Justice with their position that "artificial insemination of human beings should be made a punishable offence because it disregards the personality of the child and could lead to severe psychological conflicts". This was no doubt informed by the publicity around experimenting with the practice of AID on women in concentration camps during the Second World War.
'Ruling on Custody of A.I.D. Children', *Observer*, 16 February 1958, p.11; 'Test Tube Baby Legal in Italy', *Toronto Star*, 8 November 1958; 'Artificial Insemination Denounced', *Times*, 12 February 1958.

[289] 'Question of Adultery – Artificial Insemination considered by court', *Times*, 6 December 1957.

[290] 'Test Tube Baby Ruling', *Daily Mirror*, 11 January 1958, p.20.

[291] Ibid.

was used as a more direct route to divorce, perhaps based on precedent set in the United States.

Throughout the postwar period, adultery remained the easiest way to achieve divorce, but producing proof was difficult. A hotel bill was frequently submitted as evidence – often manufactured by one spouse as 'proof' to get a divorce. In the period before 'no fault' divorce, when some people faked an extra-marital affair in order to accelerate the process, perhaps AID became grounds by which some married people sought to expedite divorce. As Claire Langhamer argues, whether or not the actual incidence of adultery was increasing over the period, there was "a very real public perception that extra marital affairs were more common across social categories than had previously been the case".[292] Through the mid-twentieth century adultery remained "an explicitly public concern".[293]

The MacLennan ruling triggered a range of reactions: the Archbishop of Canterbury condemned the practice, an ITV documentary examined all aspects of the treatment, and the topic was raised in Parliament – once again calling for an official inquiry. The Archbishop of Canterbury, Dr Geoffrey Fisher, was infuriated by the MacLennan ruling and was quick to respond with strong criticism of AI making a speech to the Convocation of the Province of Canterbury. Referring to "the evil" of women having 'test-tube babies', he believed AI should be made a criminal offence or be controlled by law, including a registry of all such children. His greatest concern was that "A.I.D. is an offence against the social and legal implications of marriage".[294] Dr Fisher stressed the

[292] Langhamer, 'Adultery', 99.
[293] Langhamer, 'Adultery', 101.
[294] 'Evil' of Test Tube Babies', *Daily Mirror*, 15 January 1958, p.10.

threat posed by AI, particularly as a result of the secrecy involved – unhinging the security in knowledge of one's origins:

> It is impossible to tell how many cases there are. I have seen it stated that there are only some four or five specialists to cater for the whole country: the doctor in the television interview said that she acts in 50 to 60 cases a year, two-thirds of which produce A.I.D children. But the evil of A.I.D. children does not rest on numbers. The institution of marriage is meant among other things to give to children the security of knowing who their parents are, and to give to society the same security. By the device of A.I.D that security is destroyed at the roots.[295]

*The Spectator* agreed in part with the Archbishop, that AID without the husband's consent should be made a ground for divorce, but it raised the question of whether it should be allowed when the husband gives consent or alternatively when there is no husband. The *Spectator* article drew attention to the idea that children are central in the home, but also criticized the direction this sentiment might be going and questioned a person's right to parenthood:

> Most people seem to think that if a woman wants a child she should not be deprived of the chance of having one. For myself I find it slightly unsavoury that children should be reduced to the level of television sets and washing machines — something that no good home should be without.[296]

This comparison between parenthood and consumerism is a rare but interesting reference to the societal pressure to have children in the same way that families were expected to have the latest consumer technologies. What very few people were talking about explicitly at this time was the potential for the commercialization of reproduction – an argument which became much more prominent in the 1980s.

**Pushing the State Into Action**

The attention and outrage directed at the MacLennan case meant that a government inquiry was on the horizon; the public stir created by the case could not be

[295] ''Deliberate Deception' of Artificial Insemination', *The Times*, 15 January 1958.
[296] 'A Spectator's Notebook', *The Spectator*, 17 January 1958, p.67.

ignored. *The Spectator*, assuming that the Government would appoint a committee to investigate AI, predicted and criticized the expected inaction:

> Then, after the committee has reported and made its recommendations, the Lord Chancellor will get up in the House of Lords and say: 'Her Majesty's Government do not think that the general sense of the community is with the committee in their recommendation, and therefore they think that the problem requires further study and consideration. Certainly there can be no prospect of early legislation on this subject'.[297]

As expected, one week after the Archbishop of Canterbury's speech, artificial insemination was a topic of discussion in Parliament. Two MPs, John Parker (Labour) and David Llewellyn (Conservative) asked R.A. Butler, the Home Secretary, to consider a select committee or commission to consider legislative changes in light of the growing number of children born by artificial insemination.[298] In response, R.A. Butler and John MacLay (Secretary of State for Scotland) drafted a memorandum that was presented to the Cabinet on 20 February 1958, six days before the scheduled debate in the House of Lords. The memorandum, 'Artificial Insemination', outlined the relevance of the issue: Lord Wheatley's decision in the MacLennan case, followed by the Archbishop of Canterbury's condemnation of the practice, had "re-awakened public interest in the subject generally, and there is increasing pressure for action by the Government".[299] Although the RCMD had dealt in part with AID, it was not within the scope of that Commission to deal with the wider implications of the practice. Butler and MacLay concluded that "some form of enquiry into the whole matter cannot now be avoided".[300] They recommended a Departmental Committee of 8 or 9 people, with at least two members from both the medical and legal professions, that would address the social and

[297] Ibid.
[298] 'M.P.'s Questions on Insemination', *The Times*, 22 January 1958.
[299] National Archives, London, CAB/129/91-A1/0047 'Artificial Insemination', Cabinet Papers, C.(58) 47, 20 Feburary 1958.
[300] Ibid.

legal concerns of the practice. On 25 February, the recommendation of a Committee was discussed by the Cabinet Ministers. Butler said the practice was a legal muddle, with the Churches divided on the social question; not knowing what to do, it seemed sensible to suggest a committee of enquiry.[301] Lord Kilmuir (the Lord Chancellor) proposed to announce in the House of Lords that an enquiry was needed, particularly on the social side. The legal issues too, he pointed out, were very complicated – aside from adultery, there were also the issues of nullity and illegitimacy to deal with. Legislation could not be proposed without further investigation. Charles Hill (then Chancellor of the Duchy of Lancaster) stressed that prohibition or regulation would cause resentment, particularly because the practice has been underway for some time. The Prime Minister, Harold MacMillan, was reluctant to take any action as the transcript of the Cabinet meeting suggests:

> Look at reports we have had, and can't act upon, e.g. Wolfenden Rpt. Why bring this fresh trouble on our heads? Suppose the Ctt^ee recommend prohibition or regulation. We cdn't enforce it. C^d we not limit the enquiry to study of legal aspect only? Don't get into ques of morality. Report on that just before Election won't be helpful. Anyway, what prospect of agreed report?[302]

As in 1949, when the Labour government was reluctant to touch the issue of an inquiry, in 1958 the Conservative government was just as hesitant – but inaction and postponement was no longer an option. The Government feared being confronted with an "embarrassing responsibility", with a report that recommended prohibition or regulation that would surely "give offence to large sections of public opinion".[303] In response, Butler suggested that the enquiry be restricted to the legal consequences of the existing practice, and the Cabinet agreed.

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[301] National Archives, London, CAB/195/17-A1/0011, C.C. 18(58), 25 February 1958.
[302] Ibid.
[303] National Archives, London, CAB/128/32-A1/0018

The question of what to do about AID moved from the Cabinet to the House of Lords. On 26 February 1958, Lord Blackford put forward the motion that "artificial insemination of a married woman by a donor other than her husband is tantamount to adultery, that it should be sufficient ground for divorce, and that all children so conceived are illegitimate".[304] The motion was a direct challenge to the MacLennan case ruling. However, since the MacLennan ruling was made under Scottish Law it could not necessarily set a precedent for cases elsewhere in the United Kingdom.[305] In the week leading up to the debate in the House of Lords, both the Archbishop of Canterbury and the Archbishop of York announced their intention to speak at the debate. *The Times* reported that Lord Kilmuir (the Lord Chancellor) would respond on behalf of the Government, though it was anticipated that he would not promise legislation, as it was felt in "Government circles" that "until public opinion has had more opportunity to form and express itself" legislation will not be secured.[306] The House of Lords debate raised questions about the distinction between public and private issues, the importance of public opinion, the potential for the practice to be driven underground, the affect on the family, and the right to parenthood. There was general agreement in the House that an inquiry should be made, and at the conclusion it was announced that a Departmental Committee would inquire into AID and make recommendations.

Only a few months earlier, the peers had debated the Wolfenden Report, published in 1957. The Wolfenden Report on Homosexual Offences and Prostitution had recommended the decriminalization of homosexual behaviour in private between

[304] 'Law on Artificial Insemination', *The Times*, 30 January 1958; 'The 'test tube' wife won't tell', *Daily Mirror*, 30 January 1958, p.5; 'Artificial Insemination of Married Women', House of Lords Debate, 26 February 1958, vol 207 cc926-1016.
[305] Andrew, ''Phantom Fathers' and 'Test Tube Babies'', *A Handbook of Infertility in History,* 2016.
[306] 'Archbishops to Speak', *The Times*, 21 February 1958.

consenting adults. The debate over the Wolfenden Report raised questions about public and private distinctions and the importance of public opinion in guiding legislation – themes which carried over to this discussion of artificial insemination. The important distinction made by the Wolfenden Committee between public and private concerns informed not only the House of Lords debate, but also the Feversham Committee inquiry which followed.[307] Lord Pakenham, a Labour peer who was moderate on the Wolfenden Report (though he opposed gay rights in later years), was surprisingly hostile to artificial insemination. He closed his speech with an emphatic condemnation of AID:

> We must, and I believe this country will, reject with horror this brain-wave of Beelzebub. We must redouble our efforts to relieve the distress of those who in their affliction turn towards this terrible remedy…we must reaffirm once more our Christian purpose and re-dedicate the quality of our family life to nobler ends.

Lord Chorley, also a Labour peer, remained consistent with his views of nine years earlier and argued in support of AID: "I think personally that [artificial insemination] ought to be encouraged and made more readily available rather than proscribed in the way that has been advocated by so many noble Lords this afternoon." Like Lord Pakenham, he compared the debate over AID to that had over the Wolfenden Report, stressing the distinction between private and public conduct:

> I believe that to make this practice illegal or a criminal offence would be to take a very grave decision, because it surely strikes at the liberty of the citizen. It is a commonplace of political wisdom that criminal law is not concerned with private morals but, as the Wolfenden Committee have recently reminded us and stressed so clearly in their Report, is concerned only with public conduct, and with public conduct which injuriously affects public order in a community.[308]

There were many commentators who saw the practice of AID as a private matter, but others believed the continuance of AID would negatively affect public order and the community as a whole.

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[307] Pfeffer, 122.
[308] 'Artificial Insemination of Married Women', House of Lords Debate, 26 February 1958, vol 207 cc926-1016.

The Lords were particularly concerned with public opinion and how best to shape it. It was felt that an approach to public education – different from the headlines in the press – was needed to appropriately shape public opinion, particularly when the topic had commanded such interest. The Lord Chancellor commented on the fevered attention to the subject:

> I find it difficult to remember a topic which in so short a space of time has aroused as much interest in the newspapers, on the radio and, indeed, among men and women …This is due partly to the novelty of the subject to many people, because it has hitherto been rarely discussed, at infrequent intervals; and partly, as I have said, to the face that it concerns so intimate and private a matter of human life.

More than general attention to the subject, there was concern over how the press was shaping opinion – and making AI seem acceptable. Lord Kinnaird was particularly concerned at how recent press coverage might shape public views:

> Public opinion is formed very much more by the headlines, in the newspapers, and those headlines, as I have read in the Press, have been misleading on this point. Here is one which says: "Insemination Not Adultery: Judge's Ruling". I believe that that is a misleading statement. The public will say, 'They say that it is all right'.[309]

The Lord Archbishop of York stressed that part of the urgency in dealing with the matter of AID was due to this trend in public opinion, and the necessity for the government to act as a guide:

> There is an idea abroad…that A.I.D. can, so to speak, be brought within the terms of a decent fulfillment of the contract of husband and wife…It is for the trend of public opinion that this fact urgently needs to have recognition in our law of divorce. Towards that public opinion and public sentiment your Lordships' debate to-day is able to give a lead.

The Marquess of Reading argued that before any legislation was advanced, the Government should have the support of public opinion:

> If legislative action is to be taken upon a matter of this kind, it would be right, and it would certainly be advantageous, for any Government to have behind them the feeling that the public support them in the direction in which they are going. It is my belief that in present conditions the public are mystified, uneasy and still groping in the dark in quest of authoritative information upon what is to many people a new and striking and equally, to many people, a repulsive subject. But it is a question which is before the public, just as it is

[309] Ibid.

> before your Lordships' House, and I do not believe that, in present conditions, the public either have the information or the means of obtaining the information.[310]

But, he went on to argue, that at the time there was not an "instructed public opinion" because the case presented was a "fragmentary and sensational" one – implicating the popular press and media – and what was needed was a "comprehensive and responsible one". Lord Chorley appeared as the voice of dissent in his support for individual freedoms. He said that the Chamber was far out of touch with public opinion in these sorts of issues:

> I believe that the march of events is against the views which have been expressed by most noble Lords this afternoon, and that the weight of what I, at any rate, regard as progressive opinion is against the proposal to try to put down A.I.D. in one way or another.[311]

Lord Kinnaird insisted that it was the Government's duty to make the position on AID clear to the public, because at the time the public was seen to be floundering:

> I am quite sure that the public do not know where they are. Since Lord Wheatley has given his judgment in the case that has been mentioned, I believe the public are more than ever at sea, and that as a result of that decision this practice may grow…there is a grave danger that Lord Wheatley's judgment will be misunderstood.[312]

There was a general sentiment among the Lords that the narrative around AI required government intervention, lest the public come to believe AID was an acceptable way to conceive a child. This is perhaps not surprising, and can be seen as self-serving. The peerage system relied on hereditary succession, and the legal status of AI had the potential to impact those assurances. In Britain, in particular, there was a great deal of significance attached to legitimacy and hereditary inheritance, which titled families relied upon. These long traditions and assumptions about 'legitimacy' are particularly prominent in classed societies. If the certainty of hereditary succession disappeared, it

[310] Ibid.
[311] Ibid.
[312] Ibid.

threatened not only individual family life, but the entire monarchical and peerage systems as well. Yet how the issue should be dealt with divided the Lords, particularly on the question of regulation and legislation. In addition to an inquiry, arguments were made in favour of changing the divorce law to include AID (supported by Lord Blackford and The Lord Archbishop of York), and for making AID a criminal offence (advocated by the Archbishop of Canterbury and Viscount Astor). However, when it came to the question of regulation and prohibition, there was apprehension over the potential consequences. Lord Amulree, Lord Chorley, and the Lord Bishop of Exeter all expressed concern at the practice being driven underground if it were made subject to regulations or deemed a criminal offence. Yet the Archbishop of Canterbury stood firm to his 1948 pronouncement that AID should be made a criminal offence. Lord Chorley issued a strong warning that if donor insemination was forced underground its practice would compare to that of abortion:

> If this matter were to be made criminal and driven underground, it would be the bad type of man – for example, the man who does abortions – who would come into this kind of work, instead of reputable doctors doing it, as at present.[313]

Not surprisingly, the Archbishop of Canterbury welcomed it being driven underground for the exact same reason:

> Let this practice be driven underground, as abortion is, and no responsible doctor would practise it; it would have the ignominy that it deserves. For myself, I should expect the medical profession to welcome a step which would relieve them of a spiritual, moral and social responsibility which does not belong to the medical profession alone.[314]

Apparently the Archbishop of Canterbury was willing to ignore the large numbers of 'illegal' abortions taking place each year in Britain. Most significantly, the Lord Archbishop of Exeter had changed his opinion on artificial insemination since 1948,

[313] Ibid.
[314] Ibid.

when he signed the Archbishop of Canterbury's Report advocating for AID to be made a criminal offence. In 1958, in agreement with Lord Chorley, the Lord Archbishop of Exeter said he would no longer support the 1948 report:

> …such a step would be gravely unwise. It would certainly have the effect of drawing the conduct of this practice from the responsible hands in which it now rests to totally irresponsible, possibly even disreputable, hands, as has happened in the case of abortion.[315]

The subject of donor insemination divided the Lords on multiple issues, with the threat AID was seen to pose to the family becoming central to the debate. Lord Blackford argued that all the reasons couples turned to AID were selfish:

> They gratify the longings and desires of the husband and the wife. But they take no account of what effect their action may have upon the religious aspect; upon the community; upon the family unit; and, above all, upon the end product: the child.[316]

The welfare of the child had taken on growing social significance in the aftermath of the war, influenced by psychological theory, and embossed on child-centred welfare legislation like the Family Allowances Act, the Education Act, and even the National Health Service. Lord Blackford questioned the considerations of choosing to conceive via AID, underlining his belief that individual desire for parenthood was not reason enough. To his mind, personal desire ignored the well-being of the child, and the broader social implications for the family unit. In a period of perceived social threats – both external and internal – condoning a practice that was perceived to possess the seeds to dismantle family life and psychologically scar the child born via this 'new' method, was seen as too great a risk to British society. The strength and integrity of the family unit, Blackford argued, defined the strength and integrity of the community:

> I think this country believes very strongly in the family unit, and some of us feel that there is a tendency for the family unit to weaken in these days, through the

[315] Ibid.
[316] Ibid.

> enormous increase in divorce; through the rush and hurry of modern life; through the laxity of parental discipline…[317]

Lord Denning also worried about the affect AID might have on the family: "It seems to me that if this practice became widespread it would strike at the stability and security of family life: it would strike at the roots of our civilisation."[318] The Lord Bishop of Norwich, too, was centrally concerned with how AID might affect the "sanctity of family life". The Lord Chancellor had the final word on the matter: "…we must all agree that in fact today the family is the basis of society; and before welcoming any process which may upset that basis we must give that process the most careful examination."[319] This emphasis on the community – of which the family unit was a central part – pushed uncomfortably against arguments in favour of individualism.

The argument for the stability of the family seemed to bump up against arguments for the freedom of choice and the right to parenthood. This points to an early example of a shift that became more pronounced in the late 1970s. This question – whether parenthood is an inalienable human right – was an important feature of this debate and to those that followed in succeeding decades. In 1948, the UN Declaration of Human Rights included the "right to marry" and "found a family", regardless of race, religion, or nationality.[320] But, of course, the definition of 'family' and what it meant to 'found' one was and is open to interpretation: does establishing a family necessarily mean to have children? Does it necessarily mean a right to biological parenthood? What means of founding a family are social acceptable? The flexibility of this definition of 'the family' is significant, and its interpretation as a human right became more central to the

[317] Ibid.
[318] Ibid.
[319] Ibid.
[320] 'The Universal Declaration of Human Rights'. United Nations. http://www.un.org/en/universal-declaration-human-rights/ accessed February 2016.

reproductive rights debates of the late 1970s and onward. The framework also reflects a broader shift. Stephen Brooke argues that by the late-1970s there had been a shift in the focus of sexual issues from family and maternity to the individual, which was expressed through both the women's and gay liberation movements.[321] As with birth control and abortion, there was a shift in the way discourse around reproductive technologies and infertility was articulated in the 1970s. This marked a transition from a family and community-centred view, to one that prioritized individual human rights. This debate in the late 1950s therefore marks a tension over views on the purpose of parenthood between the community benefit (for the family, society, nation) and individual rights (of woman, man or child). This shift is coded in the legislative reforms of the late 1960s (ie. abortion, homosexuality, and divorce reforms); and can be seen in the extension of contraceptive access regardless of marital status in the early 1970s; in unmarried motherhood and lesbian parenthood with AID in the late 1970s; and, not least, with IVF and surrogacy in the 1980s.

This tension between the liberty of the individual, and the stability of family and marriage as social institutions was apparent in the Lords' debate. Lord Chorley said that the "question of liberty" was central to the discussion and "fundamental to this matter". To deny a couple the "free right to get a child in this way" was wrong, and represented an intrusion "into the marital relationships in a way which I think the law has always set itself against – the relationships which should be sacrosanct from the prying eyes of the law and of the State".[322] In essence, Chorley argued that married couples had a right to

[321] See Stephen Brooke, *Sexual Politics. Sexuality, Family Planning, and the British Left from the 1880s to the Present Day*, (Oxford: Oxford University Press, 2011).
[322] 'Artificial Insemination of Married Women', House of Lords Debate, 26 February 1958, vol 207 cc926-1016.

parenthood, and it was not the concern of the State or the law. The Archbishop of Canterbury opposed this view, arguing that the desire for a child that cannot be fulfilled naturally should be redirected towards other aims. Speaking of the childless couple, he said:

> We can understand and sympathise. But how many psychological longings there are which men and women have and which they have to learn to control and sublimate! If this particular longing is to be satisfied, it can be only at a great, and some of us think a disastrous, price…It cannot but destroy the integrity of marriage as ordinarily understood.

This notion of individual right and the family unit were clear points of conflict among the peers, as they were in the *BMJ* correspondence debate fifteen years earlier.

The press reported widely on the House of Lords debate, and the response to the announcement of a government inquiry assumed that it would cover the entire field of the matter, not simply the legal aspects.[323] Therefore, by May 1958, the Cabinet was forced to expand the inquiry to examine the wider social and medical aspects of the subject.[324] By June 1958, there was still concern that the report "would be controversial and potentially embarrassing to the Government". [325] However, the public had already been critical of the Government's inaction and would expect the investigation to not be limited to the legal aspects.[326] The formation of the Departmental Committee went ahead.

**Promoting 'Test Tube Babies' in the Press**

As was recognized in the House of Lords debate, the Press had a vital role in educating and guiding public opinion – and it is to that influence of newspapers and other media that this chapter will now turn. The MacLennan case was covered by virtually all

[323] 'Procreation by Proxy', *The Times*, 27 February 1958; 'Inquiry into A.I.D.', *The Times*, 27 February 1958.
[324] National Archives, London, CAB/129/93-A1/0019.
[325] National Archives, London, CAB/128/32-A1/0047.
[326] National Archives, London CAB/128/32-A1/0047.

the national newspapers, including the *Daily Express, Daily Mail, Daily Mirror, Daily Sketch, Daily Telegraph, News Chronicle, Guardian, Observer* and the *Times*.[327] This divorce case provoked a variety of responses, though none of the papers were quick to denounce the practice. In fact, several emerged with human-interest stories sympathetic to the AID family.

The *Daily Mirror* and *Daily Express*, in particular, capitalized on family narratives around artificial insemination. Such 'human interest' stories were central to the success of the popular newspapers.[328] The *Daily Mirror* was quick to jump on the case in December 1957. Reporting Mrs MacLennan's side of the story in 'My Test Tube Baby — By Her Mother', a *Mirror* writer interviewed her in her Brooklyn home:

> In New York today slim, blonde, Australian-born Mrs. MacLennan, 30, went to work as usual at the hospital where she is a nurse. She told me: 'My little girl was born in July 1956 - a darling little blonde-haired girl I named Melanie'. 'Melanie is two and a half now and she is growing up so fast in America I almost wish I was back in Britain again where children seem to grow up more slowly.' Mrs MacLennan, who used to be a professional ice-skater said her first husband was killed during the war. She first met Mr. Ronald MacLennan while she was appearing in an ice show in Glasgow in 1946 and they were married in Edinburgh in 1952. Mrs MacLennan went on: 'Both of us wanted children desperately. We were heartbroken when our first baby died at birth.' 'Later I travelled between Australia, America and Britain. On one of my visits to America I was artificially inseminated'.[329]

Papers were fond of such 'true stories' of test-tube families that humanized and de-medicalized the practice. The *Mirror* presented a sympathetic view of Margaret's life as

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[327] The popular press worked on the premise that 'sex sells' and as a result, "sex-related reporting became far more wide-ranging, extensive, and detailed". In the postwar period, the tabloid press actively opened up the public discussion of sexual issues. Reporting on Kinsey's 1953 study is indicative of this, as is the coverage of issues like contraception and abortion, which were discussed more openly in the popular press in the period. Bingham also argues that the papers were not interested in merely reporting – they also wanted to shape opinion and be active in debate. The press "certainly destabilized the notion that sex was a private, intimate activity that should remain confidential". Bingham has stressed the educative importance of popular newspapers, particularly in the realm of sexual knowledge. Since such knowledge was limited, most people relied on informal sources of information and newspapers printed a wide range of stories dealing with sex and sexuality that contributed to public attitudes. Particularly after the launch of ITV in 1955, adding a new level of competition, the popular press was forced to take more risks in order to maintain the loyalty of its younger readers.
Bingham, *Family Newspapers*, 256, 10,12.
[328] Ibid, 264.
[329] 'My Test Tube Baby', *Daily Mirror*, 7 December 1957, p.7.

marked by the tragedies of losing her first husband in the war, and losing her first child at birth. Despite having AID in another country without her husband's knowledge, the paper implied that Margaret MacLennan deserved a happy life. The *Mirror* positioned MacLennan as the beautiful, blonde protagonist in a narrative where, after tragic loss, she was now a single working mother living happily in America. It is perhaps curious that only brief mention was made of the eventual divorce granted to Ronald MacLennan. On 28 February 1958, Lord Wheatley granted a decree of divorce to Ronald MacLennan on the grounds of Margaret MacLennan's 'misconduct' by adultery, since there was no evidence that the child had been conceived by AID. The finding was reported in the *Daily Express*, *Daily Mail*, and even the *Toronto Star*.[330]

Similar to the *Mirror*, the *Daily Express* supported AID, and responded to the Archbishop's comments in January 1958 with an article, 'For the Primate – A Story of Two Happy Wives'. Mrs X, a 36 year old mother of a seven-month-old boy explained that after six years of marriage she asked her husband how he would feel about a "test-tube baby", to which he replied: "To share in its environment and its upbringing – that's ample for me".[331] Speaking of her baby's beauty, Mrs X said she believed the child resembled her husband. It appeared that she felt no religious conflict in their decision to use AID: "This baby has made us more united because we both believe that science is a gift of God and should be used for man's benefit".[332] In this story, science was a saviour rather than a threat to the family. The second woman interviewed was Mrs Y, 32 years old, who turned to AID after a still-birth – she was told it was impossible for her to have

[330] 'Man wins a divorce in A.I.D. case', *Daily Express*, 1 March 1958; 'Test Tube' Case: Man Gets Decree', *Daily Mirror*, 1 March 1958.
[331] 'For the Primate – A Story of Two Happy Wives', *Daily Express*, 16 Jan 1958.
[332] Ibid.

another child. She explains that her marriage was "slipping" and that it was essential for her to have a child – her husband agreed that she should have a "test-tube baby". Their little boy was now four years old, and not to leave Mr Y out of the article, the paper quotes him as saying, "Of course I spoil him".[333] Both Mrs X and Mrs Y refer to their decision not as having a procedure, or AID, but as having a "test-tube baby". The *Express* article stressed the agreement between husband and wife, the centrality of children to marriage, and the normalcy of family life after AID. The popular press appeared to use the colloquial 'test tube baby' to desexualize the practice for readers. The focus was placed on the outcome of the practice – a baby – rather than what was seen as an unsavoury medical procedure akin to adultery. This language was family oriented, and by focusing on having a baby, rather than a procedure, it appeared to further distance AID from claims of adultery.

A few days later, the *Express* published a letter from a husband whose wife had a "test tube baby". The paper assured readers that although anonymous, the letter's authenticity had been verified. The husband described the difficult years of seeing numerous doctors, sub-fertility experts, operations, hormone injections, and thousands of pills. When the couple heard of a doctor in London's West End having success with AI they decided to go ahead. After eight months and a £52 10s. fee, his wife was pregnant. Dismissing any suggestion of jealousy, the husband wrote:

> I don't care who the donor may be, I don't give a damn for the ethics of the matter – the greatest thing in the world has happened to the most loved person in my life and, if I can rake up the money, I'll do exactly the same thing all over again as soon as possible![334]

[333] Ibid.
[334] 'My wife is having a Test Tube Baby', *Daily Express*, 20 Jan 1958.

These articles were structured to generate empathy and understanding from readers, many of whom were opposed to the practice. This was shown by a Gallup Poll in March 1958, which indicated that forty-nine per cent of respondents disapproved of AID.[335] Moreover, nine out of ten letters received by the *News Chronicle* in February 1958 on the issue of artificial insemination denounced the practice.[336] Despite this opposition, the letters selected for publication presented a balanced view of public concern. Therefore, the press can be seen as actively trying to shape a more positive public opinion on donor insemination through both its opinion pages and articles. The human interest stories in the press conveyed a level of emotion that was designed to tug at the heart-strings and suggest that 'Mrs and Mr X' could be anyone.

Though not a tabloid paper, the *News Chronicle* presented a series on AID that included two human interest stories – one of Mrs. X and the other of Mrs. A – both of whom had children as a result of AID. Neither were concerned with the moral criticisms made by the church and others – and simply explained how happy they were with their families. Yet they were extremely protective of their identities, fearing the stigma of the label 'test-tube baby'. When asked if she would have still had the child if legal registration documenting the mode of conception were required, Mrs. X replied: "I do not think so. It might have affected his whole life to have carried that label. We might have tried to have our own child".[337] Statements like this underline the stigma attached to children conceived by AID: that they were somehow unnatural, or less than human. Such articles aimed to nudge public opinion towards acceptance and tolerance.

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[335] Gallup (Ed.), *The Gallup International Public Opinion Polls*, 449, 454.
[336] 'AID: Right or Wrong? Nine out of ten say WRONG', *News Chronicle*, 13 Feb 1958; Wellcome Library, London, SA EUG/N.66; Naomi Pfeffer, *The Stork and the Syringe*, 120-21.
[337] 'The phone rings – a mother talks of AID twins', *News Chronicle*, 5 Feb 1958.

The *Daily Express* took this one step further. The paper used photographic evidence of 'normal family life' to help reinforce a positive view of AID and the family. In March 1958, the *Express* devoted a half-page to a photo of a family of seven – mother and father with five daughters – with the headline 'Which Girl is the Test Tube Baby?'. [Figure 4.5] The paper revealed that six-year-old Carol Anne, the eldest child in the centre of the photograph standing next to her father, was the 'test tube baby'.[338] Telling the story of the Knights, a 'large united family' in Sydney, Australia, the article and image reassured readers that there was no visible stigma or indicator attached to a child conceived by artificial insemination. The *Express* celebrated the family and explained that they were proof that having a child born by AIH was 'in every way a happy event', and that Carol Anne was 'in no way different from her sisters'. This story is notable since, due to the social stigma attached to artificial insemination, it was unusual for parents and children to be pictured and named. All accounts of AI conception in Britain were shrouded in anonymity, protecting the identities of both parents and children. The Australian family had conceived by artificial insemination by husband (AIH), which was more publicly acceptable and did not carry with it the same controversy as did using a donor. It is significant that there was a safe geographic and psychological distance from Britain in this case. The same sense of safe distance can perhaps be seen in the case of Margaret MacLennan, who was Australian by birth and had emigrated to America after leaving Ronald MacLennan. AID may have been perceived as more socially acceptable when it took place outside of Britain, or did not involve British nationals. These two cases provided a relatively innocuous means for the popular press to discuss AI,

[338] 'Which Girl is the Test Tube Baby', *Daily Express*, 12 March 1958.

unhindered by censorship of the parents' identities, about this 'technology' leading to joyful parenthood and a happy family life.

Telling the story of this Australian family, the article and image was reassuring readers that there was no visible stigma or indicator attached to a child conceived by AID. She appeared as 'natural' and 'normal' as any other. By appealing to the emotions, these stories had the power to diffuse some of the debate by generating sympathy. They also sought to normalize the technology – drawing on the importance of children to marriage. In other words, these articles suggested, an AID child was better than none at all. The threat to the stability of the family was less of a social concern than a couple remaining childless. The point these papers made was that it was about the well-being of the family – both parents and children. They tried to emphasize the normalcy of family life with a 'test tube baby'.[339] By appealing to the emotions, 'human interest' stories in the press had the power to diffuse some of the anxiety and intensity of debates about AID by generating sympathy. In this way, the popular press played a significant role in encouraging acceptance of AID and of children conceived by assisted reproductive technologies. But this acceptance was, of course, contingent upon and contained within the boundaries of heterosexual marriage.

**Public Opposition**

The topic of AI was a juicy one for the newspapers, but did this type of press coverage influence public perceptions? Gallup Polls to gauge public opinion on artificial insemination were conducted in 1949 and 1958, the peak years of debate on the issue.[340]

[339] On how the press celebrated the happiness an AID child could bring to the family in the 1950s see Herbst-Lewis, *Prescription for Heterosexuality*, 113-114.
[340] In 1949, an Australian newspaper reported on a Gallup Poll conducted on artificial insemination. Gallup polled people in both England and the United States, asking if they had heard of 'test-tube babies' or

One poll took place in January 1949 (the month that *Breach of Marriage* opened in London's West End and the Cabinet discussed a possible inquiry), another was conducted in January 1958 (following the MacLennan case ruling) and the final poll was done in March 1958 (following the House of Lords debate and the announcement of a departmental committee investigation).[341] Public awareness of AI was quite high across the period, and did not increase by any significant margin over the decade. In 1949, 85 per cent of those polled had heard or read about artificial insemination or 'test tube babies'. By January 1958, this proportion had grown to 88 per cent, and by March 1958 to 89 per cent. By contrast, in the United States in 1949, only 75 per cent of Americans polled by Gallup had heard of AI or 'test tube babies'.[342] This 10 per cent difference is surprising as the practice in the US had grown much faster than in Britain, through a cursory examination of press coverage in the *New York Times* suggests that much American coverage was focused on debates in Britain. Presuming the accuracy of the polls, the broader awareness of artificial insemination in Britain could be attributed to

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artificial insemination. 85% of people in England said 'yes', while only 70% of Americans said 'yes'. When asked if they approved or disapproved of people having children by artificial insemination, disapproval ratings were significantly higher in England. In Britain, 45% disapproved, 23% approved, and 32% were either undecided or uninformed. While in the US, 31% disapproved, 27% approved, and 32% were undecided or uninformed. This report conflicts with actual data of the Gallup Poll conducted in the US in 1949. Which shows that 75% of Americans had heard of 'test tube babies'; 43% disapproved of having children by this method, 40% approved; 17% were undecided or had no opinion. The poll was followed up again in 1953, asking Americans if they had heard of 'test tube babies' and for those who answered 'yes', whether or not they approved of people having children in this way. The 1953 poll showed that only 67% of people had heard of read about artificial insemination. The approval rating had hardly changed in four years: 43% disapproved, 40.5% approved, and 16.5% had no opinion.
Gallup (Ed.), *The Gallup International Public Opinion Polls*.189, 449, 454; 'Gallup Poll: Test Tube Babies Frowned on in U.S. and U.K.', *The Advertiser*, 11 June 1949.

[341] The questions were phrased differently in each instance, so a direct comparison is not possible. The existing evidence points to a number of shifts. First, the specificity around the terminology of artificial insemination was more defined by 1958 (when respondents were asked for their opinion on AI by husband or donor); in 1949, by contrast, respondents were asked about AI in a very general way. This indicates a growing understanding of the different methods, but also a focus on the controversial element of the practice – which was the donor.

[342] Gallup Poll #440, Question QN11B, 4/7/1949 Accessed http://institution.gallup.com on 16 September 2013.

wider press coverage at this time; it may also be related to the popularity of science fiction literature that suggested such processes early on, as did Marie Stopes in *Married Love*. Broadly speaking, the subject of artificial insemination received more publicity in Britain during this period.

Polls in Britain suggest that any press campaign to make AID permissible was largely unsuccessful. Attitudes to the practice did not change much between 1949 and 1958. Of the 1000 respondents polled in January 1949, 45 per cent disapproved of artificial insemination generally (of the 85% who had heard of AI). The other 55 per cent were divided: 23 per cent approved; 17 per cent had no opinion. The majority of those who disapproved did so on the grounds that it was an 'unnatural' practice. By January 1958, the questions had become more refined to refer particularly to AIH or AID. When asked if they approved of AIH, 33 per cent approved, 35 per cent disapproved, and 20 per cent were undecided. When those who approved of AIH were asked about AID, 45 per cent disapproved, 40 per cent approved and 15 per cent were undecided. In March 1958, when asked how they felt about AID, 49% disapproved, 21% approved and 19% were undecided.[343] What these polls demonstrate, more than anything else, is that public awareness and perspective on artificial insemination did not change substantially from January 1949 to March 1958, despite the media barrage. If anything, there seems to be less acceptance of AI in 1958 than there was in 1949.

Letters written to the editors of the national dailies in 1958 also support this finding of significant public opposition. Public feedback in the press was in part sympathetic to couples trying to conceive in this way, but ultimately most disagreed with

[343] When asked whether AID should be allowed if both the husband and wife consented, 39% agreed. Still, the majority of those polled believed that secretly seeking AID without a husband's consent should be grounds for divorce (56%).

the practice. Letters expressed concern over a number of issues including but not limited to: accidental incest (with a sister and brother of the same donor father unknowingly marrying), wrongful inheritance (since 'test-tube babies' were considered illegitimate), and the mechanics of adultery when a syringe was to blame. These fears were based on traditions of succession, the assumption of heredity, and the continued practice of labelling children as 'illegitimate' when not conceived within marriage. These fears also speak to ideas of classifying and categorizing people in a hierarchy, based not on class or race but on the conditions surrounding the moment of conception. Most felt that some official record of both the donors and the children should be put in place for the future protection of society, which was ultimately enacted in the Human Fertilisation and Embryology Act (1990, 2005).

Newspapers attempted to present a balanced view on the issue. As mentioned earlier in this chapter, in February 1958, nine out of ten letters received by the *News Chronicle* on AI denounced the practice.[344] However, the letters selected for publication attempted to present a more equal divide of public concern. The following is a sampling of letters to the Editor from the *News Chronicle* and *Daily Mail* between January and February 1958:

> "…If A.I.D. can bring happiness and help to save a marriage that is under strain, it is a blessing."
> James Ottaway, Drake Street, W.C.1[345]
>
> "A child conceived in this revolting way is a sin against all laws of nature."
> Fred. J. Phillips, Truro[346]
>
> "There is general sympathy towards childless couples who yearn for a family. But if A.I.D. technique is practised on an increasing scale, who will know whether any entry in the register

[344] 'AID: Right or Wrong? Nine out of ten say WRONG', *News Chronicle*, 13 Feb 1958; Wellcome Library, London, SA EUG/N.66; Pfeffer, 120-21.
[345] 'Letters', *New Chronicle*, 17 Jan 1958.
[346] 'Letters', *News Chronicle*, 17 Jan 1958.

> of births is genuine? No one would ever be sure whether his mother's husband is indeed his father…A.I.D. should be practised in sparing fashion and an official record kept which would be open to inspection to those most closely concerned."
> A.R. Thompson, Petts Wood, Kent[347]
>
> "The use of A.I.D. in some special cases seems praise-worthy up to a point. What is immoral is the deception… The most monstrous thing is the deception of the children. That parents and children shall be 'known' to each other – and to society – is the fundamental social ethic underlying the whole idea of the sanctity of marriage."
> (Mrs.) Joan Snell, Letchworth[348]
>
> "One of the dangers of allowing uncontrolled A.I.D. is that marriages might take place between half-brothers and half-sisters who have been kept ignorant about the circumstances of their birth. The risk is all the more real because donors seem to be drawn from a restricted circle. One, according to Hugh McLeave, has fathered as many as 17 children. If we must have A.I.D. on medical grounds, then at least have a registration system to avoid the dangers of inter-marriage."
> S.G. Markham, Kilburn High Road, N.W.6. [349]
>
> "Sir – The most important consideration in any community is the child, the citizen of the future, not the woman who would have any sort of child so long as she might call it her own.
> Heredity and environment are forces which cannot be ignored, and what sort of moral heritage can any child expect from a test tube; or what sort of moral environment from a mother who would accept such a means of motherhood with its possibilities of criminal or immoral heritage?"
> (Mrs.) E.B. Yiend, Hemel Hempstead [350]
>
> "How about sparing a thought for the unfortunate child? What will be its reaction when it grows up to learn it came out of a tube?"
> D. Edwards, Grantham [351]

Inaccurate assumptions about a literal test-tube conception aside, these letters underline the hugely divisive nature of the issue.

## Documenting AI on Television and Radio

The MacLennan case was discussed on television almost immediately after the ruling. Televisual treatments of the case mixed editorial comment, reportage, and exploration of public opinion, and so provide an intersection of reactions to the case. On January 16 1958, a half-hour documentary on artificial insemination appeared on ITV entitled 'A Blessing or a Sin?'. The Granada TV programme was in direct response to the

[347] 'Letters', *News Chronicle*, 7 Feb 1958.
[348] 'Letters', *News Chronicle*, 7 Feb 1958.
[349] 'Letters', *News Chronicle*, 7 Feb 1958.
[350] 'Test Tube Babies', *Daily Mail*, 20 Jan 1958.
[351] 'Test Tube Babies', *Daily Mail*, 20 Jan 1958.

Archbishop of Canterbury's speech that week, and aimed to address questions raised by Dr Fisher and by the Edinburgh divorce case. A prompt response to the debate, the programme offered views from both sides – and took the opinions of ordinary people on the street, a reporter, religious leaders, and legal and medical experts.[352] It did not sensationalize the topic, but presented an informative documentary-style approach. By the late 1950s, few medical practitioners had any first hand experience or even 'hearsay' knowledge of the practice. In this way, media outlets were essential in the dissemination of information to ordinary people. The programme interviewed eleven ordinary people on the street of which five were in opposition, four were in support and two were neutral offering a balanced perspective. Interestingly, all four interviewees who were strongly in support of AID were men, and four of the six in opposition were women.[353] Media reporting (including TV, press, and radio) suggested that the public was more accepting of AID than the Gallup Polls and letters to the editor indicate. The following examples of 'street interviews', from 'A Blessing or a Sin', represent the public division:

> "What do you think about artificial insemination?
> Man: *I think it is a jolly good idea*
> Why?
> *Well, I think it gives a lot of people a chance to have a child when otherwise they possibly could not have one.*
> You do not think it should be made a crime?
> *Good lord no! Certainly not!*"[354]
>
> "Have you any views about artificial insemination?
> Woman: *Yes, I am afraid I do not agree with it at all.*
> Why?
> *Well, it seems a very wrong way to do things somehow. I mean marriage is such…is a married state and I do not think you should have any artificial help towards it at all.*"[355]

[352] Wellcome Library, London, GC/193/E/15/7, 'A Blessing or a Sin?: transcription of Granada TV programme re artificial insemination', 16 January 1958.
[353] Wellcome Library, London, GC/193/E/15/7.
[354] Ibid.
[355] Ibid.

It is unclear whether this opposition to 'artificial' means was also applied to 'artificial' birth control. Brian Inglis, deputy editor of the *Spectator*, conducted the remaining interviews in the studio. Dr Alfred Byrne, the medical correspondent for the *Guardian* and the first to be interviewed on the programme, estimated that between 1000 and 1500 children had been born in Britain via AI since 1941.[356] Byrne described the procedure of AID, the difference between AIH and AID, and explained the importance of the donor's identity remaining a secret. Up next was a representative from the press. Miss Pat Taylor, a *Daily Sketch* reporter, had the day before the programme interviewed a mother of a 'test tube baby' and was now on television describing this interview: the mother was 40 years old, middle class, and "an ordinary normal type of woman that you could see walking down any local high street any day".[357] When asked if the mother was happy, Miss Taylor replied:

> Oh, she was terribly happy. This baby has…well, as she said to me 'it has fulfilled my life'. She nearly had a nervous breakdown before the child arrived because she did try and adopt a child, but there are so many thousands of couples waiting for babies for adoption that there are just not enough babies to go round.[358]

This narrative underscored the notion that having a baby was essential to a woman's happiness; that if it was not possible there were often negative psychological consequences; and that adoption was not a practical option based on supply and demand. The programme also interviewed the Clerical Secretary of the Church of England Moral Welfare Council – Rev G.R. Dunstan – who supported and reiterated the views expressed by the Archbishop of Canterbury earlier that week. Dr Letitia Fairfield, President of the Medico-Legal Society, spoke on behalf of the Roman Catholic Church which opposed

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[356] 'Test tube babies 'not so evil' says Bishop', *Daily Mirror*, 17 January 1958, p.3.
[357] Wellcome Library, London, GC/193/E/15/7.
Unfortunately, it was not possible to retrieve a filmed copy of the programme, therefore there are no visual supplements to the transcript.
[358] Ibid.

AID as a "violation of the Catholic conception of marriage".[359] Transitioning into the final interviews with the editor of the *New Statesman*, a barrister, and a doctor, Inglis said: "Well now, the churches are down always on making a tremendous thing against AID, but we must have the liberal view as well".[360] The final interview of the programme was with an anonymous doctor (likely Dr. Mary Barton) who described her practice in AID: dealing with 50-60 cases per year since 1940, with a success rate of 57.7%; having mostly middle-class but some working-class patients, with ages ranging from 22-42 years old. One of the most controversial issues was the "secret men" used for the procedure. The doctor described the donor selection process:

> "…Doctor: I use as donors always or nearly always married men, with a child or two of their own, and mostly in professional work.
>
> Inglis: How do you select them? Through personal knowledge?
>
> Doctor: They have to satisfy certain standards. They have to be…the family history has to be faultless. Their physical characteristics have to be good. They have to have good health and high fertility.
>
> Inglis: Do you find that the mothers have any…?
>
> Doctor: Oh yes, they sometimes ask for special features.
>
> Inglis: Can you tell me the sort of thing…?
>
> Doctor: Well, Jewish couples very often ask for a person of Jewish birth. Occasionally they ask for certain physical characteristics. I had one lady who was very anxious that she should have a very tall donor because all the menfolk in her own family were very short.
>
> Inglis: Have you had any curious instances in relation to this and can you recollect anything that has interested you particularly?
>
> Doctor: Well, I had one husband who said that he was all in favour and he would like to give his wife everything she wished for, but he must have a son who was a very good swimmer. I was not able to fulfil that however."[361]

[359] Ibid.
[360] Ibid.
[361] Ibid.

Another concern was the health of a marriage after AID. To the doctor's knowledge, only one marriage had broken off after a child was born by AID, but she could not prove this. Barton explained that she did not follow up with the families after the child was born as she did not want to "interfere with their privacy":

> …if you have got a doctor writing year by year to ask you how little Johnny is getting on and so forth – I feel that you take away their sense of privacy, that you make them feel that they have become a kind of guinea pig – under observation.[362]

The closing statement of the programme underlined the pronatalist thought of the period that promoted traditional gender roles in the family: "You can be sure that the wish of every women – the wish of every woman to have a baby – is not very easily going to be stifled by the church or by the law or by anyone else. Goodnight".[363] The discourse of the period largely promoted this belief that having a baby was both a biological imperative and a means of psychological fulfillment for *all* women. The presumption that motherhood was a natural desire for all women also supported the underlying message that neither church nor state should have control of this reproductive choice.

The relationship between the state and reproductive technologies became a point of controversy after the programme aired. The following day, nearly all the national dailies ran a feature on 'A Blessing or a Sin?'.[364] The state's position on AID became a hot-button issue when it was suggested that artificial insemination was available at no cost through the National Health Service. A full-page feature in the *Daily Sketch* reported that the programme had "revealed to millions on ITV last night that test tube babies … are available under the National Health Service".[365] Using information provided by the

[362] Ibid.
[363] Ibid.
[364] Newspapers that featured a review of *A Blessing or a Sin* included the *Daily Telegraph*, the *News Chronicle*, the *Daily Mail*, the *Daily Mirror*, the *Guardian*, and the *Daily Sketch*.
[365] 'Test Tube Babies on the State', *Daily Sketch*, 17 Jan 1958.

Ministry of Health, it was reported that AID "could be got on the Health Service if the doctor considers it necessary …[but] we have no means of knowing whether in fact artificial insemination is being carried out on the health scheme".[366] In theory, the NHS could have been providing AID to couples unbeknownst to the Ministry of Health or to the general public. Of primary concern in the newspapers was the numbers of 'test tube babies' in existence and the notion that they were being 'created' under the NHS without anyone's knowledge. Public investment in the nationalized health care system meant that there was a demand for knowledge of any such controversial practice. The *Times*, presumably doubting the accuracy of Pat Taylor's claims, wrote directly to the Minister of Health the day after the documentary aired asking for confirmation of whether AID was done under the NHS, to which the Ministry replied that they had "no information about cases of A.I. carried out under the Health Service".[367] As indicated by an internal note for record, the Minister wanted to insist that AID was never provided under the NHS, but he was advised such a statement would not be accurate.[368] The *Times* further requested statements from the British Medical Association, the Royal College of Obstetricians and Gynaecologists, the Family Planning Association, the Royal Society of Medicine, and the Director of the Fertility Clinic at University College Hospital. All but the latter declined to take any official position on the procedure.[369] With a strong eugenic bent, the Director of the Fertility Clinic criticized the donor selection process, drawing particular attention to the possibility of disease and unknown racial ancestry:

[366] Wellcome Library, London, GC/193/E/15/7.
[367] National Archives, London, MH 58/403, 'Artificial insemination: policy, correspondence and newscuttings; memorandum by Ministry of Health', 1944-1958. See also, 'Cautious B.M.A. Comment on Artificial Insemination', *Times*, 18 Jan 1958.
[368] National Archives, London, MH 58/403, 'Artificial insemination: policy, correspondence and newscuttings; memorandum by Ministry of Health', 1944-1958. See also, 'Cautious B.M.A. Comment on Artificial Insemination', *Times*, 18 Jan 1958.
[369] 'Cautious B.M.A. Comment on Artificial Insemination', *Times*, 18 Jan 1958.

> Not enough trouble was taken, for example, to ensure they were not carrying syphilis at the time. They might, too, have negroid ancestry. A sufficient genetic tree could not be established for each donor.[370]

The Director said further that a man becoming a donor alone indicated there was something wrong with him, even if no payment was given. The relationship developing between the medical profession and the media remained an uncertain and tense one. The creation of the NHS brought about new social relations between doctors and patients on one hand, and hospitals and the public on the other.[371] As one letter to the *BMJ* in 1954 attested: "…every citizen should feel a full sense of responsibility for [the service]…[this] cannot develop unless the administrative and medical powers-that-be take the public into their confidence, stop being secretive…and start inviting consumers to offer their suggestions".[372] This letter reframed patients as 'consumers' and emphasized the importance of public confidence in the Service. There was a vocal faction in the profession that felt that the "public would appreciate and benefit from more information about the medical services…The press could be a vital link".[373] The public was invested in the NHS – both literally and figuratively – and as a result desired greater transparency. Therefore, this moment reflects the intersections between health 'consumers', the popular media, and the state.

As press and television coverage on artificial insemination gathered momentum in early 1958, the BBC Woman's Hour also weighed into the debate, with a radio show on 'The Unknown Seed', broadcast on 18 February 1958. This kind of programming was standard fare for Woman's Hour, a radio programme launched in 1946 and known for its

[370] 'Cautious BMA Comment on Artificial Insemination', *The Times*, 18 January 1958.
[371] Kelly Loughlin, 'Spectacle and Secrecy: Press Coverage of Conjoined Twins in 1950s Britain', *Medical History*, 49(2), April 2005, (pp.197-212), 211.
[372] Loughlin, 211; S.Swingler, 'Press Publicity', *British Medical Journal*, 1954, 644-5.
[373] Loughlin, 211; D.Morris, 'Correspondence', *British Medical Journal*, 1954, 272.

unusually frank discussion of personal, sexual and relationship issues.[374] During 'The Unknown Seed', two women and two doctors took part in a discussion on artificial insemination, which was recorded in the consulting rooms of a London specialist for the purposes of privacy.[375] The mother of a 'test-tube baby' was interviewed and told listeners: 'Our little girl is gorgeous and looks exactly like MY HUSBAND AND ME'.[376] A second woman, who was trying to conceive through AID, explained that her husband approved of the treatment:

> We believe that when two people love each other it is no concern of anyone else what they decide to do about children. It is a purely personal and private matter. We also believe it is not God's will that in those marriages where children are desired the husband and wife should be denied a family.[377]

These narratives were framed around the strength of marital and familial love. The programme countered this warm, fuzzy view of family life by interviewing a woman who opposed 'test-tube babies'. Mrs Noreen Hughes of Newport, Monmouthshire criticized the would-be mother:

> How terribly wrong that the sacred and beautiful act of conception should be exploited and distorted to fulfil the untamed desire of a childless wife, so selfish in her desire to prove herself a woman that she will use a child as a means to an end.[378]

Although ostensibly presenting both sides of the issue, the dominant narrative of the radio programme followed the same format as stories in the popular press. It emphasized that mothers were blissfully happy with their babies, and did not care how they were

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[374] Some controllers disapproved of the openness of Women's Hour, with one saying in 1948 that 'it was "acutely embarrassing" to hear a discussion of the menopause in the early afternoon'. Bingham, *Family Newspapers*, 40.
[375] 'Disease Education by the B.B.C.', *British Medical Journal,* 22 Feb 1958, 450.
[376] 'A.I.D. Baby Looks Like Us', *Daily Mirror*, 19 February 1958.
[377] 'A.I.D. Baby Looks Like Us', *Daily Mirror*, 19 February 1958.
[378] 'A.I.D. Baby Looks Like Us', *Daily Mirror*, 19 February 1958.

conceived. But within this narrative the fathers – both biological and social – were almost entirely absent.

The BBC's approach to the topic of artificial insemination had changed over the course of the decade. In 1949, the BBC refused to broadcast *Breach of Marriage* on its airwaves but by 1958 was breaking new ground in both radio and medical television. This is not to say that *The Unknown Seed* was uncontroversial – there was still a warning issued before the programme that listeners who would find the subject distasteful should turn off their radio sets until the next scheduled programme.[379] A leading article in the *British Medical Journal* the following week criticized the BBC Broadcast, saying that it was "determined to make people's flesh creep" and sought to "fortify the public taste for the morbid and sensational".[380]

Public investment in the National Health Service led to increasing interest in medical issues generally from 1948. The creation of radio and television programming dealing with science and medicine suggest that there was an expectation of greater transparency in the medical profession, and a public desire to peer behind the metaphorical 'curtain'.

**Dramatizing AID for TV and Film Audiences**

In a limited way, then, the popular media encouraged a progressive liberal view of marriage and the family: while it was not typical to conceive via artificial insemination, it was possible to have a happy marriage and family life within this model. This message was strengthened in dramatizations of the effect of AID on marriage, in which the narratives overtly discouraged divorce and emphasized the importance of reconciliation.

[379] Pfeffer, 120-121.
[380] 'Doctors Criticize A.I.D. Broadcast', *The Times*, 21 February 1958.

The MacLennan case inspired both an episode for television and a feature-length film. These dramatized retellings reframed the case, providing a more optimistic outcome in which the couples were reunited in spite of their difficulties in starting a family. These portrayals emphasized the legal and emotional grey areas around AID, and the potential harm that the practice could inflict on a marriage, but in both examples the fictional couples were ultimately reconciled. In May 1958, Dan Sutherland wrote an episode for 'Armchair Theatre', a television run of single plays that was broadcast from 1956 to 1974, entitled 'Breach of Marriage'. This episode was based on his 1949 play of the same name. The story follows a husband and wife who are unable to conceive naturally and turn to artificial insemination. The couple visits a doctor with the hope of arranging AIH. However, the doctor concludes that the husband is 'suffering from tuberculosis', and a donor is used instead. The wife and doctor keep the substitution a secret from the husband 'who is on the verge of a breakdown'.[381] The dramatic ending involves 'a chase which leads to an unmasking of the donor's identity, to a threat of divorce, and to the point of suicide from which [the husband] returns'.[382] The drama closes with the reconciliation between the husband and wife. This play implied that infertility and artificial insemination both put a great strain on marriage, but that this strain could be overcome. This further suggests that even if the majority of the public still were not supportive, the popular media was sympathetic to AID by the late 1950s.

This happy ending in the televised version of 'Breach of Marriage' had been rewritten since the play was originally staged in 1949. Reviewing the tele-play, the *Catholic Herald* drew attention to the re-writing of the ending:

[381] 'Strong Conflict of Television Play', *The Times*, 5 May 1958.
[382] 'Strong Conflict of Television Play', *The Times*, 5 May 1958.

> …if my memory serves, the playwright's whole point was the impossibility of reconciling husband and wife after the deed. The taste of the masses now demands the husband's contemplation of suicide followed 'immediately by a touching reconciliation as though nothing had happened, and all had been justified'.[383]

The change in *Breach of Marriage* – from a tragic to a happy ending – is analogous to the change in public expectations of marriage. AID no longer meant the end of a marriage. Even if the majority of the public still were not 'on board', the agenda of the popular media was clearly sympathetic to AID by the late 1950s.

The shift in the story's conclusion from 1949 to 1958 raises important questions about the possible shift in public opinion. Were such examples of popular culture acting as agents of change, and encouraging more tolerant attitudes, or were they reflecting the status quo? Central to this chapter is the question of public opinion, understanding, and acceptance of what was seen as a new medical technology. It has been suggested that the media was central to shaping and reflecting public understanding of infertility and reproductive technologies in this period. The Government was acutely concerned with the need for public opinion to be more clearly expressed before any decision was made on legislation. The *Breach of Marriage* TV programme, and others like, it would have been the force to shape general opinion about the topic.

There is evidence that the 'Breach of Marriage' conclusion re-write was representative of broader attitude changes to marriage. Claire Langhamer has pointed to such a shift in the advice pages of *Women's Own* dealing with adultery and marital expectations. In the 1940s, the magazine recommended 'concealment' when women wrote telling of their extra-marital affairs: "dishonesty was suggested as a legitimate strategy in defence of the marital unit".[384] Yet by the late 1950s the advice concerning

[383] 'Few Words by Jotter', *Catholic Herald*, 9 May 1958. Also see 'Television', *Spectator*, 22 May 1958.
[384] Langhamer, 'Adultery', 103-4.

adultery had changed: "secrecy as a strategy was superseded by the advice to talk to each other, but only in conjunction with the experts".[385] The Marriage Guidance Council was often recommended, as the magazine encouraged forgiveness and reconciliation.[386] This shift therefore suggests a broader change at work in the 1940s and 1950s.

A feature-length film on the subject of artificial insemination released in Britain in the summer of 1958 reaffirmed the media's support of AID, and the desire for a happy outcome. 'Question of Adultery', also written by Dan Sutherland, told the story of a married couple with a tense relationship that was further threatened by AID. The film had wide release in both Britain and North America and it once again raised debate over the moral ethics of 'test tube babies'. The film received lukewarm reviews, but garnered significant attention based on its subject matter. As the *Mirror* put it: "Arguments about test-tube babies go on — whether it is right or wrong to have them. And the latest contribution to this topic - the X certificate film 'A Question of Adultery'…adds nothing new".[387] Premiering in July 1958, 'Question of Adultery' (or The Case of Mrs Loring – as it was known in the US) told the story of a married couple with a tense relationship that became threatened by AID [Figures 4.6, 4.7, 4.8]. The husband (played by Anthony Steel) was a race-car driver with a temper and a jealous streak. The wife (Julie London) became pregnant and hoped a baby would improve the state of their marriage. Crisis unfolded as the couple were involved in a terrible car accident: the wife miscarried and the husband was rendered sterile. Desperate to have a child, the wife suggested artificial insemination. Although the husband was reluctant, he consented. After AID had

[385] By the 1960s, discussion about divorce and leaving a marriage when one partner was adulterous was far more common.
Langhamer, 'Adultery', 104.
[386] Langhamer, 'Adultery', 104.
[387] 'Jealousy and a test-tube baby', *Daily Mirror*, 4 July 1958.

successfully been performed, the husband changed his mind and filed for divorce on grounds of adultery. Much of the film was based in a courtroom where the jury had to decide whether adultery was committed. This narrative indirectly referenced the recent MacLennan case, but the film turned the 'real life' story on its head. The jury, not typically used in civil cases, is a fictional device. Its failure to reach a unanimous verdict is perhaps intended to represent the division in public opinion. Rather than ending in divorce, the film concluded with the reconciliation of husband and wife.[388] The 'happy ending' narrative with a 'test tube baby' on the way proved popular once again.

## Conclusion

This chapter has traced the debates over AI from 1948 to 1958, seeking to draw connections between seemingly disparate cultural trends: from Parliament to popular culture, marriage quizzes to sci-fi cinema, and court cases to feature films. It also tracks a shift in cultural expectations of marriage, and argues that the role of the media in attempting to guide the public toward acceptance of AID by presenting stories of reconciliation and happy families is an important message of the popular discourse around assisted conception. It suggests that the popular media acted as an agent of change, and in so doing pulled the state into the discussion, which ultimately led to the establishment of the Feversham Committee.

This chapter has explored how expectations of marriage, gender roles and family life intersected with scientific advancements (both real and imagined) to create a crisis around artificial insemination in the 1950s. This was demonstrated in court cases, in Parliamentary discussion, and in the media. The response of the popular media to the

[388] 'Maybe It's Just a Question of Cliches', *Globe and Mail*, 28 February 1959, p.13.

MacLennan case stressed the importance of working through marital difficulties and maintaining the strength of the family in the face of infertility. The popular press, television, radio and film encouraged reconciliation, implying that relationship problems caused by childlessness and AID could be overcome, and that divorce was not the best solution. The legal and moral ambiguities surrounding AID made for great news and storytelling. The publicity given to the MacLennan case generated narratives sympathetic to the use of AID, that emphasized the importance of preserving marriage in the face of challenges. However, these narratives also suggested that there was no longer only one way to start a family. The MacLennan case was therefore not only a catalyst for growing public awareness and discourse on reproductive technologies, at a time when knowledge of sex and reproduction remained limited, but it also contributed to reshaping notions of how families could be constituted.

The media interest in AID provoked by the MacLennan case had multiple results, one of which was pushing the government to create a departmental committee to examine the practice. A government committee to investigate AID was announced in the House of Lords on 26 February 1958, and was front-page news in the *Daily Express* the following day (though was pushed to pages 9 and 12 in *The Times*).[389] By the end of the year, the Committee was requesting reports from various organizational bodies, including the British Medical Association, Family Planning Association, Eugenics Society, and Medical Women's Federation. Reporting on the Feversham investigation, the *Mirror* reassured parents that they need not worry that anyone discover their child had a "phantom father" as all details would be kept confidential.[390] Despite the media's

[389] ''Test tube' babies: an inquiry', *Daily Express*, 27 Feb 1958.
[390] 'AID Babies – A Family Life Probe', *Daily Mirror*, 29 Dec 1958, p.5.

advocacy, the stigma around AI remained. It is to this government-sponsored investigation that the final section will now turn. The final section of this study focuses on the Feversham Committee, which came about as a direct result of the MacLennan case and ensuing media coverage. Although the government had been nudged in 1943, 1945, and 1949 to institute such an inquiry, it was not until 1958 that demand reached a boiling point.

# *Chapter 5*

## *The Investigation of the Feversham Committee on Human Artificial Insemination, 1958–60*

On the morning of 24 September 1958, the Departmental Committee on Human Artificial Insemination – commonly called the Feversham Committee, after its chairman – began its first meeting in Room 101 of the Home Office in Whitehall. Lord Feversham opened the meeting and stressed the need to "get down to detail…however unpleasant".[1] The Committee had been announced by the Macmillan government in February 1958, after intense public debate over artificial insemination following Lord Wheatley's ruling on the MacLennan divorce case.[2] At its inception, the Committee was designed to investigate the legal aspects of the practice and report on any recommended legislation. However, based on the extensive media coverage and the public expectation that all aspects of the practice would be explored, it was quickly realized by Parliament that ignoring the social aspects of the practice would be unacceptable. The official terms of the Committee were:

> …to enquire into the existing practice of human artificial insemination and its legal consequences and to consider whether, taking account of the interests of individuals involved and of society as a whole, any change in the law is necessary or desirable.[3]

However, behind closed doors the investigation became focused on marital relations, family structure, social class, race, and morality. Over the course of eighteen meetings,

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[1] National Archives, London, HO/342/6

[2] The Committee was announced on 26 February 1958 in the House of Lords, and all members were officially appointed on 3 September 1958.

[3] Although the committee examined the practice of both A.I.H. and A.I.D., the focus was almost exclusively on the latter.
*Report of the Departmental Committee on Human Artificial Insemination*, 1.

one hundred organizations and individuals provided evidence.[4] The committee interviewed a variety of individuals and bodies, including medical professionals and organizations, religious denominations, legal bodies, and other organizations concerned with "marriage, family life and the welfare of children".[5] Among the witnesses, only twelve individuals had first-hand knowledge of the practice – having performed AI themselves – and it is this evidence on which the majority of the official Report was based, and on which the following chapter will be largely focused. Notably, no patients were asked to provide evidence despite this omission being pointed out in advance.[6]

The evidence obtained from the interviews with these twelve medical doctors established the basis of the published Report and informed the Committee on both the clinical and cultural implications of the practice. The evidence provided by these practitioners has only recently been opened (2010–11), and these papers illuminate the clinical practice of artificial insemination and establish a social context for infertility treatment and healthcare in the 1950s. The work of the Committee and the evidence provided by witnesses offer new insights into broad social concerns about the 'right type' of parents, while also providing a clinical history of the practice.[7]

This chapter suggests that the Feversham Committee demonstrated that race, class, and gender-based prejudices informed thinking about AID; these prejudices were

[4] *Report of the Departmental Committee on Human Artificial Insemination*, 1.
[5] Ibid, 2.
[6] Letters from the public directed towards the Committee included one from a woman who was infertile and expressed that her experience and views would be useful to the Committee, however there is no evidence she was ever contacted. Additionally, Margaret Jackson's husband (also a doctor in Exeter) pointed out in a letter that Committee members did not reflect the 'barren and subfertile' who they were representing. Although most of these letters from the public opposed AID on religious grounds, a couple pointed to the risk posed to the system of hereditary succession, with reference to the monarchy and Lords.
National Archives, London, HO 342/3, 'Letters from the Public', 1958-60.
[7] Carolyn Herbst-Lewis has addressed this 'screening' process conducted by physicians in the United States in the 1950s and 1960s, arguing that they "strictly controlled access to donor insemination" and "took very seriously their role as the gatekeepers who ensured that only suitable couples had access to this technology" Herbst-Lewis, *Prescription for Heterosexuality*, 128, 117.

provoked by concerns regarding the Welfare State, marital relations, and family life in Britain. The tensions revealed in this evidence also speaks to the 'unevenness' of a growing social permissiveness in the late 1950s.[8]. The Feversham Committee represented the culmination of social, religious, political, and medical debate on the highly contested topic of artificial insemination. When the report was issued, it was not the public response that was notable – it was the lack of any meaningful response. After such heated exchanges through 1958, in particular, the fire under AID had all but completely burnt out by 1960.

## The Outcome of the Feversham Report

In its published report, released in 1960, the Committee recommended that AID should be strongly discouraged but, at the same time, that it should not be regulated by law or be declared criminal. Essentially, the Committee backed the status quo.[9] The Report outlined legal recommendations to institute a new ground for divorce (if AID was performed without the consent of the husband), as well as allow the annulment of marriage on grounds of impotence if AIH had been performed. It was further recommended that in Scotland a child conceived by AID should have the same rights as an adopted child, and in England the child should be entitled to family inheritance, though there should be no change to laws concerning legitimacy or registration of birth.[10]

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[8] See Frank Mort, 'The Ben Pimlott Memorial Lecture 2010: The Permissive Society Revisited", *Twentieth Century British History*, Vol.22, No.2, 2011, pp.269-298.

[9] *Report of the Departmental Committee on Human Artificial Insemination*, 82.

[10] There was one significant difference in adoption law in Scotland, compared to England: in Scotland, "from the age of seventeen adopted persons had the right to be given the information which would link the Adopted Children's Register with their original entry in the Birth Register, without recourse to a court order as was the case in England and Wales". This enabled adopted persons to trace their birth parents. Therefore, secrecy in adoption was not enforced in Scotland as it was in England. Furthermore, before 1964 in Scotland, adopted persons could inherit from their 'natural' parents (but not their adoptive ones). Thus, the recommendations by the Feversham Committee suggested that children conceived by AID in both

The Feversham Committee's approach was "in favour of leaving the position as it is at present", but the members explained – perhaps disingenuously –that this was not a mark of indifference or indecision. Rather, it was a strategic choice to neither oppose nor approve of the practice in the hopes that, once informed, prospective parents would not turn to AID and "the practice [might] diminish or entirely disappear".[11]

The Committee was divided on the subject of the inquiry. Religious opinion was "almost entirely unanimous in condemning the practice as a sin" and there were those on the Committee who agreed, arguing that "A.I.D. is unethical and a danger to the institution of marriage as an essential part of the social structure of this country".[12] On the other hand, there were those who believed that the practice was "a justifiable exercise of the liberty of the subject which carries no threat to others".[13] For the most part, it was agreed that AID fell within the boundaries of 'private morality', which was not the business of the law, and therefore came within the category of "liberties", along with adultery.[14] The Committee believed that AID fell into somewhat of a grey area of offences: "although they are public in that they concern more than a single person and disturb the harmony of society, are still not of a nature or quality which demands punishment by the criminal law".[15] In this sense, the members sat somewhere in the middle ground. The Committee further stressed that AID should be considered "in its proper perspective", with the number of resulting births per year not upwards of one

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England and Scotland be entitled to family inheritance, though it was not entirely clear what role the anonymous donor might have in this.
Jenny Keating, *A Child for Keeps: The History of Adoption in England*, 130.
[11] *Report of the Departmental Committee on Human Artificial Insemination*, 79.
[12] Ibid, 80.
[13] Ibid.
[14] 'Liberties' were defined as not prohibited by law but also receiving no encouragement. *Report of the Departmental Committee on Human Artificial Insemination*, 80.
[15] *Report of the Departmental Committee on Human Artificial Insemination*, 80.

hundred.[16] They speculated that in the future the use of reproductive technologies might increase to a stage that the state could "no longer leave the matter to the decision of individuals", while on the other hand it was suggested that male infertility might be reduced and would therefore diminish the use of AID. When the Report was issued, the Feversham Committee concluded that AID should not be prohibited by any statute.[17]

Notably, two members of the Committee issued a memorandum of dissent against the recommendations of the majority. Peggy Jay and John Ross agreed with the majority of the recommendations, but disagreed primarily with the suggestion that the AID child would remain 'illegitimate' under the law. Both members had worked closely on children's rights: heading committees for schools at the London County Council, and serving as head of the children's department at the Home Office, respectively. Jay and Ross recommended that the definition of legitimacy be extended to include a child born as a result of AID, and the father (mother's husband) be listed on the registration of birth.[18] Jay and Ross also took issue with the Committee's limited definition of fatherhood – restricting it to its biological definition. They argued that, "insufficient account is taken of the husband's role of father in his association with his wife during her pregnancy, and of his assumption from the time of the child's birth of the full responsibilities and satisfactions of fatherhood".[19] Moreover, they did not agree that AID was a threat to marriage or "the principle of monogamy", believing that the Committee's suggestion that AID would lead to a "general disregard of the obligations of marriage" were unreasonable, since the practice involved a relatively small number of couples "who

[16] Ibid, 81.
[17] Ibid, 72.
It was 30 years before the HFEA saw the State intervene with legislation.
[18] Ibid, 85.
[19] Ibid, 83.

are anxious to have a family".[20] They recommended that a child born by AID with the husband's consent should be deemed legitimate and should be legally registered as such.

When the Report was published on 21 July 1960, the Government quietly accepted the recommendations, yet there was a stated reluctance to take action on points requiring legislation. While all of the involved Government departments approved of the majority recommendations in principle, the Lord Chancellor's Office did not believe that there was any urgent need for legislation – nor did the Scottish Home Department; it was suggested that a Private Member's Bill would be more suitable.[21] The impetus for the Committee was driven by media attention and public interest, rather than a concerted effort from the government. Therefore, it is perhaps unsurprising that no action was taken. The formation of the Departmental Committee was a typical government response, which sought to document and understand a 'social problem' that appeared to threaten the institutions at the core of family life. Moreover, since the death of Lord Reading (who had lent support to the issue in 1949 and 1958) there had been no parliamentary interest shown in the Committee's recommendations. The last official word on the Report came in June 1961 with a Home Office memo explaining that acceptance without action was the protocol, concluding that "in the circumstances it does not seem necessary at this stage to prepare a paper for the consideration of Ministers".[22] Essentially, it was felt by government departments that there was no need to legislate, and with Lord Reading's

[20] Ibid, 84.
[21] Private Members' Bills had a very high failure rate: "Campaigning groups and MPs were conscious that bills were more likely to be passed if they were limited to one or two key clauses. Private members' bills also allowed the government to keep officially clear of controversial legislation because they were not government sponsored; nonetheless, it always maintained ultimate control over the legislative agenda. The government was required to provide sufficient time for the discussion and debate of legislation and to successfully engineer the bill through its various committee stages."
Evans, 'Other Woman', 57.
[22] National Archives, London, HO 342/5, 'Departmental Committee on Human Artificial Insemination: Consideration of the Committee's recommendations', 1960-1961.

passing in September 1960 government advocacy for action on the subject was lost. All fell quiet on the artificial insemination front after the Report was published.

After the frenzy of media attention in 1958 following the MacLennan case, the lack of media attention to the Report is notable. There was relatively little press attention, and those papers that did address the Report either summarized the fence-sitting recommendations ('A.I.D. Should be 'Strongly Discouraged'', *The Times*, 22 July 1960) or attempted to sensationalize what was a fairly unremarkable report. In typical style, the *Daily Mirror* splashed a sensational headline across a two-page spread: 'PHANTOM FATHERS – A.I.D. is bad, bad, BAD…experts tell Home Secretary'.[23] The article began:

> Test-Tube babies with phantom fathers are now being born in Britain at the rate of TWO A WEEK…The babies owe their existence to AID – Artificial Insemination by Donor. Each is conceived after the artificial insemination of a married woman with sex-cells donated by a total stranger.[24]

The *Mirror* pulled the most shocking details from the Report to present to the public, though it did not have much to work with, and then closed the article by telling readers that the Cabinet would be taking no action. The *Daily Mirror* also reported on an upcoming BBC 'Lifeline' programme on 29 July 1960 that took the report as a basis in interviewing couples who had experienced AID (as recipient and as donor).[25] *The Spectator* took a more critical position on the Report, from the perspective of the welfare of the child.[26] When compared with the flurry of media activity on the subject only two years earlier, this was scant attention and, as hoped by the Government, the issue fell flat with the media and the public alike.

[23] 'Phantom Fathers', *Daily Mirror*, 22 July 1960.
[24] Ibid.
[25] 'Test-Tube Babies', *The Daily Mirror*, 29 July 1960.
[26] A. Hallidie Smith, 'Nobody's Baby', *The Spectator*, 16 September 1960.

This chapter raises a variety of questions about the meaning of the Report. Is the Report and the lack of response, from politicians and the press, indicative of a 'permissive' turn? Were other sexual and reproductive issues taking the place of AID? Was the public bored of the topic after an over-saturation in 1958? Was it, very simply, a quiet acceptance of a once-controversial practice? Or was it more meaningful: the reluctant acceptance of a new definition of the family?

## Departmental Committees and Social Issues in the 1950s

This chapter is informed by the approach taken by Frank Mort on the Wolfenden Committee (1954-57).[27] Mort's analysis of the Wolfenden Committee concentrated not only on the ultimate recommendations and their historical significance, but on the evidence given by witnesses, and the questions with which the committee was preoccupied:

> Significant questions about the investigative methods and the personal obsessions that shaped the committee's work, along with their gendered vocabularies for discussing sex and their competing ideas about sexual behaviour, can be brought into focus via an interpretation that highlights culture as an active ingredient in the making of policy.[28]

This chapter builds on this interpretation and presents an overview of the Feversham Committee – its aims, recommendations and members – as well as a close analysis of the ways in which evidence was gathered and interpreted, highlighting both the preoccupations of the Committee members and the witnesses interviewed. The Feversham Committee should be seen as part of a longer tradition of the ways in which social issues were investigated officially.

[27] Frank Mort, *Capital Affairs: London and the Making of the Permissive Society*, 2010.
[28] Mort, *Capital Affairs*, 143.

The Feversham Committee investigation, concerning reproductive science, marital relations, and family legitimacy, followed closely on the heels of the Wolfenden Report, on homosexuality and prostitution.[29] Both were centered on issues of morality, therefore it is useful to briefly consider the latter Report and how it informed Feversham. Both Reports defined their respective subjects as issues of 'private morality', and legal 'liberties' that should not be considered criminal. The Wolfenden Report "laid out the ethic of privatized morality, marking a clear separation between the public domain of legal intervention on sexual matters and the sphere of individual consent".[30] The report famously declared in its introductory chapter: "It is not, in our view, the function of the law to intervene in the private lives of citizens, or to seek to enforce any particular pattern of behaviour".[31] There is broad agreement among historians that the Wolfenden report significantly influenced government intervention on matters of sexuality and morality in the 1960s – the "so-called permissive legislation".[32] The two Committees shared a particular historical moment and the outcome of Feversham rests significantly on the social impact of its predecessor, not only in its ultimate recommendations but also because Wolfenden was used as a reference point and comparison by both Committee members and witnesses during the investigation. This was particularly prominent in discussions with religious leaders, which will be discussed at the end of the chapter.

The majority of the Feversham Committee records were only opened at the National Archives in 2010 and 2011, fifty years after the Report was published, and therefore offer new evidence in the history of infertility and reproductive medicine. For

[29] The Wolfenden Report was published on 4 September 1957, and the Feversham Committee was announced on 26 February 1958.
[30] Mort, *Capital Affairs*, 140.
[31] Ibid, 141.
[32] Ibid.

this reason, the Committee has not received much historical attention. However, this is being remedied. Gayle Davis has recently published a chapter examining the response of Scottish medical professionals and organizations during the Feversham Committee hearings.[33] This present chapter extends the coverage by examining the evidence provided by medical practitioners of AI outside of Scotland. This source brings the historian, without access to patient records, nearer to a clinical history of AID at this time, while also providing candid observations and reflections from those who were directly involved with the controversial practice.

The verbatim evidence taken during the Committee's oral interviews was typed in a question-answer format with some of the records underlined with marginalia added.[34] This appears to have been done for purposes of compiling the report, which therefore offers an indication of the priorities of the committee, not only in their lines of questioning but also in the areas of the evidence they later stressed in preparing the official report. The Feversham Committee archive can be read "not simply as documentary evidence but as revealing the tensions and contradictions that marked official discourse".[35] At a surface level, the Committee was interested in the operational practice of AID from the medical perspective: How many children were born by this method each year? Who was practicing AID? How did the referral process work? Who was having AID and how accessible was it? Yet beyond this, gendered roles within marriage, and individual 'suitability' for parenthood, were deeply embedded in the

[33] See Davis, 'Test Tubes and Turpitude'.
[34] It is unclear who made these notations, and for what purpose. However, in the context of the Wolfenden Committee, Mort points out that Wolfenden's "pencilled marginalia…provide insights into the chairman's reactions". Therefore, it is possible that the marginalia in this case were notes made by Feversham. Mort, *Capital Affairs*, 177.
[35] Mort, *Capital Affairs*, 143.

interview process. The ways in which these issues were discussed is revealing of broader social changes and concerns.

**The Committee's Membership**

Throughout the summer of 1958, the Home Office struggled to fill the Committee membership positions. Two offers of Chairmanship were refused before Lord Feversham accepted, and seven invitations to fill the eight member positions were declined.[36] The *Daily Mail* caught wind of these troubles, writing:

> …it was pointed out that many people, especially women, were not willing to serve on the committee as they found the subject too distasteful. It is understood that several experts on social welfare who are Roman Catholics refused to help.[37]

In fact, Lady Inskip had written to Home Secretary Rab Butler politely declining the invitation explaining that, "the subject is one on which my husband feels so strongly that he would be very unhappy if I undertook the work".[38] Most invitations that were declined explained that busy schedules did not permit involvement, but there was also the question of the morality, controversy, and discomfort inherent in the subject. It is unclear whether this rate of membership refusal was typical of departmental committees, but the controversy surrounding this subject likely made it a less popular Committee on which to serve. However, the membership of the Departmental Committee was in many ways typical of other Commissions and Committees of its kind. The members were middle and upper-class professional 'experts', leading citizens, and authorities on law and medicine. They included professionals from the medical, political, and legal realms, as well as lay

[36] Sir Geoffrey Crowther and Sir Philip Morris declined the Chairmanship. Dr. Gillie, Lady Dugdale, Countess of Limerick, Lady Inskip, Mr. Lee, Professor Seaborne Davies, and Sir George Coldstream all declined invitations to serve as members. Stevenson, Tunbridge, Jay and Whitley were all 'first choices' and accepted the positions, but the others were more difficult to fill and involved a lot of back and forth with various government departments with suitable suggested members.
[37] National Archives, London, MSC 424/1/7, 'Departmental Committee on Human Artificial Insemination: Setting up of the committee', 1958-1959.
[38] National Archives, London, MSC 424/1/7.

people who informally represented the church and children's welfare.[39] The Earl of Feversham (Charles Duncombe) (1906-1963) was named as Chairman of the Committee in August 1958. He was a Conservative politician, who attended Eton as a student. He also served on the Departmental Committee on the Social Services in Courts of Summary Jurisdiction in 1934, and was president of the Child Guidance Council. He sponsored the Children and Young Persons Act (1933), which focused on the protection of children, including in criminal and employment matters. He believed that "a secure childhood would prevent many problems", which sounds reminiscent of Bowlby's position on child development.[40] Primarily, he was involved in mental health work; he chaired the Committee on Voluntary Mental Health Services, which published its report in 1939. The result of this Report was the amalgamation of several voluntary mental health organizations to form the National Association for Mental Health in 1946, of which Feversham was elected Chairman.[41] In the House of Lords, he initiated debates on mental health legislation and was a supporter of the Mental Health Act of 1959, which attempted to de-stigmatize attitudes toward mental illness, redefine the terminology, and integrate psychiatric facilities within the broader health care system.[42] He was also Chairman of the National Advisory Council on the employment of the disabled.[43] At the time of the Committee, he was fifty-one years old and had one daughter.[44]

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[39] The Earl of Feversham, Peggy Jay, Justice Stevenson, and Ronald Tunbridge were the most vocal committee members during the interviewing of witnesses.
[40] Tony Booth and June Statham (eds), *The Nature of Special Education: People, places and change,* Originally published 1982, (New York: Routledge, 2005), 103.
[41] Kathleen Jones, *Lunacy, Law and Conscience, 1744-1845: The Social History of the Care of the Insane*, (London: Routledge, 1955), 201.
[42] Nick Crossley, *Contesting Psychiatry: Social Movements in Mental Health*, (Abingdon, Oxfordshire: Routledge, 2006), 85.
[43] 'The Earl of Feversham'. The Helmsley Archive. http://www.helmsleyarchive.org.uk/info/HA07395.pdf
[44] National Archives, London, MSC 424/1/7

The other members included Dr. Lettice Priscilla Fitzgibbon, who was a hospital anaesthetist and juvenile court magistrate and had five children – four daughters and a son.[45] Mrs Peggy Jay (Margaret Christian Jay) (1913-2008) was a local government politician, had attended Oxford, and served as a Labour member of the London County Council, chairing committees for schools and arts and leisure. Jay was "noted for her advocacy for the poor and marginalized"[46] and had four children: two sons and twin daughters.[47] Dr. David Thompson McDonald (d.1959), was the medical officer of health for Belford, Northumberland, and had been president of the North of England branch of the British Medical Association. He had two children – a son and a daughter;[48] Dr Sidney Ronald Matthews replaced McDonald after his death in June 1959 and served out the duration of the term.[49] Mr Ralph Risk (1891-1961) was a Scottish solicitor and was President of the Law Society of Scotland from 1955-56.[50] He served in both World Wars and had five children: three boys and two girls.[51] Mr John Ross, was retired at the time of the Committee but had formerly been head of the Children's Department of the Home Office and chairman of the Marriage Guidance Training Board. There was no mention of Ross being married or having children in the literature or press reports.[52] The Hon. Mr. Justice Stevenson (1902-1987), who was a Cornwall-born lawyer, and later a judge, was

[45] National Archives, London, MSC 424/1/7
[46] Edmund Dell, 'Margaret Christian (Peggy) Jay', *Oxford Dictionary of National Biography*, (Oxford University Press, 2004), Online edition, January 2012.
[47] National Archives, London, MSC 424/1/7
[48] National Archives, London, MSC 424/1/7
[49] *Report of the Departmental Committee on Human Artificial Insemination*, ii.
[50] David Brewerton, 'Sir Thomas Risk obituary', *The Guardian*, 3 July 2012, http://www.theguardian.com/business/2012/jul/03/sir-thomas-risk
[51] National Archives, London, MSC 424/1/7
[52] The Marriage Guidance Training Board "was to plan and supervise selection and training schemes for marriage guidance counselors employed by [the National Marriage Guidance Council, the Family Welfare Association and the Catholic Marriage Advisory Council]", and was comprised of representatives from these societies as well as from the Home Office, Ministry of Health and Ministry of Education. National Archives, London, MSC 424/1/7; M. Penelope Hall, *The Social Services of Modern England*, Originally published 1963, (London: Routledge & K. Paul, 1965), 154.

the defence lawyer (unsuccessfully) for Ruth Ellis – the last woman to be hanged for murder, in 1955. Stevenson had no children, and it was not clear whether he was married.[53] Professor Ronald Ernest Tunbridge (1906-1984) was a Physician at Leeds General Infirmary and Professor of Medicine at the University of Leeds, and had two sons.[54] Mrs. Elizabeth Whitley (1915-2010) [55] was a Scottish-born writer married to Reverend Dr Harry Whitley, minister of Edinburgh's St Giles' Cathedral from 1954-72, and had five children: three sons and two daughters.[56]

The Committee was comprised of eight members and the Chairman – six men and three women. Although women represented only one-third of the members, this gender balance appears progressive when compared to the composition of the Wolfenden Committee where women comprised only one-fifth of the members – and as Frank Mort has said of the latter committee, the gender ratio "was considered progressive by the standards of post-war policy and administration".[57] The Committee make-up should be seen in the context of the vastly unequal gender composition of Parliament at this time. Women in politics were a minority, representing only four per cent of all MPs in 1959.[58] Until the late 1980s, women comprised less than five per cent of all MPs, with significant change only coming in the late-1990s.[59] Proportionately, the gender balance of the Feversham Committee was the same as for the Royal Commission on Marriage and

[53] Reverend Roskill, 'Stevenson, Sir (Aubrey) Melford Steed', *Oxford Dictionary of National Biography*, (Oxford University Press, 2004), Online edition, January 2012.
[54] 'Sir Ronald Ernest Tunbridge'. National Portrait Gallery.
http://www.npg.org.uk/collections/search/person/mp142170/sir-ronald-ernest-tunbridgenational
[55] 'Obituary: Elizabeth Whitley, writer'. *The Scotsman*. 14 September 2010.
http://www.scotsman.com/news/obituaries/obituary-elizabeth-whitley-writer-1-810363
[56] National Archives, London, MSC 424/1/7
[57] Mort, *Capital Affairs*, 149.
[58] Marian Sawer, Manon Tremblay and Linda Trimble (eds), *Representing Women in Parliament: A Comparative Study*, (London: Routledge, 2006), 87.
[59] By 1997, women MPs represented 18.2% of all MPs – a significant leap from 9.2% in 1992, and only 3.5% in 1983.
Sawer, et al., *Representing Women*, 87.

Divorce (1951-1956) where seven of nineteen members were women.[60] The subject matter of the inquiry often defined the gender balance of the members. At the time, AI was seen as a 'family' issue more than a 'women's issue', but the recognition of the importance of female voices was a notable part of membership selection.

Selecting the three female members of the Committee was cause for significant discussion – both privately and publicly. In the spring of 1958, there was private correspondence among government figures concerning the choice of women for the committee membership. C.C. Cunningham (Home Office) stressed the importance of female representation to the Lord Chancellor's Office:

> We must obviously have more women on this Committee than would normally have been thought necessary with a Departmental Committee…it might be possible to find a woman whose political sympathies were more to the left, but who could also represent other interests…(One suggestion which has been put to me is that we might get a woman who edits the agony column of one of the cheap dailies – such as 'Evelyn Home', or one of the women who is nationally known because she takes part in the popular t.v. programmes.[61]

It is surprising that a media personality was considered, as this would have been a marked deviation from typical committee member backgrounds (middle and upper class professionals in medicine, law or politics). The government correspondence reveals that the female presence on the committee was important, as was having liberal political views represented. On more than one occasion, Rab Butler stressed the need to have a female committee member who would balance Peggy Jay, who was seen as politically left-leaning. Another concern from the government was to select women with "enough experience and confidence to hold her own against the galaxy of lawyers, clergy and doctors who are accustomed to imposing their views on other people".[62] Of the women

[60] 'Royal Commission on Divorce', *The Times*, 23 August 1951.
[61] National Archives, London, MSC 424/1/7
[62] National Archives, London, MSC 424/1/7

on the Committee, Jay was the most vocal and also the most progressive, though certainly not radical in her views. Women who were not mothers were ruled out as potential members since it was felt by the Home Office that "it is better to have women who have themselves had a family".[63] Parenthood was not a requirement for male members, though all but Ross and Stevenson were fathers. These membership demographics again highlight the disregard for representation from members who experienced AI themselves, or who identified with being 'subfertile'.

By reading the reports announcing the Committee members, one would think it was the first time a woman had ever held such a role. When the Committee members were announced on 6 September 1958, virtually all of the national daily newspapers ran stories on the selected individuals and these headlines were fixated on the women members of the Committee.[64] Without exception, the headlines celebrated their status as mothers and wives, while their professional qualifications were secondary. The opposite was true for male members, whose family lives were rarely mentioned in the press.[65] The *Daily Mirror*, in particular, emphasized that the three women had four or more children each but it was also the only paper to list the marital and parental status of the male members.[66] Although the experience of parenthood may have offered a valuable perspective, this qualification for membership was only demanded of women, and excluded views from 'involuntarily childless' individuals.

**The Committee Witnesses**

[63] National Archives, London, MSC 424/1/7.
[64] These included the *News Chronicle*, the *Daily Mail*, the *Times*, the *Daily Mirror*, the *Daily Express*, and the *Daily Sketch*.
[65] National Archives, London, MSC 424/1/7
[66] National Archives, London, MSC 424/1/7

Forty-nine professional or public organizations, forty-four individuals, and seven government departments representing medical, legal, social, political and religious bodies provided written and/or oral evidence to the Feversham Committee.[67] From the outset, a list of the 'usual suspects' was already formed. While medical, religious and legal organizations were comprehensively represented, social bodies that focused on women and children were less so. Women's and family-centered organizations were under-represented among witnessing bodies – not because they were ignored, but because most felt they did not have the necessary experience to weigh in on the matter. Others stated that they did not want to express their views on the subject. The FPA, for instance, said they had no official policy on artificial insemination and several doctors who worked for the Association were already giving evidence. Moreover, they felt that they were already represented medically (by individual medical practitioners like Jackson, Bloom, and Mears).[68] This was, perhaps, a way for the Association to remain relatively neutral, while individual members expressed their personal opinions. The one women-centered body that did provide evidence was the Mother's Union, which from the outset expressed strong opposition to the practice on religious and moral grounds.

When the Committee began hearing evidence, they went straight to the 'top', as it were, by interviewing medical doctors with first-hand experience practicing AI. This chapter will focus primarily on the evidence given to the Feversham Committee by members of the medical community who had practical experience with the practice of AID, and it will also consider the influence of religious opinion on the ultimate

[67] *Report of the Departmental Committee on Human Artificial Insemination*, Appendix II: List of Witnesses and Correspondents, 94-98.
[68] Others who declined included the FPA, Married Women's Association, the National Council for the Unmarried Mother and Her Child, the National Council of Social Service, and the Family Service Units. National Archives, London, HO 342/53, 'Departmental Committee on Human Artificial Insemination: Social Organisations, correspondence and invitations to submit evidence', 1958-1959.

recommendations of the Committee. During 1959, the Feversham Committee interviewed twelve doctors who were currently practicing or had practiced AID in Britain. The group of medical practitioners was comprised of six women and six men – this 50:50 split represented a much higher proportion than the number of practicing female doctors in Britain. The 16,000 female medical practitioners in Britain in 1959 represented approximately fifteen per cent of the total medical profession.[69] Women doctors also dominated the field of 'family planning'.

The medical witnesses to the Committee were all experienced physicians, who had been practicing medicine for between fifteen and forty-five years, averaging twenty-five years of practice each. Each doctor was asked to submit a written memorandum, answering a set of questions, in advance of the oral interview. Some also chose to submit copies of their publications and other materials on AID. The interview gave the committee a further opportunity to question the practices and beliefs of the medical practitioners. There was a broad spectrum of experience among the twelve practitioners. Margaret Jackson, Mary Barton and Reynold Boyd were the most prominent and experienced practitioners, each with more than three hundred AID cases. Margaret Hadley Jackson was Exeter-based and had overseen more than 300 cases of AID. She had been practicing medicine for thirty-six years, and had practiced AID since 1941. Jackson was a prominent and well-respected member of the FPA. Reynold Boyd was London-based and had undertaken 426 cases. He had been practicing medicine for thirty-four years, and had practiced AID since 1942. Mary Barton was London-based and had

[69] In 1921, 5.4 per cent of British doctors were women; in 1931 it was over 10 per cent; at the end of WWII women represented 15 per cent of the profession, and yet by 1971 this had only grown to 18 per cent. Wellcome Library, London, SA/MWF/H.16/2, 'Home Office Committee: preparation of memo for', 1959; Mary Kinnear, *In Subordination: Professional Women, 1870-1970*, (Montreal: McGill-Queen's University Press, 1995), 76.

overseen 313 cases of AID that resulted in live births (with a much higher number of total cases). She had been practicing medicine for nineteen years and AID since the early 1940s. Not all case numbers were tabulated by the same measure; some referenced only cases resulting in live births while others included all instances of the procedure.

Margaret Moore White, Bernard Sandler and Philip Bloom all had experience with between thirty and fifty cases. Margaret Moore White was based in London and had fifty AID cases (forty-two resulting in live births). She had been practicing AID for fifteen years, but had recently stopped – only a few months before the committee's interview (due to the RCOG ruling the method unethical). She explained that she tried to keep a low profile, offering AID to women she saw in the fertility clinics, and occasionally for a colleague who asked for her help. Moore White was involved in a way in the abortion realm – her husband was a psychiatrist and she had been asked by him to terminate pregnancies on psychological grounds. Philip Bloom was London-based and had experience with thirty-eight AID cases, while practicing medicine for twenty years. Bernard Sandler was Manchester-based and had thirty AID cases. He had been practicing for twenty-one years, but had started practicing AID more recently.

The other doctors had experience with fewer than sixteen cases – some had worked on only three cases during their careers. Eleanor Mears was London-based and had dealt with sixteen AID cases. Mears had practiced for nineteen years in England, but had spent a significant amount of time in New Zealand. Mears returned to London in the 1950s, after the death of Joan Malleson when she took over her practice. Eustace Chesser was London-based and had overseen thirteen AID cases. He had practiced for thirty-three years, but had not done AID since 1948. In 1940, Chesser had published a sex manual

(*Love Without Fear*) – which sold 5000 copies – that was withdrawn and he was consequently arrested for obscenity and chose to be tried by jury. He was also involved in the abortion realm – advising on psychological grounds for termination of pregnancies. Margaret Shotton was based in Birmingham and had done six AID cases (three of which resulted in live births). Shotton had recently stopped practicing AID – only a few months before the committee's interview. Helena Wright was based in London and had undertaken between five and ten AID cases. She had been practicing medicine for forty-five years, and had practiced AID for fifteen years. Wright was a pioneer in the birth control movement, and was the chief medical officer at the North Kensington Family Planning Association clinic. T.N.A. Jeffcoate was based in Liverpool and had overseen three AID cases. He had been practicing medicine for twenty-five years, but had not done any AID cases since 1954. No one in the Liverpool area was practicing AID at the time of the interview. Albert Sharman was based in Glasgow, but had not practiced AID since 1939. In 1934 he had established a clinic at the Royal Samaritan Hospital for Women devoted to the investigation and treatment of infertility (the first of its kind in the UK).The doctors practicing AID were concentrated in London, with seven of twelve in the capital. By 1959, when the interviews were taking place, the north and east of England and all of Scotland lacked any active or known AID practitioners. Outside of London, only Exeter, Birmingham, and Manchester offered AID services.

**Convening the Committee at Whitehall**

The first meeting of the Committee took place on the morning of 24 September 1958 in Room 101 of the Home Office, Whitehall.[70] Four years earlier, the Wolfenden

[70] National Archives, London, HO/342/6, 'Correspondence with the Chairman', 1958-1959.

Committee had its first meeting in the same room and it was described as a formal setting:

> The physical lay-out of Home Office committee room 101 was designed to promote the exchange of information in a quasi-juridical atmosphere that was redolent of a courtroom or a tribunal hearing. Witnesses remembered how committee members were seated in an expanded semicircle, distanced from themselves by a large amount of floor space.[71]

It is likely that the atmosphere of the Feversham Committee was similar in nature. A draft list of the points on which the Committee was concerned was circulated at the first meeting. Of eleven points, five were concerned with family life, family structure, and family relations (points 2 through 6), while only two points concerned any legal considerations or legislation (points 9 and 10).[72] Other considerations included the motives of the doctor, issues of registering births, and eugenic potential. The matters on which the Committee aimed to investigate included the following:

1. The motives of the doctor practising artificial insemination, and his responsibilities to society.
2. The donor's anonymity or relationship with other parties; the effect of A.I.D. on donors and on their family life; their motives for acting as donors.
3. The effect of successful A.I.D. on the relations of husband and wife to each other.
4. The attitude of husband and wife to their A.I.D. children.
5. Whether, in the interests of the children, secrecy about A.I.D. should be enjoined on husband and wife, and whether it is realistic to expect that secrecy would be maintained by most husbands and wives.
6. The effect of A.I.D. on the institution of marriage and on family relationships in general.
7. Whether records should be kept either of the birth of an A.I.D. child or of the use of donors; for example, whether there should be any record associating donors with the births of particular children, with the insemination of particular women, or with the doctor to whom they have given semen or the areas where it has been used; and whether there would be any point in making a special entry on the child's birth certificate or other document relating to him.
8. Whether information and advice on the issues involved should be made more readily available to the public.

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[71] Mort, *Capital Affairs*, 161.

[72] The remaining four points were concerned with the doctors motives in performing the procedure, in the role of the donor, the way in which records were kept for children conceived by A.I.D., whether legislation or amendments to the law were necessary, and if there were eugenic considerations.
National Archives, London, HO/342/15, 'Minutes and correspondence', 16 September 1958 – 4 November 1958.

9. Whether any new legislation and, if so, of what nature is thought desireable touching the regulation of A.I.D.
10. Whether there should be any amendment of the existing law concerning, for example, such matters as divorce, separation and nullity; legitimacy and legitimation; and inheritance and succession to titles.
11. Eugenic considerations.[73]

The Committee, which began as a legal investigation, became very focused on family relations and potential outcomes as a result of a medical procedure. The overarching concern was not with the legal status of the marriage or the child, or even a question of morality – it was principally focused on the potential effect AID would have on marital and family relationships. Central to this fixation on the family was the question of *who* had access to AID.

**Investigating Access to AID**

Although FPA sub-fertility clinics had become fairly accessible by the late 1950s, seeing a specialist for AID still presented a host of limitations – particularly for a family of less financial means.[74] Despite growing affluence in 1950s Britain, access to AID remained largely confined to the middle and upper classes. One of the Committee's prime concerns was the practical matter of the practice – *who* was having AID and *how* they were chosen. On one hand, this meant the Committee was investigating financial barriers, defined in large part by doctors who set their own fee scale, while on the other hand they were also looking at the more qualitative ways medical practitioners 'filtered' suitable and unsuitable couples from their cases. Reproductive medicine remained class-biased, in both practice and prescription. Like abortion, AID was framed as an exclusive treatment

[73] National Archives, London, HO 342/15
[74] For more on the accessibility to infertility treatments, see Chapter 2 examining the experience of infertility through correspondence with the FPA.

for ‘respectable’ couples that could afford it. ‘Suitability’ for parenthood was tied to income, respectability, and the perceived mental health of the female patient.

Discussions over access to AID were focused around three topics: fees charged by doctors, the social class of patients, and whether AID should be made available through the NHS. The latter issue had obvious implications for later health policy. The inquiry revealed that there was little standardization across the practice in terms of fees charged, and which cases were accepted. But with few exceptions, all of the doctors catered to the upper and middle classes, though some said that they would consider working class couples with ‘respectable’ professions and occupations. Some practitioners suggested that they did their best to dismantle any financial barrier, while others were unapologetic about the exclusive nature of AID as a treatment. Without question, these doctors were gatekeepers – making judgments based on their personal criteria as to who would make suitable parents and who would not.[75] Although such assessments ran far deeper than financial limitations, I will first consider the issue of monetary obstacles.

While relative affluence grew during the 1950s – memorialized in Harold Macmillan’s speech that Britons had “never had it so good” – the Feversham evidence confirmed that specialized fertility treatment was still far out of financial reach for the average working-class family.[76] With treatment length ranging from one month to two years, the financial commitment could be substantial. Fees ranged from just over three

[75] On this concept of physicians as ‘gatekeepers’ to treatment, see Carolyn Herbst Lewis, *Prescription for Heterosexuality*.

[76] The average weekly wage for an adult male in the early 1950s ranged from £7.50 to £8.30. By the early 1960s, this average had increased to between £12 and £15.35. Throughout this period, women’s wages also increased but remained only about 50% of those of their male counterparts.
For statistics on average wages, see *History of Britain and Ireland: The Definitive Visual Guide*, (New York: DK Publishing, 2011), 370; Selina Todd, ‘Affluence, Class and Crown Street: Reinvestigating the Post-War Working Class’, *Contemporary British History*, 22(4), (pp.501-519), p.6; Nicholas Crafts, Nicholas, Ian Gazeley and Andrew Newell (eds), *Work and Pay in Twentieth-Century Britain*, (Oxford: Oxford University Press, 2007), 69.

guineas per month, to up to twenty-six guineas per month. Of the doctors who were still in active practice in the late 1950s, their average fee per month was five guineas. If we take the average weekly wage in the 1950s to be £10 per household, the average private fee for AID would mean a sacrifice of more than thirteen per cent of an ordinary couple's monthly wages to fertility treatments. For many families already working within tight budgets, this added expense would have been unmanageable and simply unaffordable. However, Professor Tunbridge made an important point that put the fees into perspective: "I think we may say today £50 is not quite what it was. It is the cost of a small television set and if people want a family they are prepared to do that. It is not so prohibitive although it is a factor".[77] This buying power is suggested in the proportion of households in Britain that owned a television, which had grown to eighty per cent by 1960.[78] Therefore, relative to the purchase of popular consumer goods, AID was perhaps a reasonable expense for many, though a more difficult one to sustain over two years. For a household with little disposable income or savings it would have presented a significant financial barrier. [79]

The practitioners interviewed by the Committee justified their fees in various ways. London-based Reynold Boyd, one of the most experienced AID practitioners, explained that he charged fifty guineas for up to six months of treatment (just over eight guineas/month). This was equivalent to twenty per cent of the average monthly wage, but Boyd would sometimes waive the fee for those professions that could not afford it:

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[77] National Archives, London, HO 342/59, 'Religious bodies, England and Wales: Methodist Church', 1958-1960.
[78] Kevin Williams, *Get Me a Murder a Day! A History of Media and Communications in Britain*, (London: Bloomsbury Academic, 2010), 149.
[79] For a point of reference, £50 in 1959 has a historic standard of living value of roughly £1000 in 2014. www.measuringworth.com

> This fee appears to be comfortably within the reach of artisans, business and professional people, but has to be waived for clerks (e.g. in banks), police and other government employees, etc. of the eminently respectable but 'poor' bracket, whose margins are so desperately small.[80]

Although Boyd suggested that treatment was open to lower income couples, he still stressed preference for those with 'respectable' occupations – quietly excluding manual workers/labourers. However, he defended the accessibility of the practice, as some of his patients did not pay for AID (based on income levels). Boyd claimed that, for him, the work was reward enough; he did not need to charge everyone a fee. There were no clear criteria for selection, but the evidence implied that a 'respectable' occupation was prioritized above income level alone.

Several female practitioners offered a more accessible fee scale. London-based Eleanor Mears charged 3 guineas per insemination (nearly one-third of Boyd's fee), with a maximum treatment period of 12 months. Lord Feversham asked Mears if her fee had "any bearing on the type of patient" she obtained. Mears explained that she purposely kept her fee low since it was still a fairly new and debatable treatment. Although three guineas did not compensate for the work in getting donors, she did not feel justified in charging any more: "I only do it for people I feel I would like to help in that way because they very genuinely want a child this way".[81] Mears suggested to the committee that her motives were altruistic: she kept her fee low to open her patient base and was not making any profit on the work. But even with a smaller fee, it was revealed that her patient base was largely middle and upper class. The Chairman continued his questioning, asking if Mears had received patients from lower income groups. She responded:

[80] National Archives, London, HO 342/58, 'Doctors who have practised AID: Reynold Boyd', 1959. All Medical evidence used in this chapter is taken from HO 342/58.
[81] National Archives, London, HO 342/58

> Only since the publicity about A.I.D. last year, when I had a number of patients referred to me from the Midlands. My own practice is very much a West End practice, so that the figures referred to before you in my memorandum do not involve working class people.[82]

The Chairman asked further whether most of Mears' patients were from the professional classes and higher income groups, to which Mears responded in agreement. There was a sense that the Chairman was looking for reassurances that this was an exclusive practice confined to the 'professional' classes, rather than being open to anyone. By nature of geography – having a 'West End' London practice – Mears attracted mainly well-to-do couples, even if she made the effort to appear open and accepting regardless of class.[83] Mears also seemed conscious of the potential criticism directed at doctors profiting from AID when it was still seen as the 'Wild West' of medicine. Like Mears, Margaret Shotton (Birmingham-based) offered AID for 3 guineas per insemination. When asked about the type of couples who came to Shotton for AID she explained:

> Almost without exception they come from the well educated, intellectual class. There have been one or two others of the clerical, labouring types which I have accepted but almost all of them have been really top level intellectually and as far as I can judge morally.[84]

However, Shotton insisted that the fee was not prohibitive for any couple: "I am very much against them having to pay anything which is outside their income limit".[85] At a similar scale to Mears and Shotton, Exeter-based Margaret Jackson charged a fee that was kept within reachable limits of ordinary people: £3 13s 6d for the first visit and visits with special examinations; and £1 11s 6d for subsequent visits.

Notably, male physicians charged substantially more, on average, than female physicians. Although one would suspect generally higher fees in London, and lower fees

[82] National Archives, London, HO 342/58
[83] Mears had taken over Joan Malleson's practice after her death.
[84] National Archives, London, HO 342/58
[85] National Archives, London, HO 342/58

outside the metropolitan core, the fee scale seemed more determined by the gender of the doctor rather than by location, which may have been in keeping with other service fees. For instance, Philip Bloom (London-based) charged the highest rate of all the practitioners interviewed, quoting at the top end 125 guineas for a five-month treatment, with the lowest being 50 guineas for five months (10 to 25 guineas/month). The Chairman asked Bloom if his patients came from "any particular category of society" which could be easily defined. Bloom said his patients were middle-class, listing the following occupations for his thirty-eight cases:

> …five were doctors, two dentists, two chartered accountants, three electricians, two engineers, three members of the Foreign Office, Diplomatic Corps, and so on, and so forth, one a barrister, one a lawyer, two civil service administrators, one stockbroker, seven dons, teachers, scientists, several were somehow or other in business – managers, company directors, salesmen, that sort of thing – one was a window-cleaner, one a taxi cab owner, one a hotel manager. Those, roughly, are the categories.[86]

When questioned about how some of the latter individual in his occupational list could afford his services, Bloom advocated the dual income household, explaining that, "[w]hen there are two people working and they earn £20-£25 [per week] between them, and they live on a very low rent, they are much better off than most of us".[87] This reflects the growing number of women in the workforce and suggests that Bloom did not consider the £10-per-week single-income couple as typical candidates for his practice. His assumption was that couples had a base level income of at least £20 per week if they were to afford his services. In comparison, Manchester-based Bernard Sandler charged a more moderate fee at 35 guineas for a six-month treatment (5.8 guineas/month), and he adjusted his fees according to a patient's means. Sandler strongly stressed the importance

[86] National Archives, London, HO 342/58
[87] National Archives, London, HO 342/58

of improving accessibility to treatment and told the committee that it should be one of their main aims:

> I think it should be an important part of the Committee's work to lay down means whereby doctors and their patients could find out what facilities are available within reasonable distance of their towns for their patients to receive A.I.D. at the hands of someone experienced and fully aware of all the issues involved in this process.[88]

Sandler had patients from Glasgow, Aberdeen, and Edinburgh and found it "quite ridiculous" that patients were not able to receive the service nearer to their homes. He believed it should be an open medical treatment, explaining that the "service should be readily available for people who want it just in the same way that blood donors are".[89] Sandler appeared less concerned with income and occupation. Under the critical eye of the Committee, those doctors practicing AID were more likely to imply altruistic motivations and an inclusive selection process, not based solely on income level, yet it is difficult to know how true this was in practice. They may have also been more likely to emphasize the 'professional' and 'intellectual' nature of their patients if the questions were leading in that direction. As Carolyn Herbst-Lewis has pointed out, physicians were also motivated to 'shield' the AID family, which included:

> …protecting them from legislation or jurisprudence that would discredit the procedure and from moral judgments that might undermine the legitimacy of the child or damage the reputation of the woman or the physician.[90]

While all practitioners charged a fee, some believed it should be made widely available on the NHS. Helena Wright had a set fee of five guineas for the first consultation, but was then flexible thereafter to see how much the couple could pay and how long it might take. Yet when asked for her reasons to refuse a couple, Wright said the most common reason was financial, explaining that she had "no resources for the

[88] National Archives, London, HO 342/58
[89] National Archives, London, HO 342/58
[90] Herbst-Lewis, 117.

poor".[91] It was not only the "poor" she was speaking of but also the average couple. Following this line of class-based questioning, Mrs Jay asked if "[t]he £10 a week man is really out?", to which Wright responded: "Certainly out, yes. I think it is a great pity".[92] Although Wright did not accommodate couples in a lower income group (earning the average national wage), she believed it should be made part of the NHS – for the sake of the couples. So perhaps it was not a question of the poor being undeserving; Wright felt it was the responsibility of the State to accommodate couples, not private-practice doctors. She was unapologetic about class limitations and believed infertility treatment for the working classes was the responsibility of the Welfare State.

There were certainly practitioners who would not have advocated for the practice to be more open. Mary Barton did not discuss her fees outright, but admitted that the majority of her patients were middle-class. When the Chairman asked Barton whether her patients were "a pretty good cross-section of the public at large", Barton responded that:

> I should think I do have a pretty good cross-section, but I suppose the bulk are what we must inevitably call middle-class. I have quite a number of working-class people in good jobs, and only once have I been sent a couple on Public Assistance, and to this day I do not know how the doctor could have brought himself to send them. I have never had that experience either before or since.

While Barton suggested that her services were accessible to working-class people with 'good jobs', there is no evidence to qualify exactly what this meant. The expectation among most doctors was that couples should be expected to cover reasonable financial costs on the path to parenthood. The question remains as to whether selection for AID was based on income (whether parents could afford to support the child), or the intangible notion of 'respectability'. Since each practitioner worked from different standards, there is no cohesive policy for analysis. Peggy Jay, a vocal committee member, was

[91] National Archives, London, HO 342/58
[92] National Archives, London, HO 342/58

particularly concerned with class bias in the selection of couples and pushed witnesses to reveal medical barriers to treatment. She tried to ascertain how many couples were prevented from seeing a specialist for AID, asking how many people would come up against doctors who were not sympathetic to the cause, and how many people might meet an obstruction either at the family doctor level or the consultant level.[93] If one's family doctor declined a referral to a fertility specialist, a second opinion might be sought out, however, there was a cost to obtain a second opinion; a patient could only get free advice from the doctor with whom they were registered. This meant that in various ways, costs were consistently a barrier to infertility treatment.

More than simply the cost of the practice, the Committee was preoccupied with the class implications of AID. The Chairman pushed Margaret Jackson on the question of exclusivity, revealing his own position that AID should not be made available to all through the NHS:

> Chairman: If the practice of A.I.D. were to be accepted as a modern development of medicine in the 20th century, would it not follow as a corollary there would be a demand to so adjust the administration of the National Health Service so that all income groups should come into it, would it not then be more difficult to *obtain the best type of parents for having a child*? Would not the responsibility of the practitioner be very much greater, *dealing with a wider and poorer class* making application than it is at present, and would in fact *the standards that you have set yourself be likely to fall* due to that fact? [emphasis added]
> A: I would feel very unhappy if it were universally available without any financial responsibility whatever on the part of the parents. I am quite sure that would be wrong.

Feversham essentially stated that making AID available to "a wider and poorer class" would result in a fall in "standards" and therefore it would be difficult to ensure it was for the "best type" of parents. Although Jackson believed that some fee should be attached to the practice, she was less discriminating based on class than some of her colleagues. There is some evidence to indicate that those doctors involved in the FPA – including

[93] In this sense, there were two 'vetting' processes to access A.I.D. first through the GP, who by the late 1950s patients were reliant on for a referral to a specialist.

Jackson and Mears – were less class-biased by making their services more financially accessible to the working and lower-middle classes. Yet Philip Bloom, who was also a member of the FPA charged significantly higher rates. Therefore, the cost structure was clearly gendered. Feversham's questioning suggested his position on the matter: if all income groups (the 'poorer class') were to be given access to AID, standards were likely to fall and it would become difficult to select the 'best type of parents'. When interviewing Margaret Moore White, the Chairman once again directed questioning to oppose an opening up the practice:

> Chairman: But if the practice [of A.I.D.] were recognised to a greater extent than it is at present under certain safeguards would you not say there would be *a tendency for couples of less integrity and lower intelligence to apply*? [emphasis added]
> A: Yes, there is that possibility.
> Q: Then if there is that possibility, would you not think then it might be more necessary to institute a more thorough investigation into all factors, not only medical ones as to suitability?

Feversham's questioning seemed to project eugenic principles onto the practice; not only that, but he was attempting to lead the witnesses into agreement that the barriers currently in place should remain that way. Moore White's response was sympathetic to the difficulties couples faced in improving material living conditions to provide for a family, by referencing similar difficulties faced with the adoption process, and she suggested that "suitability" should not simply be based on income or occupation. There was an obvious difference of opinion within the Committee on this matter. Lord Feversham's questioning suggested that the practice should not be made more accessible, while Peggy Jay was concerned with the various barriers to treatment that were inevitably class-based, and suggested that it be made more inclusive. It is entirely possible that Feversham was playing 'devil's advocate', as he did with religious leaders, and

challenging the positions of the witnesses. However, it seems more likely that he was expressing his own beliefs and the position of the Committee.

The question of accessibility was closely tied to the role of the National Health Service (NHS). Implicit in this discussion were questions about the role of the state in matters of family planning: Was AID a treatment to which all British citizens had a right? Was helping infertile couples about fulfilling individual desire for a child, or was there a social benefit? What was the role of the state and, by extension, the NHS? The Committee evidence questioned the role of the State in the reproductive lives of its citizens. Although the NHS had been in existence for more than ten years by the time the Committee interviewed medical experts, there was ample concern over the confidentiality of the health service, once again highlighting the tiered medical system. The Feversham Committee was interested in whether AID should be made universally available through the Health Service, and what might result from more open access. When asked directly, in principle, most of the practitioners supported greater accessibility to AID as a treatment for infertility, but nearly all of them expressed serious reservations about privacy and confidentiality under the NHS. Most of this concern was based on mistrust of the system – particularly that privacy and secrecy of medical records could not be maintained in the NHS. With the stigma associated with infertility and particularly the controversial practice of AID, this was an important consideration. Within this concern for confidentially, there was also a reluctance to make the treatment available to the wider population; discussion of the 'loss of standards', and too many people having access suggested that restricting it to the 'respectable' middle-class in private practice remained a priority for many practitioners. For example, Mary Barton believed that maintaining

secrecy would be impossible on the NHS where records would be open to inspection. She questioned who would take responsibility for maintaining confidentiality in "a big organisation under the National Health Service".[94] But in addition to the concern over privacy, she wanted the practice to remain exclusive in the number and type of cases:

> I think this should not be open to all and sundry. I think the cases should be very carefully sorted out and not just available to anybody who fancies it and can threaten his doctor with a change to someone else if he does not get it, and that kind of thing.[95]

Barton was certainly right in that processes would need to be in place if the practice was extended to the NHS, but most often the 'sorting' of cases was based on social criteria rather than organizational restrictions.[96] Margaret Jackson and Reynold Boyd too spoke of the problem of secrecy "leaks" in the NHS as a reason to not offer AID more openly, as did Philip Bloom who said that although it was desirable for AID to be available on the NHS, there were privacy issues that needed to be overcome before it should happen. Bernard Sandler did not think AID should be available on the NHS because secrecy could not be maintained. Expressing his frustration with the Service he said:

> The National Health Service is quite incapable of keeping anything secret…Quite honestly administrative problems in the National Health Service are such that they do not inspire me with confidence even about not mixing up two bottles of blood, never mind two bottles of semen.[97]

None of the doctors provided details of problems with the NHS, but there was an established reputation of mistrust.

The general position of the Committee and doctors was that social standing, occupation, and income level were more important than medical need or personal desire

[94] National Archives, London, HO 342/58.
[95] National Archives, London, HO 342/58.
[96] During the Committee interviews with government departments, the Ministry of Health answered the question of confidentiality by saying that AID would be treated similarly to VD clinics.
[97] National Archives, London, HO 342/58.
Secrecy and issues of documentation in the NHS were discussed in greater detail in the Government Department interviews, for instance with the The Ministry of Health.

in obtaining access to AID. Although 'eugenics' was not discussed outright during the Committee proceedings (though it was on the formal agenda), it was often implied by suggestions that people of 'lower intelligence' and the 'poorer class' would not make suitable parents – though how such individuals were defined was not discussed. The implication was that only the 'best and brightest' should be 'permitted' to conceive in this way. The evidence questioned the role of the State and, with it, whether parenthood was a right. Most of the medical witnesses advocated state-funded infertility treatment, which would help close the gap between public and private healthcare. However, this outcome did not seem desirable for Feversham.

**Vetting 'suitable' couples**

Beyond the class-based vetting of AID applicants, the Committee was acutely interested in the marital relationships of candidate couples. The members were concerned with the assessment process and the power balance in the marriage: the gendered dynamic within marriage was a significant factor in the selection process, as was the doctor's line of thought in determining a 'suitable' couple.

Candidate couples were vetted by AID practitioners, similar to how they might have been by an adoption agency. Each doctor had a slightly different criteria: for some, this process was based on personal opinion including "hunch", "common sense", and "intuition", while other doctors stressed the importance of clinical insights and the referrals process, which placed more weight on the opinions of other medical experts. The common factors considered by practitioners that emerged in the interviews in assessing a couple included: responsibility, maturity, integrity, financial stability, cultural background, medical referrals, lack of coercion by either partner, emotional state, mental

stability, and potential stressors. Many of these factors relied on a psychological assessment. Emphasis was placed on both individual and marital well-being, but class-based indicators like education, occupation, and the state of a couple's home were equally prioritized.

These doctors worked with a range of assessment criteria, but stressed the flexibility within these categories. For instance, Reynold Boyd considered "personal integrity and responsibility", the "wealth of husband", "health of mother", "stability of marriage", and lack of coercion to be of prime importance. Boyd also took into consideration their personal recreations, the cultural background of the couple, the size of their house, and income. However, he stressed that there were exceptions to these categories:

> …lots of young people are, to my mind, made by a family. They do not have everything before they get a family…it is not made up on how good a home they have got, or how much money; it is made up entirely on an assessment of their responsibility and the reasons they have. I suppose it is largely made up on hunch…The ones that I finally deal with are so transparently stable and honest, and it is the one thing in the world they want.[98]

Boyd stressed that his decision was based on personal qualities of honesty, responsibility, and stability rather than material wealth. The committee asked Boyd if he felt his 'hunch' should be corroborated by a psychiatric opinion. Boyd said that if he felt a case warranted a psychiatrist visit, that was reason alone not to take that case. This tension between specialties, and particularly a negative association with psychiatry, was present in a number of interviews. In the late 1950s, perceptions of mental illness and psychiatric treatment remained highly stigmatized. Psychiatric mental hospitals were still largely separate from general hospitals and tended to be located on the outer limits of the city, where they were overcrowded with resident patients. Although this began to change from

[98] National Archives, London, HO 342/58.

the mid-1950s, it was not until the 1959 Mental Health Act when the division between mental and general hospitals was broken down and outpatient treatment became more common.[99] Nevertheless, Peggy Jay pushed the point that Boyd acted on a 'hunch'. Concerned about the barriers to access, Jay questioned Boyd further about his 'hunches' and unwillingness to accept psychiatric opinion:

> Do you feel sufficient confidence in your hunch to know this person really – you have not specifically referred to it in terms of the marital relationship – the stability of their mutual life. You feel that that is within your own competence to judge? You do not ever feel the need to have a second opinion on those intangible matters?[100]

Boyd responded that he had a wealth of experience in such cases and had total confidence in his own judgment. Similar to Boyd's 'hunch', Eleanor Mears described using her intuition in making choices about suitable couples for AID:

> I must emphasise the fact that as a woman I rather feel my way into these situations, and I am not sure I would be very good at explaining this to you…I use what psychological insight into other people I have to help me judge this. I am sorry I cannot be much more specific.[101]

Helena Wright based her decisions on "common sense and experience", including "the way they talk, what their education has been, and their interests, and so on".[102] For these practitioners there were no hard and fast criteria, but they instead worked within a general assessment of suitability using various individual, social, and cultural markers. These unscientific 'hunches' were value-based judgments relying on the personal experience and bias of the doctor, but the physicians were likely unaware of some inherent biases and how they may have influenced their decision-making process. This remains a contemporary issue in medical practice: "most decision-making performed in medicine

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[99] Hugh Freeman, 'Psychiatry and the State', *Psychiatric Cultures Compared: psychiatry and mental health care in the twentieth century*, Edited by Marijke Gijswijt-Hofstra. (Amsterdam: Amsterdam University Press, 2005), 123-28.
[100] National Archives, London, HO 342/58.
[101] National Archives, London, HO 342/58.
[102] National Archives, London, HO 342/58.

contains an irreducible intuitive element and is thus vulnerable to these biases and heuristics".[103] Intuition undoubtedly plays a role in decision-making, in a clinical role and elsewhere, but the issue here is that there were no clear criteria and no second opinions – making one poor judgment on 'hunch' could be the end of the line for a couple seeking infertility treatment.

Other physicians described a more methodical approach to selecting couples for AID. Margaret Shotton stressed the importance of financial stability, and was particularly concerned with occupation. She would spend at least thirty minutes talking with both the husband and wife, and often longer with the wife on several occasions; she would wait at least two months for them to think it over before making the decision. Although she was not a psychiatrist, Shotton did her "best to try and assess their emotional state".[104] She expected them to have good reasons for wanting AID and said that she asked the couple to convince her that it was the right treatment for them. Philip Bloom stressed his formal qualifications in marriage assessment, and explained that he tried to estimate any underlying emotional problems in addition to determining how 'grown up' the couple was, and how aware they were of the responsibility they were undertaking. He would typically see couples on at least two occasions before making a decision. Margaret Jackson stressed her reliance on referrals from the general practitioner or consultant who were in a better position to know the couple, and upon meeting the couple she would have "a pretty shrewd idea which way strings are being pulled".[105] Jackson did not list any criteria she had for assessing couples, but said the reasons to say 'no' were more

[103] See the abstract for KH Hall, 'Reviewing intuitive decision-making and uncertainty: the implications for medical education', *Medical Education*, 36(3), 2002, (pp.216-224).
[104] National Archives, London, HO 342/58.
[105] National Archives, London, HO 342/58.

obvious, using the example of a wife coercing the husband: "If a very masterful woman enters my consulting room bringing behind her a reluctant and timorous husband I shall divert the conversation into some other channel".[106]

The 'vetting' process was a very personal judgment on the couple, their marriage, and their social status – often based on only one meeting. Peggy Jay, in particular, questioned how equipped the doctors were to assess patients in this way and whether it should be left to a more suitable specialist (psychiatrist or marriage guidance counselor) or balanced between a number of doctors. Although material wealth was not the prime factor, the door to AID was far more open to middle and upper class couples, unless they exhibited indications of marital turmoil or emotional instability, which would raise a red flag.

**Gendered power dynamics within marriage**

Part of the Committee's interest in how each physician assessed a couple was based on the gender roles and power balance of the marriage. The Members were concerned with the relational dynamics of couples pursuing doctors; specifically, the Committee suspected wives of coercing their husbands into agreeing to AID. To the Committee's surprise, the doctors revealed that the husband was often the principle driver in the pursuit of fertility treatment, which is consistent with Kate Fisher and Simon Szreter's findings on the gendered responsibility around sex and reproductive decisions before the early 1960s.[107] This evidence is also consistent with my findings based on the correspondence between the Family Planning Association and potential patients: both

[106] National Archives, London, HO 342/58.
[107] For male dominance in sex and family planning, see Fisher and Szreter, *Sex Before the Sexual Revolution* and Fisher, *Birth Control, Sex and Marriage*.

men and women wrote to the FPA for help with infertility, with thirty-seven per cent of the letters being penned by husbands.[108] Despite the assumption of the Committee – that a dominant wife was pushing her spouse into agreeing to treatment – it was quite often the husband who initiated the inquiry into AID. This image of the 'dominant wife' wanting a baby by AID was based on the assumption that a woman was not fulfilled or complete before motherhood. Yet it was also based on the perception that if a wife was pursuing donor insemination (with a reluctant husband) there was either a pathological condition or unhealthy marriage to blame. However, fatherhood was not seen in the same way. Although biological fatherhood was important, men were not perceived as having the same desire for parenthood as women.

The majority of the physicians interviewed confirmed that the husband played a significant role in the pursuit of AID. Both Reynold Boyd and Margaret Jackson – two of the most experienced practitioners – stressed the role of the husband and the joint decision in seeking out such treatment which, of course, also validated the practice. Boyd told the Committee that it was the husband who often initiated the discussion: "The initial suggestion comes as often from the husband alone…as from both husband and wife who have together rejected adoption of which so many have a deep and well-founded distrust based on personal experience".[109] This negative approach to adoption was a common theme in the Committee evidence, and will be explored later in this chapter. Boyd said that cases where the wife appeared to be the more dominant party only occurred in about twenty per cent of cases – and in those instances Boyd would see the husband alone on a number of occasions to ensure he was not being coerced. Margaret Jackson put it more

[108] See Chapter 2 on the experience of Infertility.
[109] National Archives, London, HO 342/58.

strongly: "I would say the request, the move, the push, comes from the husband nearly always. He is the one".[110] The Committee pressed Jackson on this point, further asking whom she would "describe as the dominant partner to resort to A.I.D.?"[111] Jackson again said that she believed it was a very mutual decision. Justice Stevenson pushed Jackson to speculate about the husband's motives in desiring AID: Did he feel sorry for his wife? Did he feel responsible? Or did "the husband personally desperately want a sort of synthetic fatherhood"?[112] Jackson reiterated that the "decision to start a family in this way is a mutual one".[113] Mr Ross continued the line of questioning asking once again about the husband's motives in wanting AID: "What percentage of the husbands want a child as distinct from wanting to please their wives or transfer their responsibility to A.I.D.?"[114] Jackson stressed again that the husbands must want a child:

> I cannot believe any couple would go to the trouble they do unless he wants to start a family…these people have married with the very firm notion in their minds they want to bring up a family and are totally dismayed if they find they cannot.[115]

Only Helena Wright countered this experience by telling the Committee that it was the wife who was the "prime mover" in asking for AID, but she would always see the couple together to assess the dynamic. However, Wright's experience with AID represented only a fraction of the cases undertaken by Jackson and Boyd (at best, three per cent of their case experience).

The meaning of and motivation for fatherhood was understood in different ways by different Committee members and witnesses. Some Committee members struggled to understand a husband's interest in AID, or even having a child at all. Lines of questioning

[110] National Archives, London, HO 342/58.
[111] National Archives, London, HO 342/58.
[112] National Archives, London, HO 342/58.
[113] National Archives, London, HO 342/58.
[114] National Archives, London, HO 342/58.
[115] National Archives, London, HO 342/58.

projected feelings of guilt and responsibility onto the husbands, assuming parenthood was a social and marital expectation rather than an emotional desire for the experience of fatherhood. Throughout the interviews, gender roles were projected onto AID couples, in which women were positioned as 'obsessional' and 'neurotic', and men as having the very root of their masculinity threatened. There was a perception that the wife was both domineering and mentally unstable, while the husband was guilt-ridden and vulnerable. This underlines the stigmatized perception of infertility. In the Committee proceedings, the 'condition' of the modern woman was sometimes suggested to be pathological: she was either 'neurotic' and 'obsessive', or 'domineering'.[116] Such characterizations point to the influence of psychology. Perceptions of masculinity and femininity were destabilized during the 1950s as a result of changes in the culture of home and work.[117] It was a period of transition and tension, with gender roles changing.[118] With more women working outside of the home, there was a conflict around the role of women in society. By 1958, nearly 8 million women were working – many of whom were married and over thirty.[119]

A number of the Committee members were suspicious of women who desired a child by AID. On several occasions, it was suggested that such women were suffering from a pathological psychiatric condition: obsession, neuroticism, or some form of mental illness. There was an additional implication that wives were coercing their supposedly guilt-ridden husbands. Gayle Davis has examined the extent to which medical

[116] See Gayle Davis, 'Test Tubes and Turpitude: Medical Responses to the Infertile Patient in Mid-Twentieth Century Scotland'.
[117] See Stephen Brooke, 'Gender and Working Class Identity in Britain During the 1950s', *Journal of Social History*, 2001, pp.773-795.
[118] Ibid.
[119] See Denise Riley, *War in the Nursery*.

practitioners pathologized women being treated for infertility.[120] Using oral evidence from the Feversham Committee's interviews with Scottish medical bodies and practitioners, Davis had shown that the Royal College of Surgeons of Edinburgh and individual doctors characterized female patients seeking infertility treatment as suffering from 'neurosis', being 'of a highly nervous disposition', and 'emotionally disturbed'.[121] Dr. Maclennan (from Scotland) told the Committee that, "he would only send patients for such therapy whose outlook was 'scientific and detached', because the remainder 'started off as a normal woman wanting a baby but…finished up as an obsessional neurotic'".[122] This attitude was informed by a long medical history that pathologized women and their bodies, but also spoke to the stigma of infertility and mental illness.

The Committee pushed the questioning of medical witnesses in search of cases of 'obsessional' and 'neurotic' women. The medical response was varied, but the majority agreed with the Committee that there were many cases of wives with a "neurotic obsession" for children, who were ruled as unfit for parenthood by these doctors. Such assumptions about female patients tended to ignore the social expectation of motherhood ascribed to all women, and the frustration experienced by so many couples who had spent five or ten years trying unsuccessfully to conceive with no avenue for treatment. For many couples like those who wrote to the FPA, donor insemination was viewed as a last hope for a 'normal' family.

Some members of the Committee specifically directed questioning to encourage negative characterizations of female patients. Perhaps surprisingly, female physicians

[120] See Gayle Davis, 'Test Tubes and Turpitude: Medical Responses to the Infertile Patient in Mid-Twentieth Century Scotland'.
[121] Davis, 'Test Tubes', 122.
[122] Davis, 'Test Tubes', 122.

were just as likely as their male counterparts to characterize patients in this way. For instance, Justice Stevenson asked Margaret Jackson about the mental and emotional impact of infertility on women:

> Mr Justice Stevenson: One has heard of cases of women who become mentally or emotionally unbalanced and disturbed because they cannot have a child. I suppose that does occur, does it?
> Dr Margaret Jackson: Very much so.
> Stevenson: Are women who are likely to be unbalanced in that way in your view suitable subjects for A.I.D.?
> Jackson: I would say I see many more of that type in the rest of my practice.
> Stevenson: I follow that, but if you took the view in relation to a particular female patient that she was of that type, would you consider her as a suitable subject for A.I.D.?
> Jackson: You mean, if she was obsessional about that business? If she came with a kind of fixed notion in her head she must have a baby at all costs? I think they are very, very suspect – not good parents.
> Stevenson: A proportion then of this fractional number of women who are without children are rather unsuitable subjects for A.I.D. because of an obsessional tendency?
> Jackson: Some of them are: those I would try to eliminate.
> Stevenson: It is not easy to detect, is it?
> Jackson: I nearly always can. Having detected it I then try to divert them.[123]

Although Jackson said she did not often come across such patients in her AID practice, because the women were fertile, she would divert those who exhibited obsessional tendencies. Similarly, Eleanor Mears explained that half of the cases she turned down were done so on the basis of 'obsession' or 'neurosis':

> Where a woman is obsessional about it I feel that this is not a good sign and I do not accept them. Where they are referred from a psychiatrist I am usually rather unwilling. I think a psychiatrist is inclined to refer them as the last straw when his patients worry him, and put the onus on someone else.[124]

Mrs Jay pushed the conversation further, disagreeing with her colleagues, suggesting that the cause of the 'obsession' was childlessness itself and once resolved (with the birth of a baby) the 'obsession' would be cured. Mears said the child fixation was only a symptom of a deeper issue:

> I think a woman who gets obsessional about a child is obsessional in herself. I do not think this is a single cause of neurosis. I think there are always other things, and this is her symptom. We know only too well the symptom the patient complains of when she

[123] National Archives, London, HO 342/58, Eleanor Mears.
[124] National Archives, London, HO 342/58, Eleanor Mears.

> comes in to see us is not necessarily the cause of her trouble; that may be her symptom, but it is certainly not the root cause of her obsessions.[125]

Philip Bloom agreed that any sign of 'neurotic tendency' was reason to turn down a case:

> There are many wives who have a neurotic obsession for children…women who need that child to make them realise that they are women themselves…They are neurotic, yet hospitals turn themselves inside out to give these people children, and these children could be brought up in terrible environments.[126]

This discussion, which focused on the psychology of female patients, is interesting given that male infertility was the core issue. As Gayle Davis has pointed out, when the 'norm' of maternity was desired too much by female patients they were characterized as "frustrated, obsessional, and precisely the wrong sort of person to 'function well as a parent'".[127] However, the societal pressure for parenthood was never considered a cause for such so-called 'neurotic obsession' and, as suggested, this was an affliction of women only.

There was some suggestion that there was a shift in the clinical presentation of requests for AID. Mary Barton explained that she had experienced a change in her female patients: in the early days she had more women patients who were 'neurotic', or "on the verge of a nervous breakdown from frustration and strain", but since 1949 she described her patients as "aggressively normal" and "a very, very ordinary sample of the population". Perhaps this shift Barton perceived was based on the growing awareness of AID in the public realm, which meant that people were not waiting as long to seek treatment for infertility and were therefore less frustrated – or 'neurotic'. Yet positioning the patient base in this way could also be a line of defense for AID. Nevertheless, the

[125] National Archives, London, HO 342/58, Eleanor Mears.
[126] National Archives, London, HO 342/58, Philip Bloom.
[127] Davis, 'Test Tubes', 126.

social expectation that a woman would be primarily a wife and mother remained, with or without work outside of the home.

The choices available to the 'modern woman' were also framed as potential causes of infertility. Bernard Sandler believed that the growth of gender equality was causing stress-induced infertility, and he told his female patients that they had to choose *either* a career *or* motherhood. He told the Committee of one patient who was undergoing fertility treatment, who had been married for ten years and was the principal of a dancing school:

> I said to her if you have a baby what are you going to do about your dancing school. She replied I will decide that when the moment arises. So I was really brutal and said to her you either have no motor car, no dancing school and a baby or no baby and a dancing school and a motor car but you are drifting and have drifted for 10 years. She said: 'But, Doctor, I have done my best. I have suffered. Look at the curettages and so on I have had'. I told her you are doing that as a defence mechanism. She went home and she was pregnant the next month. That is what I call stress provoked infertility. In other words in England where women are brought up to be the equal of men pregnancy is a conscious decision which they have to take…The fact of having a baby first of all requires conscious decision. She has to decide whether she is having a baby or new curtains or a new car or giving up a profession and therefore this is a conscious decision. With all the fears that go with it it means that some women are unable to make that decision and they do need some help.

While belittling this patient, Sandler explained motherhood as an exclusive choice for women that closed professional doors. In this way, Sandler explained female fertility problems as largely psychological – caused by emotional stresses inherent in the life of a 'modern woman' who (misguidedly) wanted both career and family. Despite the misogynistic undertone of Sandler's statement, twenty-first century medical studies have shown that a correlation does exist between stress and infertility, although it may only play a minor role.[128] Unfortunately, Sandler's attitude was not uncommon. In the postwar period warnings were often directed to working women who were perceived as causing

[128] C.D. Lynch, R. Sundaram, J.M. Maisog, A.M. Sweeney and G.M. Buck Louis, 'Preconception stress increases the risk of infertility: results from a couple-based prospective cohort study – the LIFE study', *Human Reproduction*, March 2014. http://humrep.oxfordjournals.org/content/29/5/1067.short.

their own infertility. In the United States, a leading expert made a similar claim: " 'The pressures of modern living and the strains of occupations in which women have been engaging are…significant causes' of infertility".[129] In the 1950s, there was an obvious tension between women as workers and mothers, and this was heightened with greater numbers of mothers working in part-time positions.[130] In Sandler's view, the modern woman could not 'have it all'. She had to choose either a family or a career. Sandler's case also underlined the changing practice of family planning; women were *choosing* and *planning* when to have a child. However, balancing motherhood with a career was not the norm, and in the late 1950s there was not a clear model for this type of work-family balance. The Committee evidence reveals anxieties over the role of women in family and society and, using that late twentieth-century cliché, the challenges for women to "have it all".[131] While women were often blamed or criticized, men were reassured of their masculinity.[132]

This concern about the role of women was contrasted with discussions over the place of men. Ideals of manhood and masculinity framed much of the Committee discourse concerning husbands. AID was considered an implicit threat to masculinity with the perception that requiring assistance to conceive reflected a loss of virility and manliness. Men who requested AID to form a family were characterized as guilt-ridden, anxious and highly vulnerable. Although a number of the Committee members assumed

[129] Elaine Tyler May, ''Nonmothers as Bad Mothers: Infertility and the 'Maternal Instinct'' (pp.198-219), in Molly Ladd-Taylor and Lauri Umansky (eds). *'Bad' Mothers: the politics of blame in twentieth-century America*, (New York: New York University Press, 1998), 199.
[130] See Stephen Brooke, 'Gender and Working Class Identity'
[131] Anne-Marie Slaughter, 'Why Women Still Can't Have It All', *The Atlantic*, July/August 2012, http://www.theatlantic.com/magazine/archive/2012/07/why-women-still-cant-have-it-all/309020/
[132] Elaine Tyler May, ''Nonmothers as Bad Mothers: Infertility and the 'Maternal Instinct'', 202.

that husbands were coerced into AID, Mary Barton stressed that social expectations weighed heavily on men as they did with women:

> …the men in the case are equally anxious to have children. I think men feel that they suffer from a social stigma when they do not have families. I think they feel they have lost face with their wives and I think they also have a tremendous guilt complex in the fact that they have denied their wives something which is essential to them.

Such descriptions were deeply gendered, as the anxiety and guilt experienced by husbands was *never* characterized as 'neurosis', which was a condition apparently experienced only by women. Of greater concern to the Committee than whether husbands were coerced, was the threat that knowledge of infertility would pose to a man's masculinity. A number of doctors advised that wives not tell their husbands of a sterility diagnosis, because it would be psychologically harmful. Doctors worried about how men's infertility would impair "their sense of masculinity".[133] Mary Barton, for one, admitted to keeping critical information from patients in order to protect their masculinity. She explained that in some cases of AIHD she would exclude the husband's semen from the sample because she knew he was sterile. When questioned on the matter by Justice Stevenson, Barton said she was justified in the deception because she had explained the minute chance of the husband being the father – with or without AIHD – and in the end no one would know who the biological father was anyway. Albert Sharman agreed that the husband should not be told of his sterility. Explaining his protocol, Sharman told the Committee:

> My technique in relation to these patients whose husbands had a complete absence of sperms was not to tell the husband he was totally sterile. The procedure was the wife was sent for and I had a heart to heart talk. I said that one should never tell the husband he was totally sterile. I saw marriages going on the rocks, ruin and divorce, through telling the husband...I usually tell the story quite truthfully to the woman and say that the best approach for the sake of happiness is to tell the husband he is impaired but there is a hope with treatment or in time things might remedy

[133] Herbst Lewis, *Prescription for Heterosexuality*, 122.

> themselves…I told the wife she was not to go home and blurt out the whole truth of the matter. She was to tell her husband that he was at fault; there was no point in being subjected to any further treatment; he was at fault, but they were to be patient and see – this was not from me but from the neurological department – that things might improve. We were not in a position to say they could not improve.

Sharman advocated maintaining a certain level of false hope for the husband in order to protect his psychological well-being and 'manhood', entrusting the wife with the diagnosis. Sharman had not practiced AID since the 1930s, so his methods could be taken as outdated, but a number of those in active practice supported Sharman's stance. Eustace Chesser echoed Sharman's position, arguing that men's knowledge of their sterility was psychologically harmful:

> Men in particular find it hard to accept any inadequacy in their sexual or procreative capacity. In fact in the case of a married man the mere knowledge of his sterility can be psychologically harmful both to himself and his wife.

Even a semen test could threaten a man's masculinity. Chesser referred to husbands 'collapsing' simply by being asked to take a sperm test. Lord Feversham asked what form such a 'collapse' might take. Chesser explained:

> His world collapses and he feels totally inadequate. I do not mean he physically collapses. Probably any point I may have will be made more clear when I say I am very reluctant to suggest that a man should have a sperm count unless I can see beforehand that he can take it if it should be negative and also, equally, accept the reaction on the wife.

Chesser presented men as highly vulnerable to any suggestion of reproductive inadequacy, and in need of being sheltered to some extent in order to preserve their masculinity. There was a level of sympathy applied to husbands, while wives endured more of a critique.

Drs Bloom and Moore White, on the other hand, felt that the men they dealt with had moved beyond linking fertility with virility and masculinity. When asked whether men were reluctant to go to a fertility clinic "for fear that his virility will be questioned",

Moore White simply said 'no'.[134] Husbands accompanied their wives to the clinic, and there was an evening session for husbands once per week at the fertility clinic which they did not mind attending. Bloom explained that more public education was still needed to dismantle the linking of fertility and virility:

> For years we have known that even asking a man to have a semen analysis done is something that is a threat to his masculinity, to his manhood. It has taken us years and years and years to get a certain proportion of the population to understand that there is no connection between fertility and virility. That situation still obtains and will obtain for a large number of years. But the people that I do see, the people with whom I carry out the procedure, of course have gone beyond that and they realise the fact that their infertility is analogous to going bald and has nothing at all to do with mental and physical health and vigour.

While doctors often kept information from women, instead confiding confidential information in their husbands, this seemed to be changing in the case of male infertility. In this instance, it was the wife who had become the trusted party with a duty to protect her imperiled and 'vulnerable' husband, because he was not really a 'man'.

As a result of concerns over a crisis of masculinity, the Committee seemed highly interested in whether 'normal intercourse' continued during AID treatment and whether doctors themselves recommended this to couples. Discussion of 'normal intercourse' was used in these interviews as a marker and criteria for 'normal marriage'; it was reassuring that despite medical interference, 'marital relations' continued along without interruption. As Carolyn Herbst-Lewis has pointed out, AID raised concern for men's sexuality, as the procedure was believed to lead to a "'homosexual panic'…which activates their latent homosexuality".[135] Therefore, in the US context, men had to prove that they "had a normal libido and had sex relations two or three times a week".[136]

[134] National Archives, London, HO 342/58, M. Moore White.
[135] Herbst Lewis, *Prescription for Heterosexuality*, 132.
[136] Ibid, 130.

The Earl of Feversham was particularly concerned with the sex lives of couples that were selected for artificial insemination. The Chairman asked Mary Barton whether she encouraged "the husband to have normal intercourse with his wife". To which Barton replied, 'No' but went on to say that it "always goes on all the time…where there is no question of impotence the married life continues as usual. It is very important".[137] The Chairman brought the question up once again later in the interview, pushing for a more precise response. Barton replied:

> I do not know that I need to encourage them, because one does not interfere. They are all normal married couples in the ordinary way. Of course, what I do say is 'What I am going to do is in no way influenced by your continuing your married life as usual', just to set their minds at rest. But I think that is very important.[138]

Although Barton did not specifically encourage sexual relations, some doctors were more direct, particularly as many believed it would improve chances of insemination.

Margaret Jackson was more overt in instructing her patients to continue married relations 'as normal'. She told the Committee:

> …at the beginning of this business I make a speech to the couple…and say: do get this straight in your heads, this business of A.I.D. must not in any way interfere with normal married relationships. You will please have your married relationships as and when you wish. As far as I am concerned it helps to have intercourse before and after the insemination. I consider it unkind to the husband to make him produce a specimen into a pot, when I know it is perfectly useless when he can have normal relations with his wife.[139]

When asked, Jackson said that 100 per cent of her cases over the past eighteen years had been having normal intercourse. If they were not, she would have been wary of taking the case on in the first place because of the "huge psychological turmoils going on".[140] Any suggestion of impotence often disqualified a couple for AID because it was taken to indicate marital and psychological problems. As with Barton and Jackson, the Committee

[137] National Archives, London, HO 342/58, Mary Barton.
[138] Ibid.
[139] National Archives, London, HO 342/58, Margaret Jackson.
[140] National Archives, London, HO 342/58, Margaret Jackson.

asked Mears whether she encouraged "the husband to have normal intercourse with his wife at the time she is receiving insemination from a donor".[141] Eleanor Mears explained that she did not prohibit it, but did not see that it made any difference. She asked that couples had intercourse before their AID appointment for medical reasons, based on the belief that the patient's cervical secretions would be in a better condition, but she did not encourage couples beyond this. Similarly, Margaret Shotton told the committee that some of her patients would have 'normal intercourse' about the same time as AID, so there was always the chance of it being the husband's, but she did "not say anything to them about their sex habits on those occasions".[142] Philip Bloom had a more direct approach and encouraged his patients to have sexual relations for stress reduction during AID treatment:

> If I advise them to have sexual relationships it is because I feel that the psychological state must be right and proper. I feel they should carry on with ordinary normal married life, also a satisfactory sexual relationship does lessen tension… a normal relationship and lessened tension may obviate [some] difficulty [in conceiving][143]

The Committee later used this evidence in arguments about legitimacy: if absolute sterility was almost impossible to diagnose and a couple was having 'normal intercourse', it followed that the husband *could* be the biological father and there was (at the time) no testing to contradict that conclusion. However, the Committee still recommended that an AID child would have an 'illegitimate' status. Paternity testing, based on blood type alone, was highly flawed and it was impossible before the 1970s to accurately confirm a child's biological father. These discussions about 'normal' marital relations are significant because they took place in a context in which masculinity and femininity were

[141] National Archives, London, HO 342/58, Eleanor Mears.
[142] National Archives, London, HO 342/58, Margaret Shotton.
[143] National Archives, London, HO 342/58

in flux. The Committee seemed to be looking for assurances that these marriages continued on 'naturally', despite 'artificial' conception. This open discussion of sex is also suggestive of why many potential Committee members declined the invitation to serve early on.

**Alternatives to biological parenthood**

Alternatives to AID – adoption, fostering and 'sublimation' – were discussed in a number of interviews and were revealing of attitudes toward adoption at this time. Margaret Jackson argued that AID was better for the family unit than adoption – primarily because, in her experience, children of donor insemination were less likely to require the services of a child guidance clinic. It was suggested that this was primarily because the AID child would never know of their 'origin', while an adopted child would likely be told and need to grapple with questions about self-identity.

Frustration and dissatisfaction with the adoption system surfaced during the interviews – but such frustrations were also very classist in nature. Margaret Shotton mentioned in her memoranda that some couples who came to her for AID did so because they had difficulty with adoption, "particularly for parents of high intellectual and social grade".[144] Shotton explained her experience with the current state of adoption:

> …in the Midlands there is very great difficulty in obtaining adopted children and as I am sure you know they grade the children that are going to adoption into various categories and the Grade A are naturally obviously the most difficult to obtain, who will go to the Grade A parents, and very often their application for adoption, which, of course, I always suggest to those people as being the obvious solution, is turned down completely. They cannot even be accepted for a waiting list.[145]

The Chairman stressed the point, saying that there were too many people of the 'Grade A' class who wanted babies also belonging to the 'Grade A' class. It is unclear how this

[144] National Archives, London, HO 342/58, Margaret Shotton.
[145] National Archives, London, HO 342/58

'Grade' was determined. Shotton explained further that she was in close touch with the Public Health Department for the City of Birmingham and virtually every baby coming up for adoption went to someone who had attended her fertility clinic. As fertility treatment became more accessible, and adoption became more difficult, attending a fertility clinic was prioritized before 'alternatives' like adoption. As Shotton said: "The first thing any couple going to try and get an adopted child is asked is have you been to the fertility clinic to see about your chances".[146] There was a classist and eugenic element to this discourse – the implication being that children put up for adoption were less desirable, less intelligent, etc., based on their designated 'Grade'.[147]

The question of fostering children followed on from this line of questioning. Mrs Jay (who was involved in children's advocacy groups in London) and Mr Ross discussed the issues involved with adoption versus fostering. There were many children in the care of local authorities and voluntary organizations, but they could not be adopted because their parents hoped to come back for them when they were able to provide. There were a great number of children in need of homes, but a much smaller number who could be legally adopted.[148] Shotton added that the couples she saw in her clinic did not want to foster a child "because there is no guarantee that it will be theirs permanently".[149]

'Sublimation' – diverting reproductive labour into activities that would be culturally and socially enriching – was raised by the Committee as a viable alternative to AID and adoption. When Margaret Jackson was asked by Justice Stevenson what the

[146] National Archives, London, HO 342/58, Margaret Shotton.
[147] In the US, doctors also made the argument that women could not 'satisfy' her 'instinct' through adoption. Herbst-Lewis, *Prescription for Heterosexuality*, 122.
[148] For fostering in the postwar years, see Jordanna Bailkin,'The Postcolonial Family? West African Children, Private Fostering, and the British State', *The Journal of Modern History*, 81(1), March 2009, pp.87-121.
[149] National Archives, London, HO 342/58.

worst consequence was of a woman remaining childless, she responded: "What is the worst consequence of being childless: waste of a good woman to the nation; waste of a good couple of parents to the nation – very important – a considerable unhappiness to two people".[150] Stevenson followed by suggesting that many people have succeeding in "sublimating" and have become "very useful members of the community". Jackson said that sublimation was the "next best thing". Dr. Fitzgibbon brought the interview back around to fostering – suggesting it as an alternative – but Jackson again said that there were institutional barriers that meant there were many children who could not go to foster parents. Mr Ross and Jackson both again mentioned the shortage of children for adoption and fostering – with a much higher demand among potential parents.

The conversation about 'sublimation' continued with Moore White. The Chairman pointed out that twenty years earlier infertility would have been taken as "an Act of God" and sublimation was expected. Moore White said she believed some women would break down if they were unable to have children, to which the Chairman suggested that it was exactly these women – those showing 'instability' – that were unsuitable for AID. Moore White stressed that the matter was not so black and white, explaining that she had terminated pregnancies for women expressing suicidal desires, but the same woman had come back to her later desiring a child and had not shown any signs of mental illness since. Justice Stevenson pushed further, asking Moore White about the "real purpose of this procedure": "Is it merely to make someone happy who would otherwise be unhappy?"[151] His question was one about individual versus community benefit. Stevenson said it was impossible to know whether the future child would benefit from the

[150] National Archives, London, HO 342/58, Margaret Jackson.
[151] National Archives, London, HO 342/58, M. Moore White.

"transaction" and therefore asked whether fulfilling maternal happiness was reason enough to justify AID. Moore White explained it on the basis of biological instinct – framed by either maternal or career inclinations:

> You might have a daughter, a career daughter and you may have a maternally-minded daughter who wants to be in the home. If you put that maternally-minded one in for a career she might break down because she is not suited. You cannot force an individual to take up a career that is against their basic wants.[152]

Stevenson replied that the last thing he desired was "to create a number of career women", but he implied that the whims of every woman to bear a child should not be granted on that desire alone; there should be a greater social benefit to such a practice. Mrs Whitley followed on the questioning by asking what a maternally-minded woman would do if she was not married, to which Moore White replied: "She takes up medicine and fertility work like I do because I did not marry until I was forty. I sublimated it."[153] The dialogue around sublimation indirectly raised questions about the right to parenthood, and the right to fertility treatment. Moore White framed the desire for children as a biological imperative for some women.

Although most of the committee gave the impression that they were accepting of AID as a reproductive technology that could help create families, Justice Stevenson still seemed to believe that reproduction should be left to 'nature' rather than 'science'. Furthermore, both Moore White and Sandler positioned women as capable of taking up either a career or motherhood, but were physically and mentally unable to manage both. For them, women were *either* career-minded or maternally-minded – and those who wanted both had to choose one or the other. It is likely that other female interviewees

[152] National Archives, London, HO 342/58
[153] National Archives, London, HO 342/58, M. Moore White.

who were both mothers and doctors – like Jackson and Barton – would have disagreed with such positions.

There were also religious restrictions placed on adoption. Mrs Jay pointed out that many children in care (thirty-five to forty per cent) were Catholic and were therefore prevented from being adopted by non-Catholic parents (who comprised roughly ninety-five per cent of the population). Catholic Reverend L.L. McReavy disputed the point saying that a larger proportion of the population (ten per cent rather than five) was Catholic. The Catholic Church witnesses held strongly to the point that Catholic children should not be adopted into a family of another denomination, going so far as to say that Catholic children would be better in an institution than with a non-Catholic family. Although they regretted the "disadvantages of institutionalism" they felt the "priceless gift of the faith" made it well worth any suffering.[154]

**Race, religion, and AID**

The 'whiteness' of the practice of artificial insemination in Britain was, for the most part, not remarked upon. However, questions concerning the religions and 'racial' characteristics of donors raised an unanticipated line of discussion in the Committee proceedings: AID in interracial marriages. Once again, while eugenic thought was not exactly on display, it was not far from the surface of this discourse. The issue emerged, to the surprise of the Chairman, over discussion of religious affiliation. The Committee questioned how a donor was chosen based on the characteristics of the husband and whether it was difficult to find Jewish or Roman Catholic donors. Both Jackson and Boyd said that it was relatively easy to find a Jewish donor for Jewish patients, though they

[154] National Archives, London, HO 342/59

rarely had Catholic patients (unless the patients were prepared to leave the Church). Whether Jewish, Catholic, or Muslim, Margaret Jackson did not believe religion mattered in the selection of a donor. As she said: "When [the child] is born it will not know what its father was: I do not suppose it could care less".[155] Reynold Boyd told the Committee that in choosing a donor he looked for someone without any clearly definable characteristics: "I do not want somebody with a very long head or a very long nose, or anything like that. The mean is all I want".[156] Boyd explained that he never had difficulty finding Jewish donors, but very few Catholics were part of his practice unless they were prepared to leave the church in order to do so, since the Catholic Church was opposed to AID. The Committee asked Boyd more specifically about race and religion: "Presumably you have not had any patients drawn from the minority religions or races – you have not had any black or coloured people?" The question was phrased in the negative, and it is likely the Chairman was not expecting this to be an issue in the interviews, assuming that all AID cases involved white couples. Boyd explained that he had patients from Bombay, India who were Moslem and he was able to meet their request to have a Parsee donor. The Chairman responded with surprise, asking a number of times for clarification around whether the family were 'Indian', 'Moslem', 'Hindoo', or 'Parsee'. Boyd stressed that these patients were a small minority and it would take him one or two years to be able to find an appropriate donor. He would not use a relative, but referred to one case of an African woman – "who came from the depths of Africa" – where he was provided with the name of a friend for AID. The Chairman continued the questioning: "In the case of a person who is coloured or a Moslem, would you make it a priority to get a donor of the

[155] National Archives, London, HO 342/58, Margaret Jackson and Reynold Boyd.
[156] National Archives, London, HO 342/58

same colour and creed?" Boyd responded with absolute certainty: "You must. There is no question of that".[157] Interracial insemination was not even a consideration for Boyd. 'Scientific racism' continued through the 1950s, as did older ideas about 'miscegenation', as a 1951 women's magazine advice column attests: "scientists do not yet know if it is wise for two such very different races as white and black to marry, for sometimes children of mixed marriages seem to inherit the worst characteristics of each race".[158] These attitudes can be seen in the Feversham Committee discussions.

The practicality of finding donors of a religious or ethnic minority was particularly difficult in less diverse populations. For doctors who were in more rural locations, like Margaret Jackson, it was often impossible to find matching donors for patients of a 'racial' or religious minority. Jackson explained that she had a number of requests from couples that had immigrated from India, Pakistan, and Ceylon but she had not been successful in arranging the cases. She said in an area like Exeter it was "really hopeless" to arrange such cases, with the presumed understanding that Cornwall was not a multi-cultural area or a draw for immigrants, as was London. In such cases, Jackson would refer these patients on to another specialist. Although Jackson did not view religion as an important consideration in AID, she recognized the importance of selecting a donor who was racially similar to the mother:

> Colour now raises a very difficult question. So far I have stuck as firmly as I possibly can. I have not attempted, nor would I feel inclined to attempt, mixing the races. We do not know where we are with that. I would not feel inclined to take a hand in it.

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[157] National Archives, London, HO 342/58, Reynold Boyd.

[158] This quote is taken from a 1951 edition of *Women's Friend and Glamour*. 'Liz' wrote for advice because she was in love with a "coloured man – but her parents were against the relationship. She wanted to know if her parents could prevent them from marrying. The magazine said her parents couldn't prevent the marriage, but she should "think things over very carefully. Many coloured men are fine people, but they do come from a different race, with a very different background and upbringing".
Elizabeth Buettner, 'Would you Let Your Daughter Marry a Negro?': Race and Sex in 1950s Britain', pp.219-235, *Gender, Labour, War and Empire: Essays on Modern Britain*, Edited by Philippa Levine and Susan R. Grayzel, (London: Palgrave Macmillan, 2009), 229.

It is not clear whether this was based on Jackson's personal belief, or whether she was resolved to follow social convention on the matter. It is perhaps reasonable to assume that she would have been conflicted, as such concerns were under debate in the *Eugenics Review* (for which she was a contributor) at this time. Between 1958 and 1960 there was concern expressed in the *Eugenics Review* over 'miscegenation', and the 'genetic quality' of West Indians, West Africans, and other immigrants to Britain.[159]

Following the evidence given by Boyd and Jackson, the Chairman approached Mary Barton with a statement on cases involving ethnic and religious minorities:

> It has been submitted to us that there are one or two specialists who have had coloured and Indian [patients]…Patients who have come to them, and they have tried to get a donor of the same colour and persuasion.[160]

Barton told the Committee that she too had similar cases occasionally. The Chairman followed by asking Barton if she made it a rule that the donor should be a) of the same colour and b) of the same race. Barton agreed, without question, but said sometimes it could not be arranged – and when it was possible it could take months to find a suitable person. The Committee seemed accepting of AID where the husband, wife and donor shared the same 'racial' characteristics, but among both doctors and committee members there was a level of discomfort and uncertainty about interracial marriage and biracial children. As documented in *To Sir, With Love*, even British-born biracial children were still often treated as not 'belonging'.[161] And as Elizabeth Buettner has stressed, "[m]ixed-

[159] For example, see 'West Indian Immigration', *Eugenics Review*, 50(4), January 1959.
[160] National Archives, London, HO 342/58
[161] See Buettner, 'Would you Let Your Daughter', and E.R. Braithwaite, *To Sir With Love* (original 1959), (New York: Penguin Books, 1977).

race children faced the prospect of being considered, in short, as 'not belonging', indeed 'belonging nowhere'".[162]

There was a strong social stigma attached to interracial marriage in Britain. The assumption of the Committee was that all AID couples were white and British-born, but a growing number of immigrants entering Britain from Commonwealth countries in Asia, Africa, and the West Indies were visibly changing the social composition of cities like London. 1958 was a flashpoint for racial tensions in Britain with riots in both Notting Hill and Nottingham, both of which produced a particular focus on relations between white women and black men.[163] For this reason, interracial marriages may have posed a particular social threat at this moment. As Wendy Webster argues, "anxiety about white masculinity" was embedded in the discourse of race with the threat of black male sexuality becoming the focus.[164] Thus, during the time in which the Committee was sitting, mixed-race relationships became the focus of increasing social scrutiny and attention. A Gallup poll in September 1958 (following the Nottingham and Notting Hill riots) asked respondents whether they approved "of marriage between white and coloured people": seventy-one per cent said they disapproved, sixteen per cent said they did not know, and only thirteen per cent approved.[165] Among young respondents (sixteen to twenty years old), who were asked the same question, there was greater acceptance, but also greater uncertainty: fifty-five per cent disapproved, twenty-six per cent did not

[162] Buettner, 'Would You Let', 229.
[163] Buettner, 'Would You Let', 231.
[164] Wendy Webster, *Imagining Home: gender, 'race' and national identity, 1945-64*, (London: UCL Press, 1998), xii.
[165] Gallup, *The Gallup International Public Opinion Polls*, September 1958.

know, and nineteen per cent approved. However, more than half of the total respondents (fifty-one per cent) had never personally known a person of colour.[166]

The social stigma of mixed race families in 1950s Britain deterred doctors from accepting such cases for AID, regardless of whether it aligned with their personal beliefs. Confronted with the request to help conceive a biracial child, doctors struggled to make the 'right' decision. Bernard Sandler provided the Committee with a case history addressing the issue of interracial marriages. Initially, Sandler had only seen the wife, and when he met the husband he "got a shock": "I found he was a negro and I was being asked to do A.I.D. for a mixed marriage".[167] Sandler explained that he considered the case "for a great deal of time" but ultimately decided against accepting the couple as patients:

> …it was too great a responsibility…to bring a child of mixed parentage into the world. Perhaps I was cowardly but I said there are very many mixed children wanting adoption and I think you ought to adopt one…I possibly denied the woman maternity for which she was longing but I did not feel that in a situation where A.I.D. at the moment is so unsettled I had any justification in introducing the problems of colour and mixed racial characteristics in this way.[168]

Although Sandler seemed somewhat regretful in his decision not to pursue this case – based strictly on race – his decision, like Jackson's, was rooted in socially accepted racism and demonstrated a reluctance to push against a tide that was intolerant of interracial families. Without apology, Philip Bloom was more abrupt explaining that 'mixed marriages' were an obvious reason to decline a case. He referred to interracial couples – "black and white, coloured and white" – as "not the right type of people" for AID. Once again, there was a particular type of couple deemed to be socially and culturally suitable parents.

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[166] Ibid; Buettner, 'Would you Let Your Daughter', 224.
[167] National Archives, London, HO 342/58
[168] National Archives, London, HO 342/58

However, these discussions suggested that it was considered acceptable – or at least less controversial – for Asian or African immigrants to conceive via AID, using a donor of the same race, but mixed-race parentage remained taboo. The medical practitioners who weighed in likely considered the welfare of the child, and felt they were doing more harm than good by shouldering a child with the weight of a racially prejudiced society. On the other hand, some doctors would have exercised their own discriminatory attitudes. However, which witnesses fell into which category is difficult to discern. Although the evidence of medical witnesses shaped the content of the Report, interviews with religious leaders offered support and confirmation of the Committee's final recommendations.

## The Importance of Religious Opinion

The evidence provided by religious groups and leaders played an important role in the ultimate recommendations of the Feversham Committee. Five denominations, represented by sixteen witnesses, were interviewed between June and December 1959 (in order of appearance): the Church of England, the Catholic Church, Jewish leaders, the Methodist Church, the Church of Scotland, and the Archbishop of Canterbury.[169] The Feversham Committee took place at a moment when religion was increasingly challenged by a series of contemporary issues, such as campaigns for the decriminalization of homosexuality and abortion. Donor insemination was one of these issues that challenged

[169] The Religious witnesses included the following:
*Church of England*: The Worshipful Chancellor E. Garth Moore, R.W. Roques, Esq., John Wren-Lewis, Esq., The Reverend G.R. Dunstan, The Archbishop of Canterbury
*Catholic Body in England and Wales*: Reverend L.L. McReavy, John Marshall, Esq., Rev M. O'Leary
*Judaism*: Dr. Israel Brodie (Chief Rabbi), Dayan M. Swift
*Methodist Church, Department of Christian Citizenship:* Revs Edward Rogers, Kenneth Greet[169], Leonard Brown
*Church of Scotland*: Rev. Neville Davidson, Rev. R.L. Small, Rev. Professor W.S. Tindal

notions of morality. There was an obvious tension between contemporary concerns and the traditional moral code espoused by religious bodies. The position of religious bodies can be seen as an example of the broader movement of change within the Churches.

There is broad agreement among historians of religion that the period between the mid-1950s and the mid-1970s marked a significant change in religious practice and adherence in Britain, though precisely when and why this happened is under debate.[170] Throughout this period, there was a decline in religious adherence: in the number of people attending church, in couples marrying in churches, in the number of children baptized, and in the numbers of clergy.[171] There are two main schools of thought on the religious crisis of the 1960s: one that sees the change as swift and palpable, and another in which the change is gradual.[172]

The Feversham Committee evidence supports the view that the late 1950s and early 1960s was "a period of cautious questioning", of "tentative new beginnings" and "ferment", acting as a "bridge" between the post-war years and the late 1960s.[173] There is an air of caution and tentativeness that reaches through the pages of these interviews. The Feversham evidence can be seen as reflective of a growing agitation that preceded the religious crisis of the late 1960s. Although the witnesses representing religious bodies were not as influential in shaping the contents Report as the medical doctors, who had themselves practiced AID, the religious leaders (specifically those affiliated with the Church of England) did lend support to the Committee's desired recommendations. Despite the fence-sitting nature of their ultimate conclusions (to maintain the status quo),

[170] Hugh McLeod, *The Religious Crisis of the 1960s*, (Oxford: Oxford University Press, 2007), 257.
[171] McLeod, *The Religious Crisis*, 1.
[172] The two historians at the centre of this debate are Callum Brown, who has argued that 1963 was a turning point in religious decline, and Hugh McLeod, who suggests that it was a longer and more gradual process that began in the 1950s with more significant decline obvious only in the late-1960s.
[173] McLeod, 60, 82, 258.

having the approval from the Anglican Church and the Archbishop of Canterbury, in particular, provided enough religious credibility to push ahead. What would the Committee have recommended if *all* religious denominations insisted that AID be made a criminal offence? Would the Committee have held firmly to their position, or would they have been compelled to recommend legislation to restrict the use of AID? How important, at this juncture, was the support of the Church? By examining the central issues of these interviews with Church leaders – the question of 'liberties' and the relationship between Church, State, and science – this section suggests that religious support was essential to the Feversham Committee's recommendations.[174]

The majority of British citizens identified as Christian, and the majority of those individuals were associated with the Church of England. It was therefore Anglican opinion that the Committee was most concerned with. The Feversham evidence represents a gradual shift that had been taking place at a leadership level in the Churches, particularly the Anglican Church, and this gradual change in position may not have yet been reflected in church memberships. Each denomination was vocal in their opposition to the practice of AID on moral and theological grounds. However, the way in which this belief was applied to the law varied. The Committee representing the Methodist Church confirmed that it was opposed to AID because "it invades the exclusive union between man and wife".[175] They likened AID to adultery: "although A.I.D does not constitute adultery it is in essence adulterous because … the seed which leads to conception is

[174] 'Liberties' ("something which is outside the ordinary class of permitted conduct, which has no legal consequences but which the law in no way recognises and does nothing whatever to encourage"). The Church of Scotland refused to accept AID as a 'liberty'. The Catholic Church insisted AID receive "no positive approval by the law".
National Archives, London, HO 342/59
[175] National Archives, London, HO 342/59

adulterated".[176] The Church of England took the Archbishop's 1948 Report as the basis of their discussions. Officially, the Church of England did not support AID and was concerned with the potential long-term effects of the practice on the stability of the mother and of the marriage, though they did *not* strongly recommend it be made a criminal offence, unlike the Methodist Church. The Chairman suggested that flexibility is needed for modern times: "it was never envisaged that there would be a possibility of such a procedure as A.I.D." The Worshipful Chancellor E. Garth Moore explained the difficult position in which the Church found itself:

> Our problem today is to see how a new set of circumstances fits into our understandings, and I would certainly agree that new circumstances may enlarge our understanding and may cause modification of our statements…[177]

Throughout the interview, the Anglican leaders were sending rather mixed messages to the Committee. While they opposed AID, they did not insist that it be made a criminal offence, and further agreed that it could be classified as a "liberty".

Perhaps most interestingly, the Archbishop of Canterbury's stance on AID began to turn. His condemnation of the practice in 1948 had softened substantially by 1959. The Feversham Committee met with the Archbishop of Canterbury at the very end of their interviews in December 1959, when they felt to be in a position to discuss with him their recommendations and, essentially, look for his endorsement. At the beginning of the interview, the Chairman opened the floor for the Archbishop to clarify his position, which was understood to be a strong recommendation that AID be made a criminal offence. However, the Chairman pointed out, the Archbishop of Canterbury's position was not aligned with his Anglican colleagues on the Bishop of Exeter's Committee, who regarded

[176] National Archives, London, HO 342/59
[177] National Archives, London, HO 342/59

AID "as a matter that should neither be lawful nor unlawful but tolerated on the same basis as adultery and fornication". The Archbishop followed by saying that it was "a new and very interesting point that [he] had not thought out".[178] He made the point that "ordinary churchmen" were instinctively opposed to AID, whereas the organizations who "give their minds to it always come to a clear judgment".[179] He seemed to be saying that the opinion of the Church was ahead of public opinion, which was overwhelmingly in opposition. The Archbishop said that the more liberal views on the subject were not shared by the church membership – they were held by the leaders, leaving a separation between the members and the leadership.

The objection on moral grounds was virtually the same across the board. Dr. Israel Brodie (Chief Rabbi), and Dayan M. Swift encouraged legislating against AID, based primarily on a theological and moral objection, though in terms of the reality of making it a criminal offence they had little suggestion of how it would play out in practice. The Jewish witnesses had recommended in their memorandum to put an end to the practice of AID (partly based on legal complications). The Church of Scotland opposed AID and advocated for legislation to prohibit the practice and make it a new grounds for divorce. The Catholic Church did not tolerate AIH or AID. They suggested than AID would lead to an increase in adultery, though the Chairman doubted this prospect saying that, "many modern influences are at work tending to break up the marriage vows; but I think there is some doubt as to whether A.I.D. is one of them".[180]

There was a moral and theological objection, but how this should translate into legislation was less clear. While all parties opposed AID on the basis that it contradicted

[178] National Archives, London, HO 342/59
[179] National Archives, London, HO 342/59
[180] National Archives, London, HO 342/59

the rights of husband and wife to mutual exclusive use of reproductive and procreative act, the Church of England and the Archbishop of Canterbury were the only witnesses to accept that religious opposition did not need to translate into prohibitive legislation. The question of whether AID could be classified as a 'liberty' – along with adultery and homosexuality – was a central issue in a number of the interviews. Throughout the Feversham Committee's interviews, but particularly on this point, the influence and legacy of the Wolfenden Report was obvious. Religious support was critical to the final recommendations of the Feversham Committee, as well as to the key legislative changes of the 1960s. The Church of England, in particular, played a significant role in the key legislative changes of the decade (including the decriminalization of male homosexuality, divorce law reform, and the abortion act) in supporting the reforms.[181] However, the Anglican position was not firmly liberal or conservative, but rather was issue dependent. Hugh McLeod has argued that there was an emergence of a 'pragmatic Christian stance', part of which was an acceptance that morality was separate from law and should not necessarily dictate legal outcomes.[182] For instance, although both Sir John Wolfenden and the Archbishop of Canterbury both disapproved of homosexuality, they agreed that there was no reason that it should be prohibited by law.[183] Furthermore, McLeod points out, Anglican leaders began investing greater respect in professional experts (for instance, in medicine and the humanities).[184] Thus, in the 1950s and 1960s the Church of England became 'an active agent of change'.

[181] McLeod, 223-6.
[182] McLeod, 232.
[183] Ibid.
[184] Ibid.

Discussion with the Anglican witnesses on the status of the AID child turned to a critique of the legal parameters of legitimacy. Garth Moore and Reverend G.R. Dunstan argued that 'legitimacy' was problematic and unfairly assigned to children for an action taken by their parents; and furthermore, that AID and adoption should be on the same level legally. Garth Moore said that he would prefer the AID child "to be treated in the same way as an adopted child is treated" though he added the caveat: "But that is a snap answer and only my own". Mr Dunstan concurred with Moore on the "analogy of adoption" and further said: "I think we have reached a point in time where the words 'legitimate' and 'illegitimate' are ceasing to have an ascertainable meaning, and I should regret the further complication of the law – and social complications – in those terms".[185] Dunstan further explained his issue with the terms: "[Legitimacy] is a moral judgment properly attaching to the action of the parents which is imposed arbitrarily on the child, and that is precisely why I hope it will be possible to keep this new possibility, the A.I.D. child, out of those terms".[186] He argued that the label negatively branded the child based on the actions of his/her parents. Dunstan continued: "my own feeling is if A.I.D. is to be practised, [adoption] is perhaps the analogy on which it would be socially most desirable to build legislation rather than on the history of legitimacy laws which goes back a long way".[187] Mrs Jay pushed him to further clarify his point, to which Dunstan explained that he believed illegitimacy remained "a grave disability in the psychological sense" but much less so in the social sense. Mrs Jay disagreed, arguing that illegitimacy continued to have a social stigma – for instance, in wanting a child to attend a certain school such a status would be a significant burden. This issue was not entirely resolved, but it suggests

[185] National Archives, London, HO 342/59.
[186] National Archives, London, HO 342/59.
[187] National Archives, London, HO 342/59 Church of England

that a shift was taking place and that some of the leaders of the Church were open to various family formations. The discussion over legitimacy suggested that Church leaders were searching for other ways in which to shape the law so that the practice of AID could continue.

The Archbishop of Canterbury ultimately supported the Committee's 'do nothing' approach. During their interview with the Archbishop, the Committee members described the desired position for AID – as a 'liberty':

> …between the criminal code of offences which must be publicly condemned and punished for the good of society on the one hand, and the private code by which the individual with moral standards governs his own conduct on the other, the ordinary man acknowledges that there is an intermediate group of recognised offences which, although they are public in that they concern more than a single person and disturb the harmony of society, are still not of a nature or quality which demands punishment by the criminal law.[188]

The Archbishop argued that to describe an 'unlawful' thing in a statute only to say that it can "be done without impediment is an ineffective way of the State" to deal with the situation.[189] By this point, the Committee had decided against implementing any regulatory procedures because it would be tacit approval. The Archbishop argued that AID should not be deemed a 'liberty' like adultery or fornication because first, it would involve setting up controls, and second, it went beyond "a personal undertaking between two persons" by involving a child.[190] The Chairman pushed the Archbishop further, by pointing out the possible middle ground (neither prohibiting nor giving approval) "by virtually maintaining the status quo and allowing moral judgment and the influence of denominations and private opinion to assert itself under the banner of liberty and freedom". The Archbishop replied: "It is a queer position for a State to take but it is a

[188] National Archives, London, HO 342/59
[189] Ibid.
[190] Ibid.

possible one – to say let this work itself out…I do not think it is a very high moral line to take".[191] But once he had made that point, the Committee took his reluctant acceptance of the status quo as a 'feasible solution' by noting as much in the margins of the interview transcript. The Archbishop essentially said that the 'status quo' was acceptable, though not moral, and expressed concern over the logistics of making AID a 'liberty'. Yet, ultimately, the Archbishop reluctantly approved "doing nothing" because the Church could still oppose the practice:

> …leaving it as it is, if you and the Government had the courage to say we have been through this purgation of a year and come to the conclusion the best thing is to do nothing – if you have the courage to say that I should rather welcome it because it still leaves us free to say it is a bad practice.[192]

**A battle between religion and science?**

Not surprisingly, the role of science and its relationship to the Church and the State surfaced in these discussions. In many instances, Feversham nudged the witnesses by suggesting that Christianity (and Judaism) should adapt to a new scientific age. For instance, the Chairman asked the Methodist leaders whether they would agree that the Christian faith should be flexible, pointing out that "the liberal view of representatives of several denominations would all show that the interpretation of the Christian ethic has to conform to the scientific age or the development of science in any age".[193] The Chairman essentially asked the witnesses if Christianity should adapt to modernizing forces and whether it was fair to impose a Christian ethic on the country as a whole. The Methodist witnesses responded that they would need "a great deal of notice of that question in that form" and they would likely "answer it in the end by a long string of conditional

[191] Ibid.
[192] National Archives, London, HO 342/59
[193] Ibid.

clauses".[194] The Archbishop reflected on the changing roles of Church and State in terms of moral guidance for the public:

> As things have developed the power of the Church … to be a policeman has disappeared, and the Church can have its views as it likes and they attract some and not others and they fight for their own life, but that leaves a complete vacuum in the community and … the vacant chair might very well be taken by science … the State has to [be]come … the moral tutor of its people, not necessarily doing what they want done which is accepting public opinion, but controlling … as far as they can the direction of how things go.[195]

The Archbishop expressed some seemingly contradictory opinions concerning AID as it compared to other 'morally questionable' issues (adultery and sex determination, for instance). At one point during interview, he made the AID child sound like a consumer product: "this is not a universal practice, it is not even a common sin; it is a mechanical device to give me something that I want when life is full of wanting things you cannot have".[196] When asked about sex determination, the Archbishop did not seem to have a problem with the hypothetical practice or a couple's desire for a certain sex of baby, saying it was simply "a specialised form" of AIH. Professor Tunbridge pushed, suggesting that sex determination could "have serious repercussions on the structure of society".[197] The Archbishop responded that:

> Society like all the rest of us has got to take some things as they find them. That is to say if all the population went redheaded they would have to take that, and if in their own private avocations people choose to have more sons they have every right to, unless of course the State found that in fact they were having far more sons than there were girls and there was no-one to marry; but then I do not think the State would be right to legislate.[198]

The Archbishop's opinion on the matter of sex determination seemed inconsistent with his argument about AID - that it is tinkering with natural biological outcomes and creating an unknown future scenario. While the opinions of the Churches remained

[194] Ibid.
[195] National Archives, London, HO 342/59
[196] Ibid.
[197] Ibid.
[198] National Archives, London, HO 342/59

important as a matter or protocol, in practice the most conservative views were ignored in favour of a more permissive and secular approach to the subject that, when pressed, was supported by the Archbishop of Canterbury and Church of England.

**Anticipating the Future**

Central to the Feversham inquiry was the question of legislation and regulation. Although the medical practitioners had been called on by the Feversham Committee to report case histories and protocol, they also weighed in on the question of legislation. Medical witnesses made projections for the future and discouraged any legislation that would fix AID within 1950s attitudes to family life. They saw the concept of the family evolving, and with it, growing social acceptance of AID. A number of the doctors anticipated a more liberal future society where the structure of the family might change including, for instance, the de-stigmatization of common law spouses, and unmarried women having children. With the suggestion that the social stigma surrounding AID would disappear with time, these doctors cautioned against legislating on the subject. For instance, T.N.A. Jeffcoate said:

> Although it is our present view that A.I.D. is not in the interest of either the individual or the community…it would appear to us that any attempt to legislate for a few hard cases would be likely to result in bad law…I think one has to recognise too that ethics and social customs might change and the impact then on the patient would be a little different because the impact at the present is conditioned by family life and so on.[199]

Although Jeffcoate had not practiced AID himself since 1954, and had only ever had three cases, he was opposed to inflexible legislation being laid down to fix the practice in a 1950s mindset. His views about the possible changes in the future was prescient:

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[199] Jeffcoate was professor of obstetrics and gynaecology at the University Liverpool and president of the RCOG
Lynda Bryder, *The Rise and Fall of National Women's Hospital*, (Auckland: Auckland University Press, 2014), 49.

> …the structure of society at the moment I suppose is based on the family and the sanctity of marriage, and everything revolves round the family unit. If in the future that were altered, it would be the recognised thing that women had children without getting married and so on, and then of course I think the reactions on the individual and indeed on the child would be quite different.[200]

Like Jeffcoate, Boyd anticipated future acceptance of the practice:

> I believe that with time the climate of opinion will so change that even the admission of A.I.D. origin will no longer stigmatise the child any more than being adopted does now. It is intolerance and destructive criticism that are making a private matter secret.[201]

Similarly, Barton expected that the stigma would disappear by the late 1970s:

> If this work proceeds, I do not see why it should carry any stigma in, say, 15 or 20 years time. It might be possible that it will be accepted as a right and proper solution to certain problems, and that couples will have no hesitation in saying what is the truth, without feeling that it would cause dire distress.[202]

Bernard Sandler recognized the general growing permissiveness in legislation (like the Mental Health Act of 1959) and saw the applications to AID:

> In the recent proposed Mental Health Bill, family is now taken to include spouse, an unmarried spouse with whom the patient has been living or known the individual; where slowly, as I see it, by legislation … they are increasing the width of what the family of a man is and I should not think it would be too great a step for the legal implications to include A.I.D.[203]

These attitudes were liberal, but were by no means radical. The Committee's recommendations and the Government's inaction meant that no legislative changes were made and the practice continued as it had done since the 1940s.

**Conclusion**

On the matter of artificial insemination, the Feversham Committee concluded that it was not the function of the State "to impose a uniform morality by means of the criminal law", and furthermore the practice was "not in any particular case offensive to

[200] National Archives, London, HO 342/58
[201] National Archives, London, HO 342/58
[202] National Archives, London, HO 342/58
[203] National Archives, London, HO 342/58

public order or decency".[204] The report and its recommendations caused very little stir – as shown by the fact that legislation around AID was not established until thirty years later, in 1990 with the Human Fertilisation and Embryology Act. But the lack of public attention is also notable, as it suggests a relative acceptance of the status quo in the practice of donor insemination. In this way, the Committee and its report marks the final chapter of a seventeen-year public debate over the subject of artificial insemination.

In a legislative sense, the Feversham Committee was not groundbreaking. The recommendations of the Committee were laid out in a way to maintain the status quo, gently discouraging the practice of AID, while at the same time supporting the ethical and philosophical position of the Wolfenden Committee. But unlike its more famous precursor, the Feversham Report provoked little media coverage, and the government did not prioritize legislation on artificial insemination or the implications it presented for the family. Feversham has not received much attention historically, but with the oral evidence records now open there is a wealth of material that sheds light on the unpublished interests and opinions of the Committee and its witnesses.

Issues of accessibility and marital power dynamics were central to the committee's interviews with medical doctors who had practiced donor insemination. While AID was largely reserved for the middle and upper classes, who could afford the associated fees, the qualities of being 'respectable' and 'responsible' were often prioritized over income level. So even as real wages were rising for the working classes, it was possible that a couple which was not in a 'respectable' occupation was likely to be ruled unsuitable for parenting. Furthermore, these criteria and categories were not

[204] *Report of the Departmental Committee on Human Artificial Insemination*, 71.

defined. Class-bias remained a key factor in accepting patients for treatment and informed the recommendations of the Committee.

Constructions of femininity and masculinity also contributed to the selection criteria for AID. The underlying concern over marital dynamics was based on the perception that the wife was often 'obsessional', 'neurotic', and unstable, while at the same time being domineering and coercive. The husband, on the other hand, was characterized as psychologically vulnerable to the truth about his medical condition. Some doctors went as far as to instruct the wife to keep his sterility a secret in order to preserve his 'masculinity' and 'manhood'.[205] The Committee seemed unwilling to accept that it was more often than not the husbands who sought out AID as a treatment for unresolved infertility. It is perhaps not surprising that issues of limited accessibility, and marital dynamics – so prominent in the Committee proceedings – had no place in the official report, which adhered to the formal style of reporting that was typical of such documents.

When the Committee's report was published in 1960, there was little in the way of media attention. After two years of conducting interviews and gathering evidence, the Committee ostensibly recommended that nothing be done to change the current state of the practice. The rush of coverage and conversation on AID in 1958 had completely dried up by 1960 – perhaps replaced by more pressing reproductive health concerns, like the thalidomide crisis (1958-61), and the trials and release of the first birth control pill (1960-1961).

[205] Most doctors declined comment on legal issues attached to the practice, for example, inheritance, or the potential of a central registry.

The same discussions about the relationships between medicine and the family continued – but through a different lens. The thalidomide crisis refocused the disproportionate attention placed on AID in the preceding years into a very clear threat – pharmaceuticals causing birth defects – that had, by the early 1960s, affected thousands of children. In a different way, the emergence of the Pill overtook concern for AID. The threat of female promiscuity, sexual liberation, and what that meant for the state of the family, now seemed far more grave than an unknown sperm donor – or 'phantom father'. It was not until the late 1960s and early 1970s, when scientific advances were being made towards IVF, that AID re-entered mainstream discourse in a much different social context. It is to this period that the conclusion will briefly cast ahead.

# *Conclusion*

## *A 'New' Brave New World*

In April 1970, an article entitled 'Test tube babies' appeared in *The Observer*. The science journalist, Gerald Leach, reflected on the moment in which he was writing, when society was on the cusp of potentially huge changes in human reproduction: surrogacy, IVF, cloning, sex determination, and embryo freezing.[1] He raised numerous concerns over the ethics and consequences of these practices, before they were a reality. Yet within this cautionary projection of what science would do to society in the future, he paused for a moment to take readers back and remind them of how quickly attitudes can change. "Twenty years ago there was much fearful talk about the way AID threatened almost every tradition of family life", Leach wrote. He recalled the Archbishop of Canterbury's commission in 1948 that denounced AID as "a breach of the marriage", and the Feversham Report in 1960 that opposed AID for its infringement of inheritance and property titles.[2] The article reminded readers of how attitudes had "softened remarkably" in recent years: "What has really occurred has been a profound change in our view of what is most important in parenthood: genes or love".[3] This moment in 1970 opened a window to look to the past and to reflect on contemporary concerns – to see the continuities as well as the changes.

This concluding chapter first provides a narrative of changes in reproductive technologies between the Feversham Report and the Human Fertilisation and

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[1] Pearce Wright, 'Gerald Leach obituary', *The Guardian*, https://www.theguardian.com/science/2005/jan/21/obituaries.pressandpublishing
[2] Gerald Leach, 'Test Tube Babies', *The Observer*, 5 April 1970
[3] Gerald Leach, 'Test Tube Babies', *The Observer*, 5 April 1970.

Embryology Act (HFEA) of 1990, encompassing the technological breakthrough represented by the birth of Louise Brown in 1978 and the Warnock Report of 1984. It then reflects on the key arguments of this dissertation, and raises questions for future research.

## I. Reproductive technologies between 1960 and 1990

As the years between 1943 and 1960 framed one debate over 'test tube babies', the period from 1968 to 1990 framed another. From the late 1960s, there was a growing anticipation around both the possibilities and risks of assisted reproductive technologies. In 1968 and 1969, 'deep freeze' babies were being born; fertility drugs led to the birth of 'sextuplets' and 'quads'; the Minister of Health called for artificial insemination to be made available on the NHS; and early successes made in Cambridge with *in vitro* fertilization were announced.[4] These developments were happening in the context of significant legal and social reforms, including the Abortion Act of 1967, the NHS (Family Planning) Act of 1967, and the Divorce Reform Act of 1969.[5] By the late-1970s and 1980s, the ethics of reproductive technologies came under increasing scrutiny with attention to *in vitro* fertilization, embryo research, surrogacy, and same-sex parenthood via AID. Yet it was not until 1990, with the Human Fertilisation and Embryology Act (HFEA), that legislation was enacted on issues that had engaged both the public and professionals since the Second World War.

There was a significant shift in the way in which reproductive technologies were articulated by the 1970s and 1980s: they became framed by the language of individual

[4] 'Deep-freeze babies', *Guardian*, 18 May 1964; 'Confined in the deep freeze', *The Guardian*, 20 June 1969, 2.
[5] NHS (Family Planning) Act gave local authorities the power to provide family planning advice to all women regardless of marital status.
Pfeffer, *The Stork and the Syringe*, 153.

human rights. As Stephen Brooke has argued, "in the late-twentieth century a different form of sexual politics developed, which had, at its heart, not class, the family, or marriage, but the individual".[6] Advancements in science and medicine set the 1970s and 1980s apart from earlier decades, but they were also marked by a deeper cultural shift as "categories of class and family" gave way to "individual rights".[7] This change offers an important framework to understand the discourse of reproductive technologies in the late-twentieth century. While this concluding chapter offers only a cursory examination of these developments, it is an important avenue for further research.

After the Feversham Report was published in 1960, the excitement that existed following the MacLennan case in 1958 had all but vanished. In the early-1960s artificial insemination was eclipsed by more pressing issues of reproductive politics: clinical trials for the oral contraceptive pill, and the thalidomide crisis.[8] Although both of these events were based on pharmaceutical developments, rather than medical procedures, they dealt with similar questions of medical innovation and regulation. Furthermore, issues related to disability and artificiality ran through these discourses – not unlike infertility and artificial insemination. Thalidomide, or 'Distaval' as it was marketed in the UK, was a mild sedative and a 'safe' remedy to ease morning sickness in pregnant women. In 1958, thalidomide was made available across Europe. However, by late 1961, studies had shown that the drug was causing limb malformations in the babies of women who had taken the drug while pregnant.[9] In Britain, 'Distaval' was removed from the market in

[6] Brooke, *Sexual Politics*, 10.
[7] Ibid, 11.
[8] On thalidomide eclipsing contraceptive trials, see Lara Marks and Suzanne White Junod, 'Women's Trials: The Approval of the First Oral Contraceptive Pill in the United States and Great Britain', *Journal of the History of Medicine and Allied Sciences,* 57(2), April 2002, pp.117-160.
[9] Although thalidomide most often effected the extremities, it also impacted other organs: gastrointestinal, gastrourinary tract, ears, and eyes.

December 1961, while in Canada it remained available until May 1962.[10] The drug was promoted as exceedingly safe: even a toddler could consume a large amount of the drug and not be negatively affected [see Figure 5.1]. A full page ad in the *British Medical Journal* in March 1961, featured a toddler getting into the medicine cabinet as the copy emphasized the safety of the drug: "this child's life may depend on the safety of 'Distaval'".[11] This ad reassured prescribers and consumers that this "outstandingly safe" sedative had been prescribed in Britain for three years, and there had been "no case on record in which even gross overdosage…has had harmful results".[12] There is an obvious and painful irony in this advertising campaign, only nine months before it was taken off the market for its debilitating consequences to babies exposed *in utero*. By 1962, thalidomide had been withdrawn from all markets. All told, more than 10,000 babies in 46 countries had been affected by the drug (many of whom died shortly after birth).[13] The thalidomide crisis led to new regulatory practices for pharmaceuticals. As the *BMJ* wrote, just a year after it had included an advertisement for the sedative: "The thalidomide story shows yet again that apparently simple treatments can belie their early reputation for harmlessness".[14]

The thalidomide tragedy coincided with the release of the oral contraceptive pill. Research on what became known simply as 'the Pill' had started in the mid-1950s, but it was not until 1961 that the Pill became available in a limited way to women in Britain,

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'Thalidomide ('Distaval') and Foetal Abnormalities', *British Medical Journal*, 17 February 1962.
[10] D.J. Hayman (Managing Director of The Distillers Company), 'Withdrawal of Thalidomide ('Distaval'), *British Medical Journal*, 2 December 1961; Andre Picard, 'For Canadian thalidomide victims, compensation is fair but long overdue', *The Globe and Mail*, 25 May 2015.
[11] 'Distaval', *British Medical Journal*, 25 March 1961.
[12] 'Distaval', *British Medical Journal*, 25 March 1961.
[13] For individual experiences, see 'The Tin Lids: the thalidomide story', UK, BBC1, 1991; 'Thalidomide: A Second Chance?', BBC2, *Horizon*, 12 February 2004.
[14] 'Thalidomide (Distaval) in Medicine Cupboards', *British Medical Journal*, 26 May 1962.

and it took more than a decade for it to be made available to all women in 1974. The FPA played an important role in the clinical trials, with studies run by both Dr. Margaret Jackson in Exeter and Dr. Helena Wright in London.[15] Throughout the summer of 1959, the press advertised for volunteers for these clinical trials, calling for "100 Wives" who wanted babies.[16] Despite concerns over the Pill, the thalidomide scandal overshadowed these fears.[17] In the same issue of the *BMJ* in which it was announced that thalidomide was being taken off the market, Dr. Eleanor Mears defended the contraceptive pill:

> When one remembers that oral contraceptive trials in various parts of the world have been going on for over six years, with no evidence of harmfulness emerging, it does seem that…gloomy forebodings are a little out of touch with reality.[18]

However, concern over the potential unknown effects of the pill continued. In 1962, Lord Kilbracken submitted a letter published in *The Guardian* that placed the contraceptive pill in the context of the thalidomide crisis:

> The recent revelations of the disastrous effects of Thalidomide added great force to the arguments of those of us who believe that many new drugs are marketed without adequate clinical trials…In the light of these facts, it seems almost unbelievable that a new drug should be made available about which such fears are felt, especially when efficient alternative methods of contraception are readily available.[19]

Despite these uncertainties, by 1980 approximately three million women in Britain were taking the Pill as a contraceptive solution.[20]

It is therefore unsurprising that there was a great deal of public suspicion and trepidation about pharmaceuticals in the early 1960s, as the thalidomide crisis had

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[15] Eleanor Mears, 'Clinical trials of oral contraceptives', *British Medical Journal*, 4 November 1961.
[16] 'Wanted: 100 women who want babies', *Daily Sketch*, 8 August 1959; 'Birth Control Volunteers Wanted', *News Chronicle*, 7 August 1959; '100 Wives Are Wanted', *Manchester Daily Express*, 7 August 1959; '100 Wives for a Planned Families Test', *Yorkshire Post,* 7 August 1959; '100 wives wanted for planned birth test', *Liverpool Daily Post*, 7 August 1959; '100 Wives wanting babies needed', *Lincholnshire Daily Echo*, 8 August 1959.
Wellcome Library, London, SA FPA/NK/239, 'Press cuttings scrapbook', 1959-60.
[17] Marks and White Junod, 'Women's Trials', 154.
[18] Eleanor Mears (Medical Secretary, FPA), 'The Contraceptive Pill', *British Medical Journal*, 2 December 1961.
[19] 'Oral contraceptives', *The Guardian*, 19 June 1962, 8.
[20] Pfeffer, *Stork and Syringe*, 143.

pointed to an 'over-confidence' in 'wonder drugs'.[21] In 1962, the Medical Research Council established a committee to oversee the safety and testing of new drugs.[22] While regulation of medical research was growing, the 1960s and 1970s were still characterized by a lack of restrictions on such work.[23]

## 1968 – 1978: Assisted Reproductive Technologies

By the late-1960s the scope, potential, and risks of reproductive technologies, particularly assisted conception, had ballooned. As the Feversham Report closed a door on one debate in 1960, another door opened in the late-1960s, as 'reproductive technologies' once again galvanized the attention of the media and the public. Fertility drugs were being used to a greater extent, often resulting in multiple births, while at the same time sperm banks were expanding and reports of 'deep-freeze' babies appeared. Moreover, while the 'phantom dad' and 'childless wife' persisted as characters in popular media, there was a new character – the 'virgin wife' – that wanted a baby but not a husband.[24] While artificial insemination was gradually being expanded within the NHS, the practice was still confined to heterosexual married couples. Yet by the late 1970s, both feminist and lesbian groups were advocating for greater accessibility to services.

The development of effective fertility drugs captured the public's attention in the late 1960s. From the mid-1960s, there has been growing concern about the use of gonadotrophins: fertility drugs that encouraged ovulation in women. In 1965, MP Shirley Summerskill, who was also a general practitioner, called on the Minister of Health to

[21] 'Wonder Drugs', *Observer*, 24 June 1962, 20.
[22] Pfeffer, 147.
[23] Pfeffer, 149.
[24] Leslie Toulson, 'Phantom Dads Cash in on Childless Wives', *The Sun*, 13 May 1971; Alix Palmer, 'The Virgin Wives', *The Sun*, 28 April 1971.

"prohibit the general use of human gonadotrophins until their safety had been proven".[25] The following year, in 1966, the Medical Research Council conducted a clinical trial on the fertility drugs.[26] The appropriate dosage of fertility drugs was difficult to establish, based on the unpredictable sensitivities different women had to the drugs, which often resulted in multiple births.[27] The media focus around fertility drugs was initiated with a story of sextuplets born in Birmingham. On 2 October 1968, six babies were born to Sheila and Barry Thorns, which raised both hopes and concerns for couples pursuing fertility treatment.[28] Tragically, three of the six babies died within three weeks of birth and this news was widely reported in the British, Canadian, and American press.[29] In 1970, more attention was being given to fertility drugs, and the potential for multiple births – often referred to in the popular press as "fertility-drug babies".[30]

Although some of these multiple birth stories ended in tragedy, with the loss of babies, others were celebrated in the joy they brought to a couple. As Derek Shipley, the father of 'quads', said: "I wanted a son. Now I've got three".[31] However, the headline still focused on the mother as the one willing to take 'birth-drugs' in order to have another child. Although the context had changed, this family story presented a romantic narrative focused on the fulfillment of biological parenthood, not unlike those that followed the MacLennan case of 1958. As Naomi Pfeffer has pointed out, the press celebrated the

[25] Pfeffer, 147.
[26] Ibid, 147.
[27] Ibid, 148.
[28] 'Instant Families', *Scottish Daily Mail*, 5 October 1968; 'The hormone mothers', *The Sunday Times*, 6 October 1968; Amy Landreth, 'Women don't really want an instant family', *The Sun*, 4 October 1968; Ann Shearer, 'The fertility drugs', *The Guardian*, 3 October 1968; 'Now mother on fertility drug has triplets', *The Guardian*, 12 November 1968.
[29] Multiple articles on the Thorns family appeared throughout October 1968 in the *The Times, The Guardian*, *The New York Times,* and the *Globe & Mail*.
[30] Bernard Sandler, 'New hope for childless wives', *Mother*, November 1970; 'Quads for Birth-Drug Mum Who Wanted Another Child', *Daily Record*, 17 April 1970.
[31] 'Quads for Birth-Drug Mum', *Daily Record*, 17 April 1970.

potential of the 'miracle' and 'wonder' fertility drugs.[32] [Figure 5.2] While medical advancements in pharmaceuticals were influential, so too were legislative changes.

The Abortion Act of 1967 had an important impact on the immediate demand for AID. The Act changed the landscape for women's reproductive health and rights. It legalized abortion up to twenty-eight weeks gestation, and made the procedure accessible within the NHS. However, it also led to a sharp decrease in the number of children available for adoption, as women were not bringing unplanned pregnancies to term. By 1972, there were approximately 160,000 abortions taking place per year in Britain.[33] This affected 'childless' couples who were now ever more reliant on assisted conception as a way to have a child. As it became easier for women to prevent or terminate undesired pregnancies, through contraception and abortion, the birth rate of Britain dropped markedly. Thus, there was a growing demand for reproductive technologies, from heterosexual and homosexual couples alike.

As demand for artificial insemination increased, both the Minister of Health and a British Medical Association panel recommended that the practice be expanded within the NHS. In 1968, the Minister of Health recommended that both AIH and AID be made available within the National Health Service, if it had been advised on medical grounds.[34] Although it was not widely available, the popular press ensured the public was made aware of these developments. In May 1971, the *News of the World* reported that an (anonymous) NHS hospital's sub-fertility clinic had extended its services to include AI. The doctor overseeing the clinic spoke about the change in perceptions: "The old

[32] Pfeffer, *Stork and Syringe*, 152.
[33] Brooke, *Sexual Politics*, 185.
[34] *Report of the Committee into Human Fertilisation and Embryology*, (London: Her Majesty's Stationary Office, 1984, 1988), 19; Lucy Frith, 'What do we mean by proper medical treatment?', in *The Legitimacy of Medical Treatment*, Edited by Sara Fovargue and Alexandra Mullock, (Routledge, 2015), 43.

prejudice against AID babies no longer exist. Most people now regard a baby born by such methods as normal and acceptable".[35] The reporter reminded readers of the recommendations of the Feversham Committee only a decade earlier, but explained that the 1967 Abortion Act had changed the landscape. Patient demand for AI had increased dramatically, and it forced the state to include it within the health service.[36]

In light of this growing demand for artificial insemination, the British Medical Association (BMA) convened a panel in 1971, chaired by Sir John Peel, to examine the medical aspects of artificial insemination.[37] The panel was comprised of six doctors, though only one was a woman.[38] The group's report in 1973 "recommended that, for the small proportion of couples for whom AID would be appropriate, the practice should be available within the NHS at accredited centres".[39] However, there was no action at that time "to establish a system of accreditation", and the couples the BMA referred to were heterosexual married couples.[40] The practice of AID continued to grow to the point that in 1982 the Royal College of Obstetricians and Gynaecologists (RCOG) attributed 1000 pregnancies and at least 780 live births to AID that year, which was thought to be an underestimate.[41] The BMA panel's report in 1973 was cautious in its recommendations, and the provision for services remained limited. The Report suggested making artificial insemination available through five clinics in England, and one each in Scotland, Wales, and Northern Ireland. This committee also recommended that donors be paid.[42] By 1977,

[35] David Roxan, 'Now it's a test-tube baby on the State', *News of the World*, 25 May 1971.
[36] Roxan, *News of the World*, 25 May 1971
[37] Jackson, *Regulating Reproduction*, 165; E.B. Hargreave, *Male Infertility*, (London: Springer-Verlag London Ltd., 1994), 428.
[38] 'Doctors Urge Test-Tube Babies on the NHS', *Daily Mirror*, 6 April 1973, p.9.
[39] *Report of the Committee into Human Fertilisation and Embryology*, 19.
[40] Ibid.
[41] Ibid.
[42] 'Doctors Urge Test-Tube Babies on the NHS', *Daily Mirror*, 6 April 1973, p.9.

clinics where 'consumers' could access artificial insemination were expanding with twenty-two centres in the UK that offered AID, though a lack of funding held back expansion.[43] In those NHS clinics where AID was offered, external funding supported the majority of the work.[44] The popular press continued to promote such services for 'childless wives', as one sensational *Daily Mirror* front-page headline advertised: "BABIES FOR SALE, £50 will buy a child for heartache wives".[45] However, when AID was conducted at an NHS hospital, the fee was normally only "to reimburse the money paid to the semen donor, which in 1977 was at most £15".[46] Yet, there were reports that some private clinic fees ran as high as £1,000 for a course of AID.[47]

In the 1970s, there was also a growing push to provide 'legitimate' legal status to children conceived by AID. The BMA panel recommended in 1973 that "[t]he definition of legitimacy should be extended to include a child born as the result of artificial insemination to which the husband has consented".[48] Similarly, in 1977, MP Joan Lestor introduced a bill in the Commons to provide children conceived by artificial insemination legitimate status, though it was not passed.[49] It was not until the Family Law Reform Act (1987) and the Human Fertilisation and Embryology Act (1990) that this issue was resolved for children conceived with donor assistance.

AID was still largely reserved for married heterosexual couples, but by the late 1970s, the practice was slowly opening up.[50] In early January 1978, the *Evening News*

[43] Pfeffer, 156.
[44] Pfeffer, 156.
[45] 'Babies for Sale', *The Daily Mirror*, 13 October 1977.
[46] Pfeffer, 156-7.
[47] Pfeffer, 157.
[48] 'Babies for Sale', *The Daily Mirror*, 13 October 1977.
[49] 'End child stigma', *Guardian*, 29 June 1977, 4.
[50] Accounts of legal disputes over surrogacy begin to appear in the late 1970s

reported that a West-End gynaecologist had provided artificial insemination to a number of lesbian women.[51] Dr. Donald Sopher reported that ten babies had been born "to established lesbian couples", who had been referred by the lesbian organization Sappho.[52] Sopher's practice was discovered when two female *Evening News* reporters went 'undercover', pretending to be a lesbian couple wanting a baby. The sensationalized article led to protests from the lesbian community as it was seen as "a pretext for an attack on all lesbian mothers".[53] The publication of the article was viewed as encouraging "a climate in which violence against lesbians and gay men could increase".[54] At the same time, in 1978, the Feminist Self-Insemination Group was established in London by a group of lesbians.[55] As Marie Stopes had pointed out in 1952, this 'do-it-yourself' approach offered affordable access to AID without relying on medical intervention. By the late-1970s, self-insemination groups often relied on donated sperm from homosexual male friends.[56] In this way, AID was put in women's control and although it was inexpensive, it obviously raised risks in terms of testing for infection and disease.[57] In light of the *Evening News* report, the medical profession was divided on the "advisability of such a practice". The British Medical Association's reaction was neutral, however other specialists argued that it went against the sperm donor's intention, was not in the best interests of the child who would suffer without a father, and who would be confused

'Hired to Have a Baby', *Daily Mirror*, 21 June 1978, p.1; 'From Lynda with Love', *Daily Mirror*, 3 December 1979, p.17; 'The perils of parents by proxy' and 'Woman hired to have a child', *Guardian*, 21 June 1978, 10.
[51] Melanie Phillips, 'Babies are born with lesbians', *The Guardian*, 6 January 1978, 22.
[52] Ibid.
[53] 'How Weekend Watch wounded Gay Pride', *Guardian*, 9 July 1979.
[54] Ibid.
[55] Tong, 167.
[56] Jalna Hanmer, 'Transforming consciousness: women and the new reproductive technologies', in *Man-Made Woman: how new reproductive technologies affect women*, Edited by Gena Corea, Renate Klein, Jalna Hanmer, Helen Holmes, Betty Hoskins, Madhu Kishwar, Janice Raymond, Robin Rowland, and Roberta Steinbacher, (Bloomington: Indiana University Press, 1987), 95.
[57] Hanmer, 94; Tong, 168.

about sexual identity.[58] Despite the BMA's neutral response in 1978, by 1979 the Association nearly agreed to a statement in its ethics handbook that AID for lesbian couples was unethical.[59] The majority of delegates believed "that it was wrong for lesbians to bring up children".[60] The resolution did not pass, but only by a very small margin (14 votes out of 300).[61]

## *In vitro* fertilization and the first 'test tube baby'

On July 25 1978, as the world waited with anticipation, Louise Brown was born in Oldham, Lancashire. [Figure 5.3] Hailed as the world's first 'test tube baby', Brown's birth represented a groundbreaking moment in the science of reproduction and the possibilities of medical research. This event marked a significant change in the conversation around reproductive technologies, despite the research being underway for over a decade. In February 1969, Patrick Steptoe, Barry Bavister, and Robert Edwards reported that they had achieved the first successful fertilization of a human egg in a 'test-tube' in Cambridge.[62] *The Times* covered the news of this development, reporting that the advantages to this advancement would help in "the study of the early development of embryos" as well as "the possibility of fertilizing eggs in this way and then reintroducing them into women as a means of curing infertility of some kinds".[63] The *Times* took a cautious approach, telling readers that although this was a step towards "test-tube babies" there were several obstacles including the viability of the embryo and risks of

[58] Melanie Phillips, 'Babies are born with lesbians' AID to motherhood', *The Guardian*, 6 January 1978, 22.
[59] 'More ethical medicine', *Guardian*, 27 June 1979, 15.
[60] Melanie Phillips, 'More ethical medicine', *Guardian*, 27 June 1979.
[61] Melanie Phillips, 'More ethical medicine', *Guardian*, 27 June 1979.
[62] R.G. Edwards, B.D. Bavister, P.C. Steptoe, 'Early Stages of Fertilization *in vitro* of Human Oocytes Matured *in vitro*', *Nature* 221, 15 February 1969, pp.632-635; John Ezard,'Limitations on test tube babies', *The Guardian*, 15 February 1969, 18.
[63] 'New Step Towards Test-Tube Babies', *The Times*, 14 February 1969.

abnormalities. Numerous letters criticizing the work and the potential for 'test-tube babies' unsurprisingly followed this announcement. In 1971, when Steptoe and Edwards applied to the Medical Research Council (MRC) for funding, their application was refused on ethical grounds, but they continued their work with private funding. In April 1976, Steptoe and Edwards reported in *The Lancet* that a human embryo had been successfully reintroduced into a woman's uterus, but it resulted in an ectopic pregnancy and was removed at thirteen weeks.[64] Two years later, Louise Brown was born via caesarean section and, in 1979, after two IVF births, the MRC reversed their decision and supported the scientific work of Steptoe and Roberts with enthusiasm. As Naomi Pfeffer has argued, "it is doubtful whether anyone then appreciated the enormous commercial potential of their work".[65] By 1982, twenty-eight 'test tube babies' had reportedly been born: thirteen in Britain, fourteen in Australia, and one in the US.[66] In 2016, over five million babies have been born via assisted reproductive technologies globally.[67]

## Regulating Reproductive Technologies

In response to controversy and growing concern over the regulation of reproductive technologies, the Committee on Human Fertilisation and Embryology was established in 1982, chaired by the moral philosopher Mary Warnock:

> …to consider recent and potential developments in medicine and science related to human fertilization and embryology; to consider what policies and safeguards should be applied, including consideration of the social ethical, and legal implications of these developments; and to make recommendations.[68]

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[64] 'Reimplantation of a human embryo with subsequent tubal pregnancy', *The Lancet*, 24 April 1976, 880.
[65] Pfeffer, 166.
[66] 'Human embryo banks proposed', *The Times*, 28 January 1982.
[67] Michelle Castillo, 'Report: 5 million babies born thanks to assisted reproductive technologies', CBS News, 15 October 2013, http://www.cbsnews.com/news/report-5-million-babies-born-thanks-to-assisted-reproductive-technologies/
[68] 'History of legislation on fertility treatment', Human Fertilisation and Embryology Authority, http://www.hfea.gov.uk/1319.html

In July 1982, the so-called Warnock Committee began its work. Its Report was issued in 1984, laying down the recommendations that would come to form the basis of the Human Fertilisation and Embryology Act (HFEA) of 1990. The Report recommended the establishment of a licensing body to regulate research and services, which was addressed almost immediately with the Voluntary Licensing Authority (VLA) in 1985.[69] The most controversial recommendations of the Report were to make surrogacy a criminal offence, and to allow for embryo research within fourteen days after fertilization. The Committee suggested that no research be carried out on an embryo beyond the fourteenth day after fertilization, after which point it would be considered a criminal offense.[70] The report also recommended that the AID child be treated in law "as the legitimate child of its mother and her husband, where they have both consented to the treatment", and that the semen donor would have no parental rights. The Committee concluded that AID "should no longer be left in a legal vacuum" but receive legal protection, for it was expected to

[69] In response to the Report, the RCOG and MRC established the Voluntary Licensing Authority for Human In Vitro Fertilisation and Embryology (VLA) to act "as a stop-gap measure until the government had formulated its response to the recommendations". In 1989, this was renamed the Interim Licensing Authority (ILA). Following this, the Surrogacy Arrangements Act (1985) implemented the first law to make commercial surrogacy illegal.
Pfeffer, 164; 'History of legislation on fertility treatment', HFEA, http://www.hfea.gov.uk/1319.html

[70] The 'primitive streak' – "the earliest manifestation of a nervous system" – was what defined for the Warnock Committee the acceptable limit of research. The Report also established the principle of anonymity in donor gametes, encouraged NHS provision for counseling infertile couples, at 18 years old the child should have basic access to information about their biological donor parents, written consent should be obtained from all parties (ie. for AID), limit of 10 children fathered by one donor, if treatment is declined a full explanation of reasons should be provided to the patient, semen donors only be compensated for their expenses, condoned the use of frozen semen in AI, recommended 5-yearly reviews of donated semen and eggs, 10-year maximum for the storage of embryos (after which point the rights of use pass to the storage authority), the storage authority be given the right to determine the use or disposal of an embryo if the couple cannot agree, encouraged the establishment of separate specialized infertility clinics, the continuation of IVF to be available within the NHS; to make a criminal offense any experimentation in 'trans-species fertilisation'. professional involved in surrogate pregnancy criminally liable, "all surrogacy agreements are illegal contracts and therefore unenforceable in the courts". A "child born by AIH who was not in *utero* at the date of the death of its father shall be disregarded for the purposes of succession to and inheritance from the latter" (the same for IVF), "legislation be enacted to ensure there is no right of ownership in a human embryo".
Pfeffer, 163; *Report of the Committee of Inquiry into Human Fertilisation and Embryology*, 81.

continue growing and "with or without official sanction…its clandestine practice could be very harmful".[71] On the question of surrogacy, the recommendation was made to make the creation or operation of surrogacy agencies a criminal offence (whether for profit or not). Three expressions of dissent were issued, including eight members of the Committee. On the question of surrogacy, Wendy Greengross and David Davies argued that it should not be made illegal, and that it was too soon to form a definitive legislative opinion on an issue that has only come to prominence in the previous year. Three other members (Madeline Carriline, John Marshall, Jean Walker) issued an expression of dissent on the issue of using human embryos in research – suggesting that the embryo have special protection and that no research be conducted on human embryos; spare embryos should be frozen with the aim of later implantation, or "allowed to die". Another expression of dissent was signed by Scott Baker, A.O. Dyson, N. Edwards and Wendy Greengross on the issue of embryo intent: that research should only be conducted on 'spare embryos', stating that human embryos should not be created for the sole purpose of research. Both official and unofficial opinion was divided on the recommendations of the Warnock Report. While there was relative agreement over making surrogacy a criminal offence, there was broad disagreement over embryo research and the question of how to define human life.[72]

## Opposition to Reproductive Technologies

There was a powerful campaign of resistance in the mid-1980s, both to the Warnock Report and to the development and practice of reproductive technologies in general. This opposition involved a diverse group of actors:

[71] *Report of the Committee of Inquiry into Human Fertilisation and Embryology*, 23.
[72] 'Human Fertilisation and Embryology (Warnock Report)', House of Commons Debate, 23 November 1984, vol 68 cc528-44; Hansard.

> …a motley collection of activists including radical feminists, Catholics, neo-conservatives hostile to the liberal attitudes typified by the 1960s, and people with physical and mental disabilities – groups which had little in common save this one issue.[73]

The most powerful arguments were articulated by the anti-abortion lobby, by the Feminist International Network of Resistance to Reproductive and Genetic Engineering [FINRRAGE: see below], and by Conservative politicians. Multiple attempts were made to legislate against Warnock's recommendations. In 1985, Enoch Powell launched a Private Member's Bill – the Unborn Children (Protection) Bill – in response to the Warnock Report's recommendations. The bill aimed to prohibit embryo research, and only permit human embryos to be used for the purpose of implantation into a woman. The bill failed to pass. These questions around embryo research and IVF became intertwined with discussion of abortion reform, and the gestational stage at which abortion should be legally permitted. In 1986, Powell's Unborn Children Bill was reintroduced by Conservative MP Ken Hargreaves, and again failed to pass. The Duke of Norfolk in the House of Lords attempted to pass the bill once again in 1989, however it was withdrawn.[74]

From the 1970s, some feminist critiques have viewed reproductive technologies as another form of patriarchal control (through the reproductive process).[75] One of the most vocal feminist resistance groups was established in 1985: FINRRAGE.[76] It argued that these technologies were harmful and exploitative to women, and undermined

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[73] Pfeffer, 162.
[74] 'History of legislation on fertility treatment', HFEA, http://www.hfea.gov.uk/1319.html
[75] Sarah Franklin, 'Postmodern Procreation: A Cultural Account of Assisted Reproduction', 323.
[76] FINRRAGE was established in Sweden in 1985 when women from 16 countries met to discuss technological development on reproduction.
Patricia Spallone, *Beyond Conception: the new politics of reproduction*, (Granby, MA: Bergin & Garvey Publishers, Inc., 1989), 1.

"women's struggle for control of [their] own reproduction".[77] FINRRAGE also suggested, in both official and unofficial discourse, that women were neglected "as the subject on whom these technologies [were] implemented", as the rights of the embryo took precedence.[78] The technologies had been framed as offering women more choice, yet they were established to further medical research, rather than support women and infertile couples.[79] The preoccupation with the rights of the embryo was criticized for taking precedence over the rights of women.[80]

## Implementing Legislation

Through the 1980s, government investigation, political debate, and both official and public discourse ultimately led to legislation concerning reproductive technologies. The 1987 Family Law Reform Act was aimed at "the law relating to the consequences of birth outside marriage; to make further provision with respect to the rights and duties of parents and the determination of parentage".[81] It established definitions for the family roles involved in artificial insemination, by defining the husband of the mother as the legal father of the child conceived by artificial insemination by donor. More broadly, the Act worked towards removing the distinction between 'illegitimate' and 'legitimate' children.

In 1990, the Human Fertilisation and Embryology Act was established based on the Warnock Report, and in August 1991 the Human Fertilisation and Embryology Authority began its work.[82] By the 2000s, modifications had been made to the original

[77] Spallone, *Beyond Conception*, 1.
[78] Ibid, 2.
[79] Ibid.
[80] Ibid, 6.
[81] Family Law Reform Act 1987, 1.
[82] 'History of legislation on fertility treatment', HFEA, http://www.hfea.gov.uk/1319.html

Act, including provision to make human cloning illegal in 2001, and the removal of donor anonymity in 2004.[83] In 2008, the HFE Act underwent a substantial review and a revised version received Royal Assent.

## II. Conclusion

This dissertation has argued that 1943 to 1960 was an influential period in the development of infertility services and discourse around reproductive technologies. By 1960, awareness and provision of sub-fertility testing and treatment had increased dramatically, and opposition to artificial insemination and 'test-tube babies' was beginning to soften. This study is significant for it offers a number of insights into our understanding of health care and family planning, gender and sexuality, the influence of science, and the meaning of the family. It traces a period in which fertility treatment and assisted reproductive technology became essential features of family planning services – services that were still largely ignored by the broader health care system. This research has raised questions about the role and extent to which the state should offer and subsidize fertility services, which continues to be an issue that nationalized health services are working through. It has also explored the ways in which infertility and artificial insemination, in particular, tapped in to existing social anxieties tied to gender and sexuality. In the years after the Second World War, gender roles were in flux: more women were in the workforce, and rates of adultery, divorce, and illegitimacy all appeared to be on the rise. Artificial insemination brought this anxiety to the surface, as it offered the solution to heterosexual marriage in crisis, as well as forebodings of a mechanical form of adultery. In a similar way, this reproductive 'technology' activated

[83] 'History of legislation on fertility treatment', HFEA, http://www.hfea.gov.uk/1319.html

both fears and hopes tied to science. For example, on one hand, AID was viewed as a 'cure' for infertility, while on the other hand, it caused alarm to those who perceived it as 'unnatural' and 'abnormal'. This dissertation has followed the ways in which these forces intersected, to place a spotlight on the meaning of the 'natural' family.

The three sections of this thesis have explored the spaces in which these issues were discussed: clinics, cultural spaces, and committees. The intersections of these spaces offer important insights. Clinical work and communications strategy converged as the Family Planning Association rebranded and shifted its aims to include 'sub-fertility'. This shift played an important role in making its work more palatable to public opinion. Sub-fertility supported the pronatalist sentiment of the postwar years, and this family-friendly approach was an important development in the 1940s and 1950s. This impact was not only in service provision for fertility treatment, but also in the dissemination of knowledge and the public relations campaign that sought to normalize clinical work and educate both the medical profession and the public about the misunderstood subject of infertility. The FPA's move to bring sub-fertility and marriage guidance under the 'family planning' umbrella was communicated through self-help guidebooks, promotional film, and the press. The FPA also relied on the support of politicians and religious leaders to generate a more favourable public opinion of its work. The Eugenics Society played a critical but largely undefined role in sub-fertility work. As a financial patron of the FPA, and as a mediator over discussions of infertility through the forties and fifties, the Society benefitted from a strategic partnership with the Association. Although the term 'eugenics' went largely unspoken through this period – its influence can be seen

in other ways: through the funding of the FPA, though the 1958 *Birthright* film, and as an undercurrent in discourse over 'suitable' parents and 'wanted' children.

This dissertation has also illuminated the important intersection between patients and the press. Infertility patients demonstrated agency in seeking out fertility services, with only limited information available. Letters written to the FPA between 1945 and 1951, reveal the emotional experience of infertility, the multiple barriers to treatment, and gendered dynamics within marriage. However, these letters also underscore the central role that the press and media played in educating the public about reproduction. As in the United States, patient demand was influential in the expansion of infertility services in Britain, and the media played an important educative role in this development.

Parallel to the establishment and expansion of sub-fertility services were debates over the practice of artificial insemination. Political, medical, legal, religious, and popular opinion all weighed in on a subject that garnered a level of public attention that was disproportionate to its practice. Central to the discourse of artificial insemination was its effect on family life. During a period of growing anxiety over gender roles, sexuality, and the stability of marriage, AID was added to the list of threats to the security of British life. It therefore joined divorce, illegitimacy, and homosexuality, as an attack on the moral character of the country. Discussion in the House of Lords, in the correspondence pages of the *British Medical Journal*, and in the Archbishop of Canterbury's Commission on Artificial Insemination, laid the foundation for debate in the years that followed.

In the 1950s, these debates entered the public sphere more forcefully as legal cases of marriage termination because of AI drummed up media attention. Two cases in Britain – *R.E.L. v E.L.* (1948) and *MacLennan v MacLennan* (1958) – generated wide-

ranging interest in the effect of AI on marriage that extended from politicians, to journalists, and even filmmakers. The spirited discussion of artificial insemination in the press forced the government's hand in calling an investigative committee. In this way, the popular media led public opinion and government action on the issue, and encouraged a more flexible definition of the 'natural' family.

This study has also shed light on the investigation of the Feversham Committee (1958–60), which has received limited historical attention. The content of the Committee's interviews with medical witnesses reveals a host of barriers encountered by couples seeking fertility treatment. 'Suitability' for parenthood was prescribed, based on race, marital dynamics, and 'respectability'. These interviews called into question the meanings of femininity and masculinity, and 'normal' sexuality, as well as revealing the persistence of the stigma associated with interracial marriage. The Committee evidence also underscores the continued importance of religious support to government investigations making recommendations on issues concerned with 'morality'.

Thus, this dissertation has traced the relationship between science, fertility, and the family in Britain during the 1940s and 1950s: from a House of Lords session on the artificial insemination of livestock in April 1943, to the report of the Feversham Committee on Human Artificial Insemination in July 1960. This period highlighted a prolonged cultural debate over the morality of assisted conception, as well as the establishment of infertility services in Britain. That the subject of AI provoked controversy is no surprise, but when taken as a discrete discourse the issue offers far-reaching insights into the social conditions of postwar Britain. The family has been used as the thematic framework from which to examine these issues. In the 1940s and 1950s

the discourse of infertility and assisted conception was focused on marriage, class, and gender roles – which was reflective of broader anxieties over the divorce rate, 'problem families', and changing notions of masculinity and femininity. The 1940s and 1950s mark an important period in questioning the definition of the family – of parenthood, marriage, and childhood. That the subject of artificial insemination seeped into the cracks of existing social anxieties, emphasizes the instability of the period and the desire to hold fast to tradition, lest anything else disrupt conventional institutions and ideas. Yet this period also demonstrates a quiet and subtle shift, marked by a hesitant openness to a 'new' family form by accepting the status quo.

In many ways, this narrative begins and ends with the concept of the 'test tube baby'. Long before the first baby was born via *in vitro* fertilization – with Louise Brown's birth in 1978 – the colloquial term 'test-tube baby' referred to children conceived via artificial insemination in the 1940s and 1950s. Correspondents to the FPA, medical commentators in the *British Medical Journal*, judges in cases of divorce and nullity, newspapers, radio broadcasts, documentaries, and dramatizations all employed this term to connote conception by assisted reproduction. While scientific advancements meant the precise meaning of the term changed, through this period it remained the popular catch-all for assisted conception.

The themes that sit at the centre of this dissertation – science, fertility, and the family – are arguably as important to present-day discourse as they were in the 1940s and 1950s. This research speaks to contemporary concerns in the realm of reproductive politics. While the social anxieties of the mid-twentieth century are certainly different from those of today, the broader concerns about reproductive technologies share many common

themes: the protection of human life, the welfare of children, the right to parenthood, the implications for society, and the meaning of being human.

The issues raised in this study give rise to contemporary questions, and point to continuities within a landscape of dramatic social and scientific change. What does postwar population discourse share with concerns over 'global overpopulation' and environmental sustainability today? As organizations like 'Population Matters', supported by the likes of David Attenborough and Jane Goodall, express similar concerns to those presented in the 1958 FPA film *Birthright*, what meaning can be drawn from these continuities? What can the FPA's sub-fertility initiative for accessible and affordable health care tell us about contemporary health policy that reflects equitable access? State subsidy of reproductive technologies, which exists in many developed countries today, rests on philosophical principles concerning health care – social equality and the right to parenthood – which were central to the aims of many physicians running infertility clinics in the 1940s and 1950s. How can the depiction of reproductive technologies in postwar popular culture help us to understand present-day media responses to scientific advancements? Developments in the late twentieth century and scientific possibilities of the twenty-first century, including cloning, editing the human genome, and 'three-parent babies', make us question the benefits and risks of medical science. Certainly, mid-century fears surrounding the potential for sex determination have to some extent been realized, as dramatic demographic consequences are apparent particularly in countries that practice sex-selective abortion.[84]

[84] United Nations data shows skewed sex ratios in East Asian countries, including China, India, South Korea, Singapore and Taiwan, as well as in former Communist countries, including Armenia, Azerbaijan, and Georgia. It is unclear how much of this is a result of human intervention or a result of other social forces.

To some extent, the lens through which we see the past is always mediated by current concerns. As this dissertation suggests, examining the history of infertility and artificial insemination in the 1940s and 1950s is a reminder about the contemporary and future importance of health care provision, of the benefits and risks of scientific possibility, and the celebration of, and tolerance for fluid family structures. It also reminds us that the future is never far from discussions of reproductive politics. When the Feversham Committee interviewed Dr. Norman Jeffcoate in 1959, he suggested a cautious approach be taken to legislating on artificial insemination:

> …it would perhaps be wise to recognise that customs and outlooks change from one era to another. There might come a time when social conduct and family patterns might change so radically as to justify a different view.[85]

An eye to the future is important in legislating on matters of reproductive rights, yet so too is historical awareness.

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[85] National Archives, London, HO 342/58, T.N.A. Jeffcoate.

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| SA/SRF | Society for Reproduction and Fertility (previously the Society for the Study of Fertility) |
| PP/CPB | Carlos Paton Blacker Collection |
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| GC/149 | Bernard Sandler Collection |
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| GC/193 | Letitia Denny Fairfield Collection |
| SA/TSY | The Thalidomide Society Collection |
| WA/HMM | Wellcome Historical Medical Museum |
| WF | Wellcome Foundation Ltd. Collection |
| PP/RJH | Robert J Hetherington Collection |
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'Nixon, William Charles Wallace (1903-1966)'. Plarr's Lives of the Fellows: Royal College of Surgeons. http://livesonline.rcseng.ac.uk/biogs/E005988b.htm
'Obituary: Elizabeth Whitley, writer'. *The Scotsman*. 14 September 2010. http://www.scotsman.com/news/obituaries/obituary-elizabeth-whitley-writer-1-810363
'Question of Adultery'. Rare Movies Blog. http://myraremovies.blog.co.uk, date accessed 25 February 2015 (no longer accessible)

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‘Stopes, Marie Charlotte Carmichael (1880-1958)’, PP/MCS. Wellcome Library Archives and Manuscripts. http://archives.wellcomelibrary.org/DServe/dserve.exe?dsqIni=Dserve.ini&dsqApp=Archive&dsqCmd=Show.tcl&dsqDb=Catalog&dsqPos=19&dsqSearch=%28%28%28text%29%3D%27marie%27%29AND%28%28text%29%3D%27stopes%27%29%29 accessed on 10 March 2016.

‘The worldwide war on baby girls’, *The Economist*, 4 March 2010, http://www.economist.com/node/15636231

*Appendix A: Biographical References for Key Figures*

| Name | DOB – DOD | Significance | Chapter references |
|---|---|---|---|
| Blacker, Carlos Paton | 1985-1975 | Dr. C.P. Blacker (1985-1975) was a psychiatrist and eugenicist. He held posts at Guy's Hospital (as registrar of psychological medicine), and from 1936 to 1960 worked in clinical psychiatry at Maudsley Hospital, London.[86] He published on psychology, genetic inheritance, and birth control. Blacker was General Secretary of the Eugenics Society from 1931 to 1952 (when he resigned), and remained Honorary Secretary of the Society until 1961, when he was 66 years old. He was also secretary of the Population Investigation Committee, a member of the Abortion Law Reform Association, and a close colleague to those at the FPA. Blacker worked in clinical psychiatry as well as at the Eugenics Society, where he advocated for contraception, population control, and later sub-fertility work. During his tenure at the Eugenics Society, Blacker transformed it "from an unfocused, amateur propaganda agency… into a quasi-professional research foundation."[87] One of Blacker's early books, *Birth Control and the State* (1926), promoted "the medicalization of contraception" as well as "its great value for the improvement of physical, mental and 'racial' health." Blacker helped establish the BCIC in 1927 (later merging with FPA), and remained closely connected with the birth control and family planning movement throughout his career. He advocated "liberal minded, scientific, reform eugenics" and was the force behind the Eugenics Society developing alliances with the FPA which the Society financed, and housed for a time at the Eccleston Square headquarters. Blacker's influence in both the Eugenics Society and the FPA will be further examined in Chapter 1. | Chapters 1 |

[86] Richard A. Soloway, 'Carlos Paton Blacker', *Oxford Dictionary of National Biography*.
[87] Soloway, 'Carlos Paton Blacker', *ODNB*.

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| Feversham, Lord | 1906-1963 | The Earl of Feversham (Charles Duncombe) (1906-1963) was a Conservative politician. He sat in the House of Lords from 1927 to 1939, at which point he left to serve in the Second World War. Feversham served as a Major during the war and received the Distinguished Service Order in 1945.[88] He was named as Chairman of the Committee on Human Artificial Insemination in August 1958, and the 'Feversham Report' was published in July 1960. He had also served on the Departmental Committee on the Social Services in Courts of Summary Jurisdiction in 1934, sponsored the Children and Young Persons Act (1930s), and was involved in mental health work and was elected Chairman of the National Association for Mental Health.[89] He was also Chairman of the National Advisory Council on the employment of the disabled.[90] | Chapters 4, 5 |
| Fisher, Geoffrey (Archbishop of Canterbury) | 1887-1972 | Geoffrey Fisher (1887-1972) was the Archbishop of Canterbury from 1945 to 1961. He was committed to the reconstruction of London after the war, chairing the churches' war damage committee; he called on the government to address the postwar famine in Europe; and was a president of the World Council of Churches.[91] Fisher has been described by a biographer as, "a conservative, headmasterly archbishop who, though warm-hearted, was determined to maintain the protestant establishment".[92] He was resistant to both theological and social change and, in many ways, "had come from a different age".[93] Publicly, he held a strong position on marriage and divorce, although privately he was more flexible in | Chapters 3, 4, 5 |

[88] National Archives, London, WO 373/55/15, 'Recommendation for Award for The Earl of Feversham', 1945. Feversham received the Distinguished Service Order, which was announced in the London Gazette on 11 October 1945.
[89] See 'Children and Young Persons Bill', House of Lords Debate, 9 June 1932, http://hansard.millbanksystems.com/lords/1932/jun/09/children-and-young-persons-bill#S5LV0084P0_19320609_HOL_155; 'Mental Health Bill', House of Lords Debate, 4 June 1959, http://hansard.millbanksystems.com/lords/1959/jun/04/mental-health-bill#S5LV0216P0_19590604_HOL_37
[90] 'The Earl of Feversham'. The Helmsley Archive. http://www.helmsleyarchive.org.uk/info/HA07395.pdf
[91] Alan Webster, 'Fisher, Geoffrey Francis (1887-1972)'. *Oxford Dictionary of National Biography*. Oxford University Press, 2004. Online edition, May 2012.
[92] Webster, 'Fisher, Geoffrey Francis', *ODNB*.
[93] Webster, *ODNB*.

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| | | the acceptance of some second marriages and divorces that were "blessed by God" or "morally justified".[94] With the publication of the Wolfenden Report in 1957, Fisher offered a "cautious welcome" to its recommendations emphasizing the importance of "'…a sacred area of privacy where people make their own choices and decisions into which the law must not intrude'".[95] However, in 1960 when D.H. Lawrence's *Lady Chatterley's Lover* was prosecuted under the Obscene Publication Act (1959), Fisher "again resorted to censure". Bishop John Robinson supported the publication of the book, and without having read it himself, the Archbishop described Robinson as "a stumbling block and cause of offence to many ordinary Christians".[96] | |
| Holland, Eardley | 1879-1967 | Sir Eardley Holland (1879-1967) was an obstetrician, serving at many London hospitals and for the Royal Army medical corps during the First World War. Holland was responsible for a 1922 Ministry of Health report on the causes of stillbirth. Holland did further work for the Ministry of Health from 1937 to 1940 advising on obstetrics and gynaecology, and with the outbreak of the Second World War he was made responsible for the evacuation plan for pregnant women in London. Holland played a critical role in the Royal College of Obstetricians and Gynaecologists (RCOG). He was involved in the founding of the College in 1929, served as honorary treasurer from 1930-9, and then (in his mid-60s) as president from 1943-6. He also served as a member of the Royal Commission on Population (1944-49).[97] | Chapter 1 |
| Horder, Thomas Jeeves | 1871-1955 | Lord (Thomas Jeeves) Horder (1871-1955) was a well-known and respected physician, with patients including members of the royal family and prime ministers | Chapter 1 |

[94] Webster, *ODNB*.
[95] Webster, *ODNB*.
[96] Webster, *ODNB*.
[97] John Peel, 'Holland, Sir Eardley Lancelot'. *Oxford Dictionary of National Biography*. Oxford University Press, 2004. Online edition January 2007. Accessed 11 November 2015.

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| | | (including George V, George VI, Elizabeth II, Bonar Law, and Ramsay MacDonald).[98] He retired from active practice at St Bartholomew's Hospital in 1936, at the age of 65. After his retirement, Horder served as consultant and advisor to a number of organizations including the Ministry of Pensions (1939), Ministry of Food (1941), and London Transport (1940-55). In addition, he chaired numerous committees devoted to subjects ranging from air-raid shelters, to cancer, to rheumatism. Horder was president of the Eugenics Society from 1935 until his death in 1955.[99] He was also President of the NBCC and later the FPA from 1931 until his death in 1955, at the age of 84.[100] The conflicting interests implied by these overlapping presidential posts bears consideration, and will be addressed in Chapter 1. | |
| Jackson, Margaret Hadley | 1899-1987 | Dr. Margaret Hadley Jackson (1899-1987; active 1930-1981) was a respected specialist in reproductive health (specifically sub-fertility and artificial insemination), a prominent member of the FPA, and also headed the Exeter and District Women's Welfare Association from 1930. Jackson practiced AID from 1940 to 1982, and was a strong defender of the practice throughout her career. She worked closely with pharmaceutical companies, conducting clinical trials for new contraceptives, and published widely on reproductive health in textbooks, *The Lancet*, *The British Medical Journal*, the *Eugenics Review*, and even in the popular press (anonymously). One of these textbooks was entitled *Problems of Fertility in General Practice*, and was co-written with Joan Malleson, Kenneth Walker and John Stallworthy. As one of the most experienced practitioners in the field of fertility, she provided evidence to the Feversham Committee in 1959. Jackson's significance in the field continues to be celebrated with awards and | Chapters 1, 2, 3, 5 |

[98] L.J. Witts, 'Horder, Thomas Jeeves (1871-1955)'. *Oxford Dictionary of National Biography.* Oxford University Press, 2004. Online edition, Jan 2011.
[99] 'Horder, Thomas Jeeves, Lord Horder of Ashford', AIM25 Archives in London and the M25 Area, http://www.aim25.ac.uk/cgi-bin/vcdf/detail?coll_id=9444&inst_id=20
[100] Leathard, 44, 90; Mrs. M.A. Pyke, 'Obituary', *The Times*, 22 August 1955, p.9.

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| | | a centre in her name. Each year the Faculty of Sexual and Reproductive Healthcare of the Royal College of Obstetricians and Gynaecologists (RCOG) awards several essay prizes under Margaret Jackson's name, on a topic associated with sexual and reproductive health care.[101] Moreover, the Margaret Jackson Centre still functions at Barnfield Hill, Exeter (where her clinic moved in 1964), "providing a self-referral, low cost counseling service to both men and women".[102] In 1971, when a report of the clinic's history was written, Jackson had been engaged in clinic work for 41 years – she was the "chief architect" in the clinic's work and their "inspiration to carry on", according to her colleague Joan Lennard.[103] | |
| Malleson, Joan | 1899-1956 | Dr. Joan Malleson (1899-1956) was a physician specializing in sexual and reproductive health, and published on contraception and infertility. She was a member of the FPA, helped found the ALRA in 1936, and was also a fellow of the Eugenics Society. Malleson was involved in the 1938 trial of Aleck Bourne, who had been charged with carrying out an abortion unlawfully. Malleson had been the referring doctor and served as witness.[104] She helped set up the FPA's Islington branch in 1934 and was involved in work at the North Kensington Women's Welfare Centre.[105] Malleson led the campaign for the setting up of the FPA's sub-fertility services in 1943, and served on the FPA's Sub-fertility committee (along with Jackson, Horder and Blacker). After her death in 1956, Eleanor Mears took over Malleson's practice. | Chapter 1, 2 |

[101] 'Margaret Jackson Prize Essay'. Faculty of Sexual and Reproductive Healthcare. http://www.fsrh.org/pages/scholarships_and_awards.asp#MJEP
[102] 'About'. The Margaret Jackson Centre. http://www.margaretjackson.org.uk/about.htm
[103] Wellcome Library, London, FPA A4/B6/1
[104] Martin, D.E. 'Malleson, Joan Graeme'. *Oxford Dictionary of National Biography*. Oxford University Press, 2004. Online edition.
[105] Davies, Sue. 'Sex and Dr Joan Malleson'. Wellcome Library Blog. http://blog.wellcomelibrary.org/2013/10/sex-and-dr-joan-malleson/

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| Pyke, Margaret | 1893-1966 | Margaret Pyke (1893-1966) was a family planning advocate, serving as the secretary of the NBCC and later the FPA from 1930 until 1954. From 1954 to 1966, Pyke served as the chairperson of the FPA.[106] She helped expand the Association, and raise its public profile. The 1955 visit to the FPA by Minister of Health Iain Macleod was orchestrated by Pyke and the publicity from this visit helped shift the public acceptance of family planning in the late 1950s.[107] Pyke was also a member of the Eugenics Society. | Chapter 1 |
| Wright, Helena | 1887-1982 | Dr. Helena Wright (1887-1982) was a pioneer in birth control, family planning, and sexual health. For thirty years, Wright held the post of chief medical officer at the North Kensington Women's Welfare Centre (1930-1960).[108] Wright was involved in the establishment of the International Planned Parenthood Federation (IPPF) in 1952 and served as both treasurer and chairman on the IPPF's medical committee.[109] Wright helped arrange abortions, adoptions, and artificial insemination, served as a witness to the Feversham Committee (in 1959), and published widely on the subject of sex in marriage.[110] | Chapter 1, 5 |

[106] Ann Dally, 'Pyke, Margaret Amy'. *Oxford Dictionary of National Biography*. Oxford University Press, 2004. Online edition, October 2007. Accessed 11 November 2015.
[107] Dally, 'Pyke', *ODNB*.
[108] Lesley A. Hall, 'Wright, Helena Rosa'. *Oxford Dictionary of National Biography*. Oxford University Press, 2004. Online edition, October 2006. Accessed on 11 November 2015.
[109] Hall, 'Wright', *ODNB*.
[110] Hall, 'Wright', *ODNB*.

**What wonders he will see**

Never before have boys had the good fortune of today's young moderns. Born into a scientific age, they'll see wonders that will eclipse all those we marvel at today. Science will be their guardian in health . . . their hope for a richer, happier life . . . the impetus behind their achievements. Today, the vast international Cyanamid organisation is weaving the threads that will make up the fabric of life in the future. For instance, to their range of life-saving drugs like Aureomycin* (chlortetracycline) and Achromycin* (tetracycline) will be added new discoveries that will help doctors conquer disease. In agriculture too, Cyanamid's Malathion* will help in the world war against pests. Every day Cyanamid's quest goes on to produce better industrial chemicals, plastics, fertilisers, dyestuffs and many other materials. Every day, Cyanamid contributes more to a brighter tomorrow.

**Cyanamid is making the world a better place**

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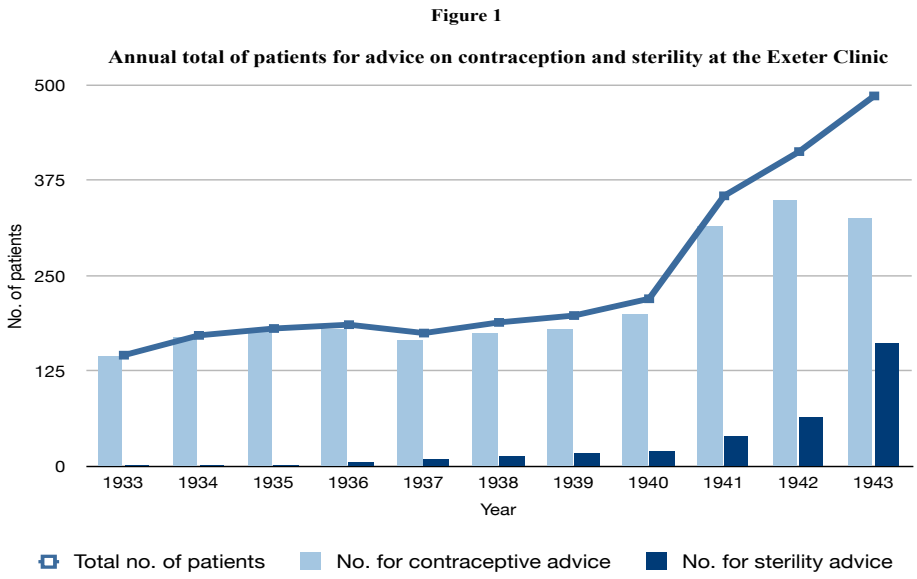
*Cyanamid of Great Britain Ltd. is part of the great Cyanamid International which embraces Lederle Laboratories Division, Agricultural Division, Mining Chemicals Division, General Chemicals Division.

CYANAMID OF GREAT BRITAIN LTD · BUSH HOUSE · LONDON WC2

Figure 1.1: 'What wonders he will see' advertisement, *The Times*, 26 August 1958.




Margaret Hadley Jackson, 'A medical service for the treatment of involuntary sterility', Eugenics Review, 36(4) January 1945, pp.117 - 125.

Figure 1.2: Annual total of patients for advice on contraception and sterility at the Exeter Clinic, 1933 – 1943

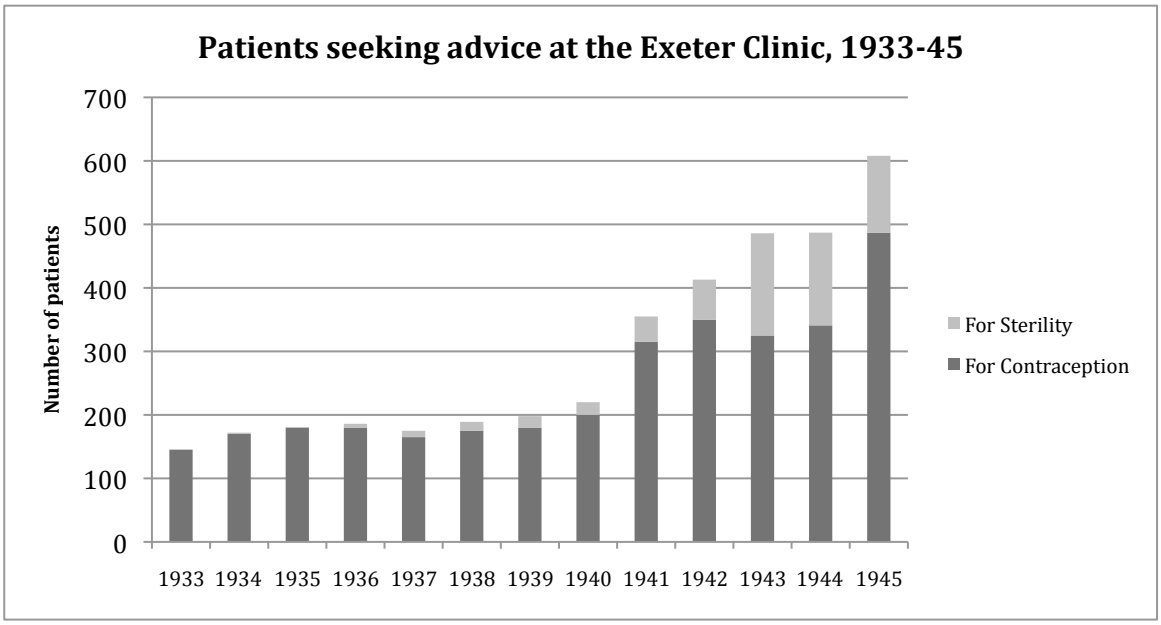
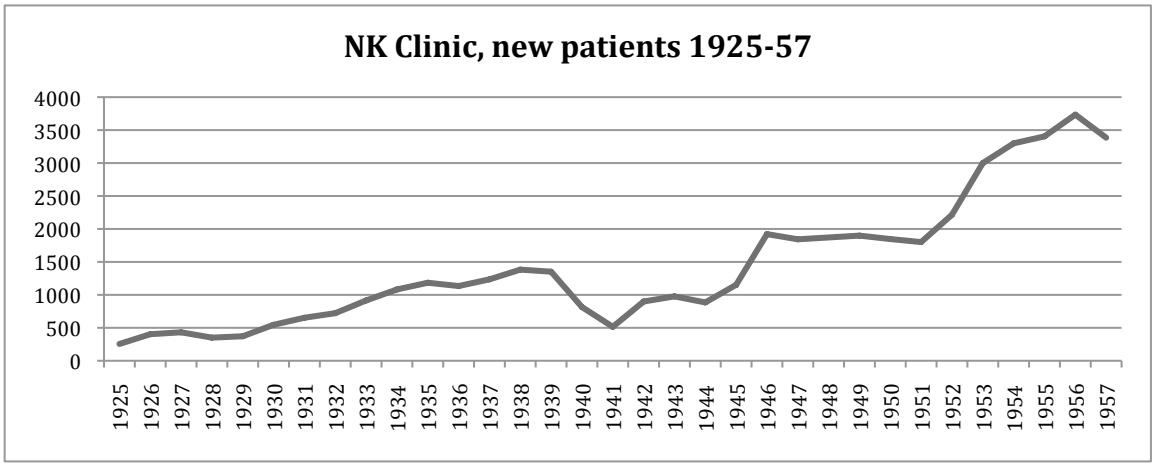
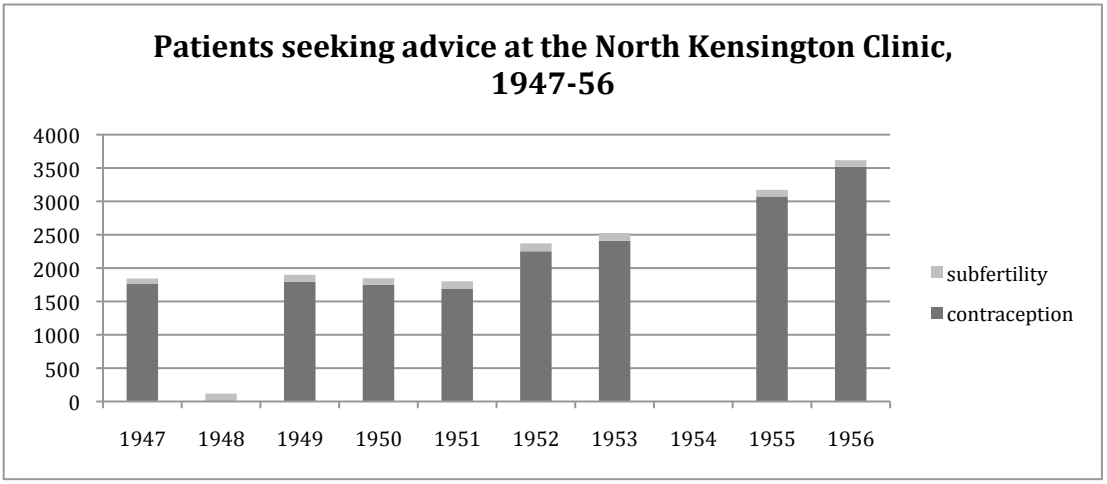



Figure 1.3: Patients seeking advice at the Exeter Clinic, 1933-45

(Source: FPA Annual Reports (SA FPA A4/B6.1, Wellcome Library); Margaret Hadley Jackson, 'The Organisation of a Sterility Service within a Family Planning Association Clinic', *Post-Graduate Medical Journal*, August 1944, pp.237-246.)




Figures 1.4: North Kensington Clinic, new patients 1925-57; Patients seeking advice at the North Kensington Clinic, 1947-56

(Source: SA FPA NK/198)

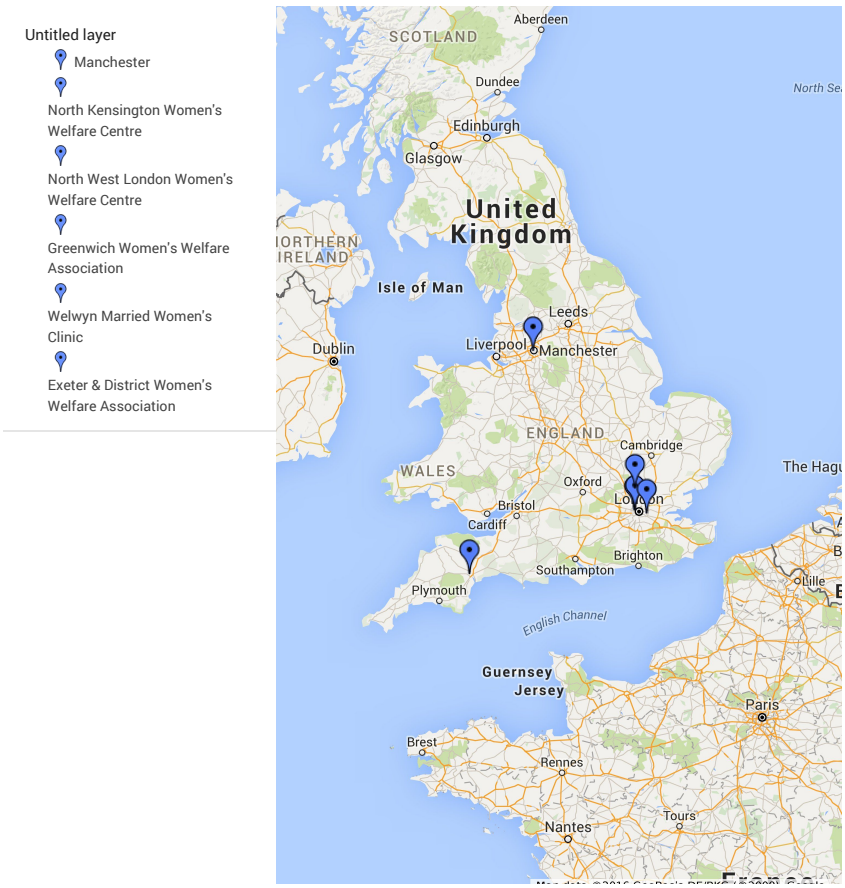



Figure 1.5: Map of FPA sub-fertility clinics, c.1950

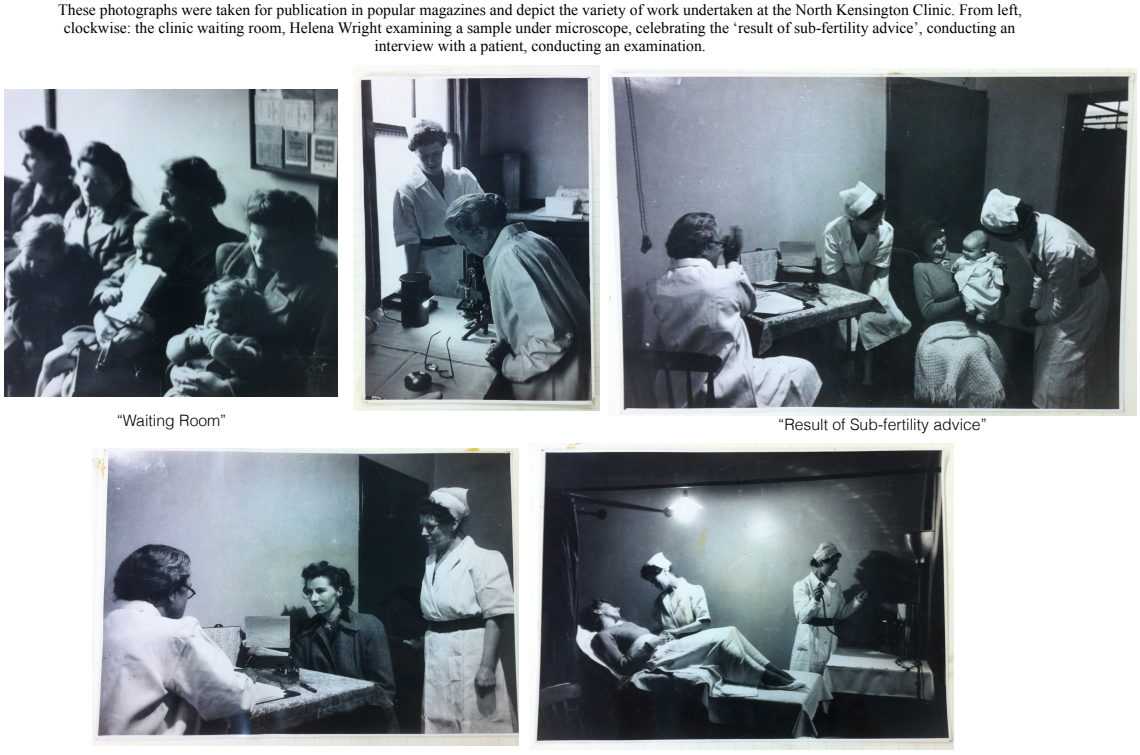



Figure 1.6: Press photographs of services at the North Kensington Clinic


Figure 1.7: Stills of opening credits of *Birthright* (1958)

Figure 1.8: Families featured in *Birthright (*clockwise from top-left: Robinsons, Wrights, 'childless' couple, abandoned children)


Still images from *Birthright* (1958)
1) Doctor interviews 'childless' wife
2) Doctor interviews 'childless' husband
3) Specialist examines sample
4) 'Active' sperm is a good sign
5) 'Wanted children' playing

Figure 1.9: Still from sub-fertility section of *Birthright*


Figure 1.11: Walworth Clinic interview, *Birthright*

Figure 1.12: Contrasting the experience of motherhood, *Birthright*

Figure 1.13: 'Medical men' discuss population issues, *Birthright*

Figure 1.14: Stock footage of famine in India, *Birthright*

Figure 1.15: Stock footage of a woman in Japan*, Birthright (*a Japanese woman near-dead on a stretcher, as the authoritative voice of Russell Brain explains the dangers of abortion in Britain and elsewhere)

Figures 1.16, 1.17: Contrasting experiences of women and birth control, *Birthright*

Figure 1.18: Contrasting experiences of motherhood, *Birthright*

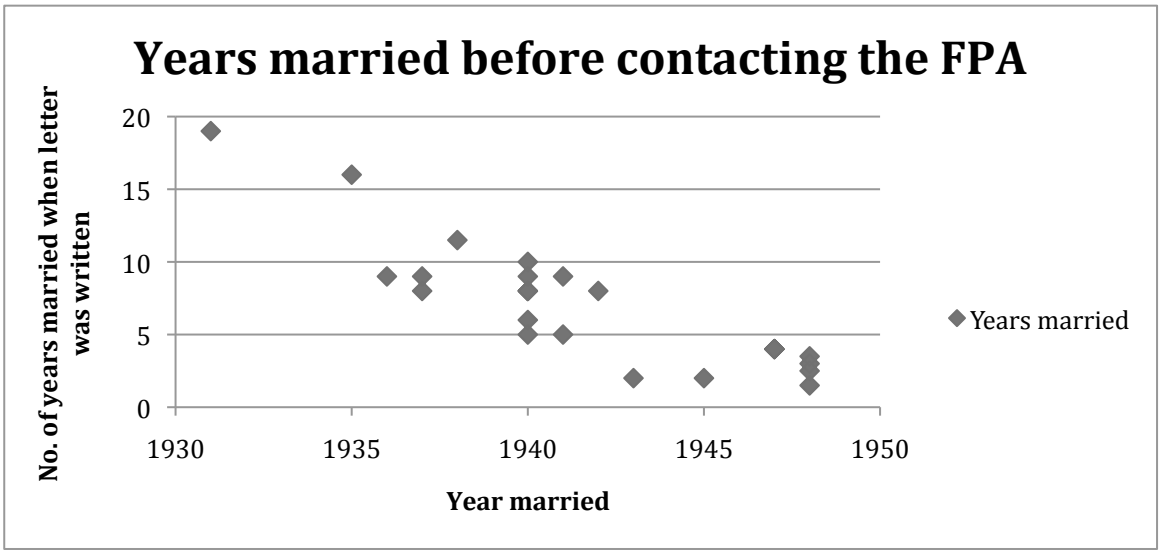



Figure 2.1: Years couples were married before contacting the FPA

(Data from SA/FPA/A3/2 and SA/FPA/NK96, Wellcome Library, London)


Figure 2.2: Cartoon of 'sub-fertile' couple from the *Daily Mirror (*Image from article 'Childless- but they don't despair', *The Daily Mirror*, 22 March 1950, p.4.)

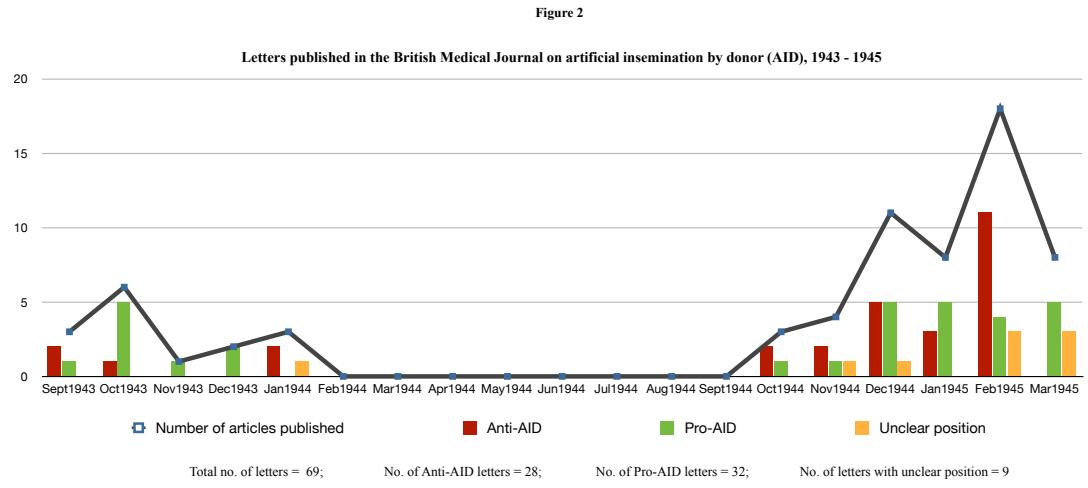



Figure 3.1: Letters published in the *BMJ* on artificial insemination, 1943-45

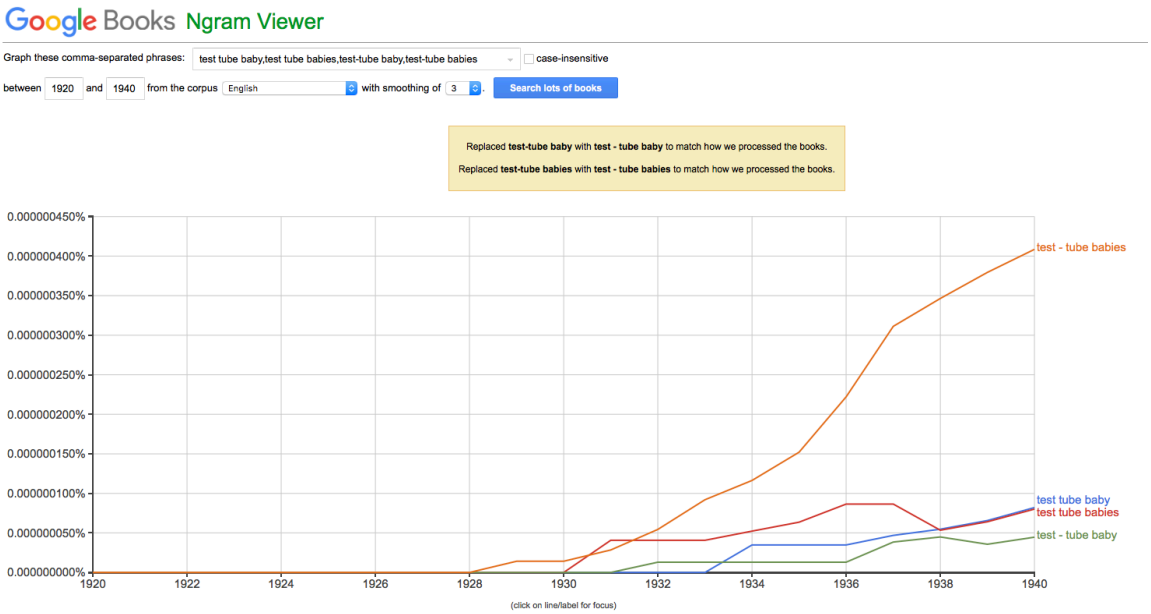



Figure 4.1: Google Ngram Viewer, test tube babies, 1920-40

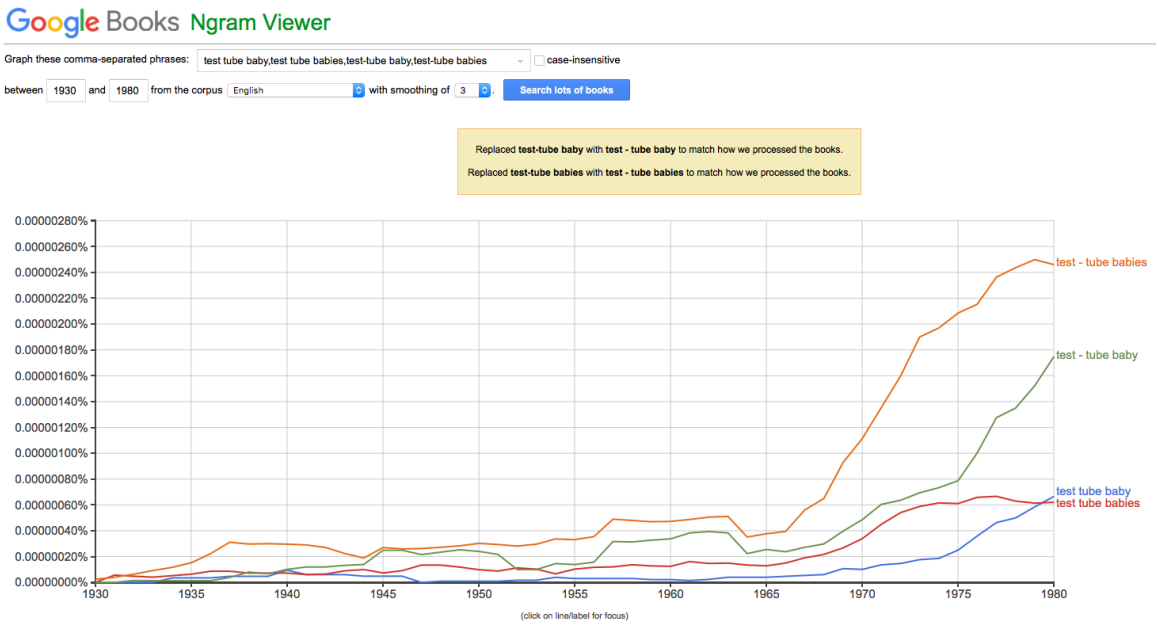



Figure 4.2: Google Ngram Viewer, test tube babies, 1930-80


Figure 4.3: Martian Nyah lands, still from *Devil Girl From Mars* (1954) http://www.nydailynews.com/entertainment/nasa-curiosity-rover-lands-mars-mars-movies-mars-real-life-gallery-1.1133849?pmSlide=1.1133844

Figure 4.4: Film poster, *Devil Girl From Mars* (1954), http://hgagnondistribution.com/en/titles/vod-only/devil-girl-mars]

DAILY EXPRESS WEDNESDAY MARCH 12 1958

5

# Which Girl is the Test Tube Baby?

EXPRESS PHOTONEWS

*PRESENTS A PROBLEM PICTURE*

THE Knights, who live in Sydney, Australia, are a large united family with just one peculiarity: one of the five bonny daughters you see on the right is a test-tube baby.

Can you tell whether it is Rachael, who holds mother's hand, on the left; Suzanne, tucked into father's arm; or one of the right-hand trio—Carol Anne, Lynette, and Denise?

Joan Knight married her husband 17 years ago, when she was 17. But after 10 years of trying to raise a family they were still childless.

**Four more**

So, after clinical examination, Mrs. Knight underwent A.I.H.–artificial insemination by her husband.

The result, and the answer to our puzzle, was the birth of Carol Anne, the girl holding on to her father by the trouser-leg. But that was not all. After her birth have come four more daughters—each naturally conceived.

So the arrival of Carol Anne six years ago transformed life for the Knights. It also makes this a rare, significant picture. It is lively proof that a child born by A.I.H. is in every way a happy event—and in no way different from her sisters.

The Knights of Sydney—the family which a test tube made possible—walk out in the sunshine.

Figure 4.5: 'Which Girl is the Test Tube Baby?', *Daily Express*, 12 March 1958.

Figures 4.6, 4.7, 4.8: Film stills, ‘Question of Adultery’, *Illustrated*, 8 February 1958

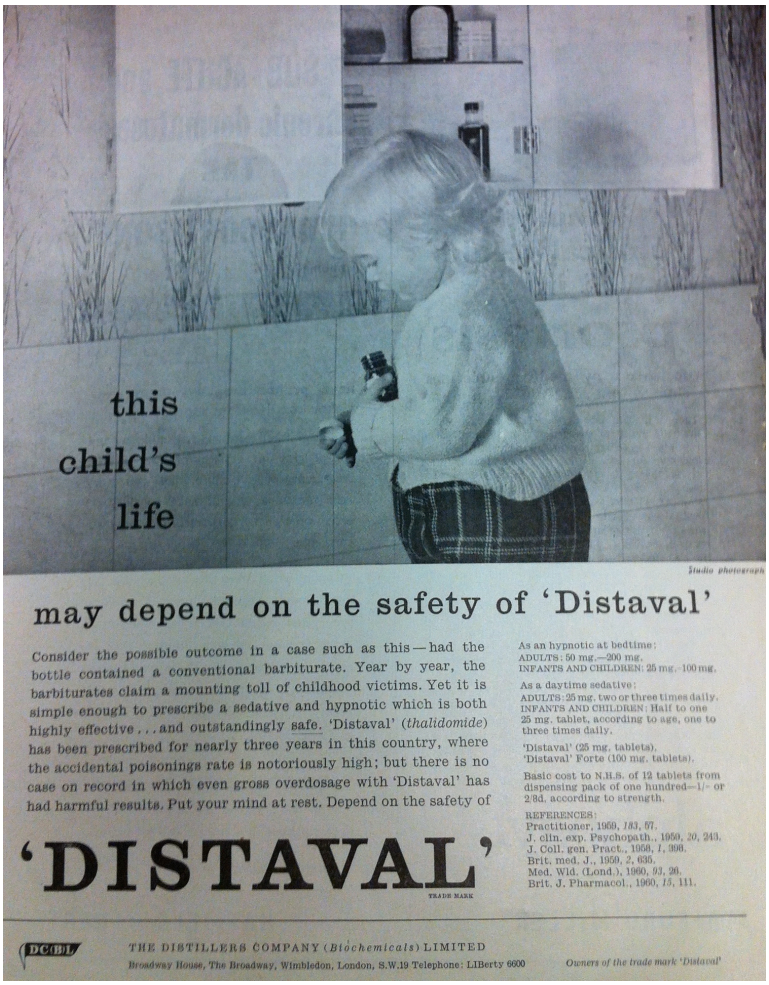



Figure 5.1: 'Distaval' ad, *British Medical Journal*, 25 March 1961

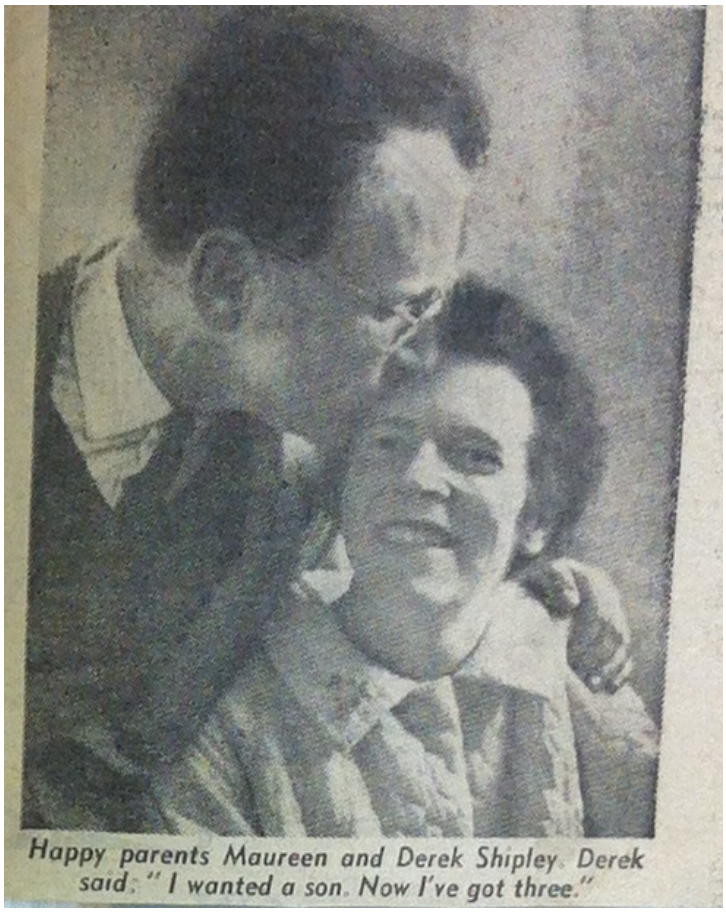



Figure 5.2: 'Quads for Birth-Drug Mum who wanted another child', *Daily Record*, 17 April 1970, 3.


Figure 5.3: Time Magazine cover, July 1978