The Doctor’s Dilemma: Paternalisms in the Medicolegal History of Assisted Reproduction and Abortion

Kara W. Swanson

“Abortion, always the doctor’s dilemma.”

“The physician should keep his fees low...otherwise the procedure may well become a racket and a doctor find himself doing A.I.D. [artificial insemination by donor] in situations which do not merit it.”

In 1954, American women experienced an unwanted pregnancy as presenting a difficult choice between bearing an unwanted child and risking an illegal abortion. Yet obstetrician/gynecologist Alan Guttmacher described abortion as “the doctor’s dilemma.” Guttmacher and his medical colleagues experienced a dilemma when their professional judgment that pregnancy termination was warranted clashed with the laws criminalizing most abortions. In that situation, the law constrained their ability to make a decision they felt to be in the best interest of a patient. To doctors, such paternalist decision-making was a bedrock principle of 20th-century medicine. Doctors had an obligation to provide, or deny, treatment to patients for their own good. This duty arose from medical expertise and separated the medical profession from lesser medical practitioners. Until the 1970s, the law severely impinged upon medical discretion to provide abortions, creating the “doctor’s dilemma.” The medicolegal history of abortion, as experienced by a practicing physician such as Guttmacher, reminds us that reproductive medicine is an area where legal and medical paternalisms meet, creating two layers of sometimes clashing control that influence access, safety, and ultimately, women’s equality. These history lessons are relevant to current pressing questions about whether and how to regulate assisted reproduction, an area of reproductive medicine that has historically been the subject of much medical paternalism, but little law-making.

The abortion laws that Guttmacher experienced as constraining were an example of legal paternalism, regulations restricting women’s options for their own good. As Justice Blackmun explained in Roe v. Wade (1973), the Supreme Court case that found such legal restrictions unconstitutional, these laws had been enacted in the 19th century in part “to restrain [the pregnant woman] from submitting to a procedure...”

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placed her life in serious jeopardy. Because women were putting their lives at risk seeking abortions, abortion except to save the life of the pregnant woman was outlawed. Women were not allowed to weigh the risks themselves. Guttmacher's dilemma was caused by a conflict between legal paternalism and medical paternalism. The laws that limited women's choices also precluded doctors from performing abortions decades later when the techniques were much safer. As Guttmacher knew from first-hand experience, many women rejected the decision made for them by the state and thousands died from criminal abortions when trained physicians, like himself, obeyed the law and refused to perform safe abortions even when in their medical judgment, such procedures were appropriate. Guttmacher experienced rigid legal paternalism as interfering with benevolent medical paternalism, and as injuring women as they were driven into the abortion black market.

While controversial in American political philosophy, legal paternalism is common. Since the republic was founded, states and the federal government have passed laws making decisions on behalf of members of the polity for their own good, from mandatory schooling laws to seatbelt laws. Regulatory paternalism in the area of reproduction, including laws criminalizing contraception as well as abortion, and laws permitting involuntary sterilization, has long been deservedly subject to intense scrutiny and criticism. Guttmacher, a life-long campaigner for increased legal access to fertility control, joined this criticism, yet believed the paternalist exercise of medical discretion in all these areas was appropriately protective of women's health. It is undeniable, however, that the combination of legal regulation and paternalist gatekeeping by a male-dominated medical profession has too often reinforced gender hierarchies that deny women full social, political and economic equality.

has also served as a thin disguise for attempts by white elites to control the reproduction of the poor, of racial minorities, and of those who are unmarried and/or non-heterosexual. For these reasons, feminist scholars and activists have critiqued discretionary medical paternalism as harshly as mandatory legal paternalism, rejecting the framing of the problem as a doctor's dilemma rather than a woman's dilemma.

Until the 1970s, the law severely impinged upon medical discretion to provide abortions, creating the “doctor’s dilemma.” The medicolegal history of abortion, as experienced by a practicing physician such as Guttmacher, reminds us that reproductive medicine is an area where legal and medical paternalisms meet, creating two layers of sometimes clashing control that influence access, safety, and ultimately, women’s equality. These history lessons are relevant to current pressing questions about whether and how to regulate assisted reproduction, an area of reproductive medicine that has historically been the subject of much medical paternalism, but little law-making.

The ability of women to access medical treatments to promote conception has had very different historical trajectory than pregnancy termination, resulting in the contemporary situation in which assisted reproduction is essentially available on demand, for those who can afford to pay. Rather than making paternalistic decisions for women, doctors treat them as consumers. In the absence of legal regulation, the rules of the marketplace control, and fertility clinics competing for patients allow women and men to purchase the treatments they want, in ways that many believe threaten women's health, encourage poor financial decisions, and/or disregard the interests of the resulting children. To lessen these harms, many have called for regulation of the assisted reproduction industry in ways that would limit women's choices, forcing doctors to deny treatment that they might presently be offering. At the same time, the medicolegal history of abortion raises justifiable concern that paternalistic regulation of assisted reproduction will replicate the mistakes of the past, protecting women for their own good with detrimental results.

Guttmacher's career offers an opportunity to compare the medicolegal history of abortion and assisted reproduction during the 20th century in order to consider the role of paternalism in assisted reproduction. During the same decades Guttmacher experienced constraint in performing abortions, he was practicing the earliest assisted reproduction technique, donor insemination. Guttmacher did not experience a “doc-
tor's dilemma" when faced with involuntarily childless women seeking help conceiving because there were no laws limiting his practice of artificial insemination. He did, however, consider how best to exercise medical paternalism and worried that the financial self-interest of doctors might replace paternalism with consumerism in ways that undermined what he saw as the patient-protective effects of medical discretion. Guttmacher continually enjoined his fellow fertility specialists to keep fees low when performing donor insemination, so that they would not be tempted to offer this treatment indiscriminately to all those who asked, bilking the childless in a profitable “racket.”

His medical perspective on the interplay between legal and medical paternalism in both abortion and assisted reproduction provides an important reminder that while such paternalism can create damaging dilemmas for women, constraining their reproductive choices, it also constrains and channels doctors. Considering regulation of assisted reproduction from this perspective provides new insight into the contemporary debates about the regulation of assisted conception, opening the possibility that regulation might be designed not to save women from themselves, but rather to balance the roles of consumer and patient as they interact with the medical profession.

An Abortion Odyssey
Alan F. Guttmacher’s extensive writings throughout his lengthy career provide a means of analyzing the interplay between legal and medical paternalism in reproductive medicine. Guttmacher (1898-1974) is both exceptional and exemplary of doctors practicing in the middle decades of the 20th century. A native of Baltimore and son of a prominent rabbi, Alan Guttmacher entered Johns Hopkins Medical School in 1919 along with his twin brother, Manfred, who became a leading psychiatrist. Alan trained as an obstetrician/gynecologist, and during his 40 years of private practice, performed both abortions and donor insemination. He was an “irrepressible boat-rocker,” discussing these controversial techniques extensively in the medical, legal and popular literatures, and advocating both for abortion regulation reform and for family creation through donor insemination. After practicing in Baltimore and then in New York City, Guttmacher finished his career as the president of Planned Parenthood Federation, a position he held until his death in 1974. While Guttmacher was exceptional as a doctor with elite training and as an outspoken public figure (thus creating a record of his opinions), he was also exemplary of the general shift in medical attitudes toward both abortion and donor insemination across these decades.

In 1972, Guttmacher published a personal reminiscence describing the evolution of his position on the legal regulation of abortion. In his opinion, abortion had been “always the doctor’s dilemma.” He described an “odyssey,” which he began as a young doctor by questioning the received wisdom of his medical school professors that the laws were appropriately strict, continued by advocating for legal reform to provide more scope for medical judgment, and ended by embracing repeal of all abortion laws. Although Guttmacher sought to preserve medical discretion to refuse pregnancy termination services, evincing ambivalence about abortion on demand, by the end of his career he saw complete repeal of the abortion laws as the best solution for the doctor's dilemma.

When Guttmacher began practicing in 1923, all abortions were criminalized except those performed by a licensed physician to save the life of the pregnant woman, so-called “therapeutic” abortions. These laws were the result of a deliberate campaign by elite physicians of the 19th century to criminalize a procedure that previously had been largely unregulated. Before quickening, a woman had been able to take steps to “restore her menses” by self-treatment, or with the aid of friends, healers, midwives or doctors without legal interference. Historian James Mohr has traced the way that self-described “regular” physicians used this campaign as part of a broader effort to strengthen the medical profession by forcing “irregular” practitioners, including midwives, homeopaths, and a wide range of eclectic healers, out of the medical marketplace. Elite physicians, like others of their socioeconomic class, also feared “race suicide” and disapproved of the declining family size of white native-born Americans, a decline that married middle-class women accomplished in part in an era of poor contraception by repeated resort to pregnancy termination. Arguing that women were making choices damaging to their own health and to the health of the nation, these doctors were able to convince most states to outlaw abortion between about 1840 and 1870. Medical paternalism and legal paternalism aligned to severely restrict women’s options to regulate their fertility.

Guttmacher had learned during his medical training to perform pregnancy termination by methods that were much less risky than those of the mid-19th century. He was also taught that “therapeutic abortion was performed to save the life of the pregnant woman and that the primary threats involved dysfunction by… the heart, the lung and the kidney.” According to his obstetrics professor, when an obstetrician believed that his patient was dying of major organ failure, he could abort to save her life. All other abortions were criminal. In addition to his training in the techniques...
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for decades to resolve, was that his medical judgment often conflicted with the law, forcing him and other like-minded doctors to deny women abortions they felt would be beneficial.

Guttmacher was deeply troubled by what he saw as the costs of the doctor’s dilemma, which he understood were borne not just by doctors but also by women. He described how as a young doctor in the late 1920s, he unsuccessfully sought permission from the chief of obstetrics at his hospital – the same doctor who had taught him about therapeutic abortion – to perform an abortion on a 12-year-old African American girl, pregnant as a result of rape by her father. The girl was forced to bear the child, because her life was not endangered. Shortly thereafter, Guttmacher learned that at a different Baltimore hospital, a young European American daughter of an army colonel, also pregnant from rape, was granted a late-term abortion. While most state statutes did not provide flexibility to perform abortions in the case of pregnancy resulting from rape, historian Leslie Reagan has documented that if a reputable doctor practicing in a hospital was able to get permission to perform such an abortion, his actions were virtually never questioned by the authorities. Across the United States, social elites were much more successful in persuading doctors to perform therapeutic abortions in non-life-threatening situations for themselves and their daughters. When therapeutic abortions were rare, medical paternalism, as expressed in the form of willingness to perform rule-bending abortions when doctors believed they were in the best interest of a patient, reinscribed racial and class hierarchies as well as gender hierarchies.

Guttmacher knew that the poor and the unlucky often turned to illegal abortionists. Just as when patients experienced legal therapeutic abortions in ways that varied with race and class, in this market too, results varied. Guttmacher referred patients who could afford the fees to two illegal physician-abortionists in Baltimore whose techniques he respected as safe, and later, to a doctor he knew in Japan, where abortion was legal. The poor and less well-connected risked their lives and health at the hands of less skilled practitioners, and Guttmacher treated dying girls and women in the aftermath of such illegal abortions. The doctor’s dilemma caused discrimination and unnecessary death.

By the 1930s, Guttmacher was advocating for legal reform to resolve the doctor’s dilemma. When he became the chair of obstetrics at Sinai Hospital in Baltimore in 1942, he acted to reduce the discriminatory access to therapeutic abortion that he felt stemmed from idiosyncratic decisions made by the chair alone. He formed a committee to respond to physician requests to perform an abortion, a step he felt “democratized” the decision. When he brought the committee approach to Mount Sinai Hospital in New York City, he was able to show that charity patients received therapeutic abortions at rates roughly equivalent to private patients, reducing the discriminatory aspects of medical paternalism under a framework of severe legal constraint. The committee approach, which became prevalent by mid-century, did not reduce illegal abortions, however, as abortion access remained unpredictable and difficult. In New York City, for example, some hospital committees would permit therapeutic abortion after a pregnant woman had contracted German measles, which often resulted in severe birth defects, while committees at other hospitals uniformly refused abortions in such circumstances. They also varied in their willingness to allow abortion after rape. With more experience, Guttmacher learned to use these discrepancies. When he was denied permission to abort a victim of gang rape at Mount Sinai, he was able to refer her to another hospital where the committee was likely to grant her request.

Guttmacher felt that a better solution to the doctor’s dilemma was to broaden the legal grounds for therapeutic abortion, thus reducing constraints on medical paternalism as enacted through hospital committees. He was not alone. After seven years of deliberation,
the American Law Institute promulgated a proposed model abortion reform law in 1962. This model law permitted therapeutic abortions when two physicians certified that there was a threat of “grave” impairment of the physical or mental health of the pregnant woman, that the child would be born with “grave” physical or mental defects, or that the pregnancy was the result of rape or incest.31 In 1967, the American Medical Association endorsed the model law.32 As a member of the New York State governor’s commission on abortion reform in the 1960s, Guttmacher went further, suggesting that therapeutic abortion also be permitted when the requesting woman was over 40 or had already borne four children.33 These were socioeconomic circumstances that he wanted to be able to take into account when he decided how to treat a patient.

After several states adopted a version of the model law in 1967 and 1968, Guttmacher was rapidly disillusioned with this reform.34 His goals were to achieve a “reduction in the frequency of illegal abortion; [and] elimination of financial and social discrimination in the practice of legal abortion.”35 These benefits to women would be created by resolving the doctor’s dilemma, or in Guttmacher’s words, permitting “today’s physician to practice a high quality of preventive and curative medicine, viewing medicine in the totality of the individual and his relationship to the family.”36 To his disappointment, abortion remained “the doctor’s dilemma” even after law reform. The dilemma now included psychiatrists, who might believe that pregnancy termination was in the best interest of a patient but not that her mental health was endangered. The mental health exception rapidly became the most common means of accessing therapeutic abortion in states like California and Colorado, where women who could afford private psychiatric consultations learned to claim that they were suicidal in order to get approval. Discrimination in access remained rampant, and illegal abortion remained the common recourse for the poorer and less savvy.37

Guttmacher therefore concluded by about 1970 that abortion should be stricken from the criminal code, and the distinction between therapeutic and criminal abortion dropped. The end point of his odyssey was reached, not for reasons of female autonomy, but to eliminate the doctor’s dilemma. He thus celebrated first New York’s decriminalization of abortion in 1970, and then the result of Roe v. Wade.38 Only in the 1970s did Guttmacher use the language of “free choice” to explain his position on abortion. He advocated choice in the context of protecting the “individual who opts against abortion” from being forced to abort, and recognizing the right of any doctor to refuse to perform an abortion.39 The AMA agreed, when in 1970 it endorsed legalizing any abortion performed by a licensed physician in a hospital, which the doctor could perform when in “the best interests of the patient,” as “good medical practice requires due consideration for the patient’s welfare and not mere acquiescence to the patient’s demand.”40 The choice was the doctor’s at least as much as the patient’s. Legal access to abortion on demand should not mean the loss of medical discretion to deny treatment, as doctors continued to answer the “personal questions” surrounding pregnancy termination based on their own experiences, reflective of their race, class, religion and other factors. Guttmacher’s odyssey brought him to what became the majority view of the medical profession, a medical-centered view that preferred unconstrained medical paternalism in place of rigid legal paternalism. As has been frequently described, Justice Blackmun’s majority opinion in Roe wrote this view into law, privileging the doctor-patient relationship and medical expertise.41

Test Tube Babies and the Law
During the same decades Guttmacher was making his abortion odyssey that led him to mistrust any form of legal paternalism with respect to pregnancy termination, he was one of the most prominent practitioners of assisted conception, which he also saw as a reproductive option to be offered by doctors exercising medical discretion in the best interests of their patients. Guttmacher did not live to see the birth of Louise Brown in England in 1978, the first human conceived via in vitro fertilization (IVF). Brown was widely hailed as the “first test tube baby,” a phrase that might have caused Guttmacher to chuckle.42 Although IVF was new, assisted conception and the term “test tube baby” were not. A German doctor had published a “history of test tube babies” in 1921.43 The struggles of childless couples to conceive have been documented since the Bible, and his book reviewed medical attempts to assist them by artificial insemination since the 18th century.

Some American doctors had tried to help patients by what they called “instrumental impregnation” during the 19th century. Enthusiasm for the technique was sufficient that at least one medical entrepreneur sold an “impregnating syringe” by mail order for home use.44 As Guttmacher was beginning medical school, New York obstetrician/gynecologist Robert Latou Dickinson brought the practice into the medical mainstream by making it the subject of his presidential address to the American Gynecological Society.45 Dickinson, who shared Guttmacher’s belief that women needed better access to contraception and
worried about the black market in abortion, also published a detailed description of the technique he had been using for decades.46

By the 1930s, women who were educated, urban, and/or well read, might come to their doctor requesting artificial insemination. In 1934, newspapers carried stories about the “test tube babies” and “eugenic babies” born to women after artificial insemination, either using semen from their husbands, or from an unknown donor, and the popular magazine Scientific American published an article on donor insemination.47 The married medical couple Hannah and Abraham Stone included a matter-of-fact description of the technique as a viable form of fertility treatment in their Marriage Manual (1935), a lay guide to reproduction and family planning, and at their New York City clinic, referred interested couples to doctors who performed it.48

Just as with therapeutic abortion, the “personal answers” of doctors regarding the advisability of artificial insemination, particularly insemination of a woman using semen from a man other than her husband, varied. Not all doctors agreed with the Stones that donor insemination was an acceptable option, instead joining the Catholic church in condemning it as immoral.49 Another lay guide to reproduction, published in 1937, called donor insemination “rather messy and almost sordid.”50 As a young doctor, however, Guttmacher embraced artificial insemination as an option for some of his patients. In 1938, he published a paper describing the five pregnancies he had initiated by donor insemination.51 Although there were no laws preventing him from treating all women who requested donor insemination, Guttmacher did not advocate free patient choice in assisted conception any more than he advocated free choice in pregnancy termination in the 1930s. Instead, he used his medical expertise to develop “indications for the use of artificial insemination in the human,” that is, the criteria he used to determine when artificial insemination was appropriate for a woman desiring to conceive a child.52

Medical paternalism is grounded in the truism that any medical treatment is only suitable for appropriate patients. Abortion, for example, is a technique only to be used on pregnant women. Guttmacher once treated a woman who died after obtaining an illegal abortion, although she had not been pregnant. She mistook the symptoms of early menopause for an unwanted pregnancy, and the abortionist failed to recognize her true medical condition, proceeding with (and botching) the requested abortion.53 Determining appropriateness is often not so clear-cut, however, leaving room for different “personal answers” and discriminatory outcomes. Guttmacher, who like all physicians of his era was trained to consider such judgments an important and suitable part of his profession, did not hesitate to articulate his approach. First, Guttmacher only considered inseminating women married to men. The treatment was to substitute for the failure to conceive through marital coitus, or, in rare cases, to replace the defective sperm of a husband known to be a carrier of a serious genetic disease, such as Huntington’s chorea. Second, the woman herself had to be fertile.54

In addition to the marriage presumption and the requirement of female fertility, Guttmacher advocated a further gate-keeping analysis by the doctor. When faced with a woman seeking medical aid to conceive using donor sperm, the doctor’s role was to determine whether she was part of a “deserving, exceptional couple.” The doctor needed to “acquaint himself with the couple and satisfy himself as much as is humanly possible of the permanence of their marriage, of the emotional stability of the individuals involved and of their ability to grasp all the psychic implications” of the therapy.55 Only then should he treat the woman as she requested.

While no one within the medical profession openly challenged Guttmacher’s assumption that doctors needed to act paternalistically in sometimes denying treatment to healthy fertile women seeking babies, not all practitioners accepted his criteria. The controversial New York City doctor Frances Seymour, for example, did not agree that the “deserving” would-be mother need be married. Seymour told newspaper reporters in 1934 that she had inseminated several unmarried “businesswomen” who desired a child. She was less interested in marital status and more in IQ, being explicitly eugenic in her goal of aiding reproduction by the fittest.56 The few doctors who were willing to publish cases from their practice of artificial insemination in the 1930s and 1940s shared the paternalism of Guttmacher and Seymour. While some admired and emulated Seymour’s eugenic approach, they also tended to agree with Guttmacher that donor insemination was a treatment only appropriate for happily married women.57

In this area of reproductive medicine, as with abortion, Guttmacher was mindful of women’s behavior when denied medical treatment. He (and other male colleagues) believed that some women, refused a medically-performed insemination, would reject adoption in favor of what they suspected was a time-honored, respectful practice of taking a non-marital sexual partner to achieve a pregnancy.58 By offering “deserving” women donor insemination, he saved them from adulterous liaisons. Still, not all women were deserving. Despite his awareness of the discriminatory way in which doctors performed therapeutic abortions,
Guttmacher revealed no concern that allowing the predominantly white, native-born, middle-class, male doctors to decide who deserved conception assistance might be equally discriminatory. Just as he was ultimately willing to put his faith in medical paternalism with respect to abortion, eliminating all legal controls, he evidently trusted that while some doctors might refuse to perform donor insemination altogether, and others might take a very narrow view of the deserving, in a non-legally restrictive environment, truly deserving women had a reasonable chance of finding a doctor who would say yes.

Guttmacher's confidence in the ability of medical paternalism in the absence of legal constraints to get it right was undoubtedly bolstered by his conviction that not all would-be parents were deserving of conception assistance, and by his experience with abortion in New York. After legalization, Guttmacher worked with other doctors to set up clinics where women from New York and elsewhere could receive abortions on request from doctors willing to perform them. He believed that there were enough doctors willing to perform abortions on request that the non-participation of other doctors was not a barrier to women's access. He did not live to see the professional marginalization of and terrorist attacks on “abortion doctors” after legalization, the steep drop-off in doctors trained to perform abortions in the decades after Roe, and the increasing practical and legal hurdles placed on women’s access to safe abortions throughout the United States.

While there was no “doctor’s dilemma” with respect to assisted conception because there were no laws criminalizing or regulating its performance, there was a legal problem that concerned Guttmacher because it threatened his goal in treating married deserving women: creating a legal family in which his patient and her husband were the parents of the child she bore. In 1936, Seymour and her husband and fellow doctor, Alfred Koerner, published an article in the prominent Journal of the American Medical Association discussing the “medicolegal aspects” of donor insemination. At law, donor insemination seemed very much like adultery resulting in conception. Adultery was grounds for divorce, and the legal presumption that a child born within marriage was legitimate could be overturned in many states by a showing of the husband’s sterility. Seymour and Koerner published the form that they asked each husband and wife to sign before treatment, attesting to their understanding of and consent to donor insemination. A half-century later, bioethicists would advocate for signed consent forms designed to promote informed consent and thereby to constrain medical paternalism by provid-
In 1942, when he reported on 27 cases of donor insemination, Guttmacher included five rules he followed: maintain complete donor anonymity, treat only deserving couples, proceed only if both would-be parents are eager, forget signed papers, and keep fees low. In Guttmacher's view, if this approach did not yield legally recognized families, the fault lay in outmoded interpretations of common law principles, what he called "balderdash." Guttmacher wanted the details of donor insemination, including patient selection and donor selection, left to medical paternalism and the self-policing of the medical profession. This position matched the endpoint of his odyssey on abortion regulation, removal of abortion from the penal code. This, he explained in 1969, would leave abortion, like "all other medical matters," under the medical practice act. He envisioned that without legal interference, "physicians could then work out their own ground rules [for abortion] with concurrence of the Board of Medical Examiners,... eliminating interference by legislators, State's Attorneys or police officers." The partial criminalization of abortion had created the doctor's dilemma because it left "the medical profession...confused as to the role they [sic] should play." There was no need to introduce such confusion into the practice of assisted conception. But Guttmacher thought it was "very important" for states to enact positive laws "legitimizing a baby sired by [donor insemination], if preceding the insemination the husband has given written consent." The law's intervention was needed, not to interfere with medical discretion but to authorize medical discretion.

Even at a time when he still supported some legal restrictions on abortions, he did not advocate for legal paternalism in assisted conception. Guttmacher did not want states to save women from foolish reproductive choices by passing laws distinguishing between therapeutic and criminal assisted conception. He used the example of the only regulation of donor insemination anywhere in the country until the mid-1960s to explain his opposition. In 1948, New York City had amended its municipal code to regulate sperm donors, although not artificial insemination itself. Guttmacher, having practiced donor insemination in Baltimore and New York City, found "no difference" and "no practical value" in the regulation. Denying that regulation was "either necessary or practical," in 1964 Guttmacher stated his views on the appropriate regulation of assisted conception, which in his opinion was self-regulation by the profession:

After all, medicine rises and falls on the integrity and moral standards of the physicians composing the profession. There is opportunity for irregular practices and cheating in all phases of medicine from allergy to surgery. All that can be done is for medical leaders to lay down the ground rules of ethical conduct by example and hope that they will be adhered to, with at times policing from within such as is now done by hospital tissue committees. It is obvious that it is far simpler for the profession to regulate hospital than office procedures and since artificial insemination falls within the latter category regulation is difficult.
was that even when well-respected, elite doctors used the procedure based on their best medical judgment, this judgment might be undermined by courts rejecting the newly created families. Therefore, according to the AMA, "legislation would seem to be clearly indicated."83 The Association agreed with Guttmacher that medical paternalism needed positive legal support in order to confirm a doctor's choice to treat childless couples by assisting conception.

Despite this AMA pronouncement, such legislation did not pass for another decade. Although small-scale studies showed that couples that had conceived via donor insemination were happy with the results, and frequently sought additional children by the same technique, the public at large and many doctors remained deeply skeptical.84 Even in the 1960s, a major university hospital refused to perform donor insemination in order to avoid controversy.85 This caution by some segments of the medical community did not constrain Guttmacher and untold numbers of his colleagues from practicing assisted conception by donor insemination, occasionally reporting the results in the medical literature.86

During the same decades that states passed abortion reform laws or repealed abortion regulations entirely, states also passed the laws legitimating donor children. The first such law passed in Georgia in 1964. Georgia's law declared:

All children born within wedlock or within the usual period of gestation thereafter who have been conceived by means of artificial insemination are irrebutably presumed legitimate if both spouses have consented in writing to the use and administration of artificial insemination.87

The statute also included a provision that criminalized the performance of artificial insemination by anyone other than licensed physicians.88 More states adopted such laws after the National Conference of Commissioners on Uniform State Laws issued the model Uniform Law of Parentage in 1973, which included a similar provision legitimating donor children.89 These laws alleviated medical worries by ensuring that donor insemination performed by a doctor resulted in a legal family. They also, however, created legal restrictions on artificial insemination for the first time, banning lay inseminations, and suggesting that sperm donors were legal fathers of donor-conceived children born to unmarried women, an outcome troubling to donors, birth mothers and lesbian co-parents.

Guttmacher did not experience such laws as creating a doctor's dilemma because they embedded existing medical assumptions into law. Guttmacher and other practitioners largely agreed that only married women were eligible for treatment, that husband consent was as important as wife consent, and that the practitioner needed to be a licensed physician.90 Instead of feeling constrained by this legal paternalism that prohibited women from establishing fatherless families, Guttmacher welcomed what he called these “new and specific” statutes regulating assisted conception as a sign that the law was “catching up” with medical progress.91 He continued to hold fast to his “credo” that emphasized the physician’s role in selecting the couple and the donor, “rules” that Guttmacher thought were so self-evident by 1960 that they needed no explanation.92 In concession to the new laws, he replaced “forget signed consents” with a new “rule” that the physician require the husband and wife to sign a consent form.83

Guttmacher’s acceptance of the donor insemination laws that created new legal restrictions on access to the technique underscored his attitude toward all aspects of reproductive medicine: that unfettered medical paternalism rather than woman-directed choice was the best way of protecting women's health. He saw reproductive procedures involving decisions whether and when to bear children as like other medical procedures. In seeking medical assistance, any woman became a patient and the doctor was the final arbiter of what was best for the patient, when performing an appendectomy or assisting conception. Even healthy and fertile women were included in this patient model; considering those he might treat as consumers was outside of Guttmacher’s understanding of the medical profession. Doctors always had the right to “counsel against abortion” and to refuse to inseminate undeserving women.94 As professionals, doctors were not technicians to be ordered by law or by laypersons to perform tasks, or retailers from which services could be purchased, but instead were always exercising their skills and knowledge according to their best judgment, judgment that was inherently superior to lay judgment.

Medical Paternalism and 21st Century Reproductive Medicine

In the years since Guttmacher’s death in 1974, medical paternalism has become the object more of scorn than of veneration. The women's health movement, critiques of human subject research, and the emergence of bioethics have all emphasized the dark underbelly of unfettered medical discretion, and the damaging choices made by doctors in deciding who was "deserving" of treatment. In place of a doctor-knows-best model, both bioethicists and women's health activists have worked to shift the balance of power so that the
doctor-patient hierarchy becomes a collaboration, or even, more like a service provider/consumer relationship. A consumer model of medical care was designed to reduce the harmful effects of medical paternalism.

This shift is perhaps nowhere more apparent than in assisted reproductive medicine. While women might wish doctors to make decisions on their behalf mid-appendectomy, beginning in the 1970s they increasingly rejected the notion that it was appropriate, for example, for doctors to decide that women not married to men lacked the necessary “indications” for assisted conception treatments. When healthy women are making reproductive choices, and then seeking medical assistance to actualize those choices, the consumer model of medical care, becomes even more compelling. This model has been embraced not only by the feminist women’s health clinics of the 1980s and 1990s, but by the for-profit fertility clinics where Americans increasingly buy assisted reproductive services. The absence of much or any insurance coverage for assisted conception has accentuated the tendency of both providers and would-be parents to consider fertility treatment in consumerist terms.

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cal paternalism is inherently variable, flexible, and malleable, while the law is more rigid, necessarily universal rather than individual, and slower to change. It is legal paternalism that threatens women’s abortion access today, through state regulations designed to constrain decision-making about abortion and drive abortion providers out of the practice. In assisted conception, too, legal paternalism is causing problems, as the earliest donor insemination laws are causing dilemmas for women and doctors alike. Some doctors wish to exercise their discretion to treat unmarried women, and some women seek to use donor sperm without the intervention of a licensed doctor. Under some state laws, the intentions of such persons to avoid any parent/child relationship between sperm donors and resulting children may not be respected.

As the demographics of the medical profession have changed to include significantly more women and non-European Americans, the range of “personal answers” to the questions of reproductive treatments also has shifted, and will continue to shift, reducing the tendency of a nondiverse medical profession to use its discretion to reinscribe hierarchies that maintain the superiority of its members. If such informal protection against the harms of medical paternalism is insufficient, we can find additional reassurance in
the ways the medical consumer model has been institutionalized and legalized through informed consent procedures and regulations, and in new laws requiring public disclosure of medical outcomes and non-discrimination in health care. These changes encourage the weakening and restraining of medical paternalism by the marketplace. This reading suggests that the current lack of regulation of assisted reproductive is optimal, although perhaps imperfect.

We could read this comparative history slightly differently, however, to consider the beneficial role medical paternalism has played in reproductive medicine. As Guttmacher was aware, the involuntarily childless have long been easy prey to shysters offering cures, causing them to put their finances and health at risk in the absence of paternalist gatekeeping. Benevolent medical paternalism included turning away patients whom a doctor could not help. Even with his optimistic view of medical paternalism and the ability of the medical profession to self-regulate, Guttmacher realized that unfettered medical discretion combined with easy money could overcome professional obligations of paternalism. Relying on the marketplace to weaken and restrain medical paternalism can be as harmful as medical paternalism itself. Patient demands for fertility treatment could lead to decisions to treat that were not for the good of the patient so much as for the good of the doctor’s bank balance, an outcome arguably present in contemporary reproductive medicine.

Guttmacher attempted to prevent this failure of medical paternalism leading to harmful overtreatment by cautioning doctors treating the infertile to “keep fees low.” Further, while both legal and medical paternalism can result in access barriers that replicate existing conditions of inequality, eliminating paternalisms does not ensure that women’s power to act as reproductive medicine consumers is equality-enhancing. Just as Guttmacher saw in the abortion black market, markets replicate existing inequalities, as well as allowing inferior goods and unnecessary services to be sold. The weakening of medical paternalism through a consumer model can exacerbate such harms, even though it is cloaked in language of promoting patient agency.

From this perspective, assisted reproduction might be a context in which what Guttmacher once called “new and specific” legal paternalism is warranted. That paternalism, however, might be most appropriately directed not at women, to save them from their own decisions, but rather at their doctors, who have too much incentive to treat, and too little to refrain from treatment. Such laws, while still constraining women’s (and men’s) choices, would in some ways be the opposite of the 19th century abortion laws, passed to improve the economic lot of the regular physicians. Instead, laws might limit profiteering, what Guttmacher called a “racket” in which doctors lose sight of their professional obligation to use their expertise to act in the best interest of their informed, empowered, but still less expert patients. Considering legal paternalism as a means of channeling or replacing medical paternalism in assisted conception provides a starting place for consideration of regulation that promotes women’s equality and agency, rather than undermines it.

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References
4. In order to focus on paternalism, this article sets aside regulatory justifications based on social harm, and harm to the fetus, although these justifications also have a long history. See, for example, R. Siegel, “Reasoning from the Body: A Historical Perspective on Abortion Regulation and Questions of Equal Protection,” Stanford Law Review 44, no. 2 (1992): 261-381, at 287-313.
9. The relationship between equality and reproductive rights is reviewed, for example, in R. B. Siegel, “Sex Equality Argu-


11. See Guttmacher, supra note 2, at 571.


15. See Guttmacher, supra note 1, at 6.


18. Id., at 8-9.

19. See Mohr, supra note 5, at 119-170; and Smith-Rosenberg, supra note 5.

20. See Guttmacher, supra note 6, at 756; see also Guttmacher, supra note 1, at 5.

21. See Guttmacher, supra note 3, at 111.

22. See Guttmacher, supra note 1, at 5; supra note 6, at 756-757.

23. See Reagan, supra note 17, at 67, 173-175. See also Luker, supra note 14, at 73.

24. Proof of such discrimination was collected at New York hospitals in the 1950s. See Guttmacher, supra note 1, at 6; and supra note 6, at 760-761.


26. See Guttmacher, supra note 1, at 5; supra note 6, at 757-758.

27. See Guttmacher, supra note 1, at 5-6; and supra note 6, at 759.

28. See Guttmacher, supra note 1, at 6.

29. See Luker, supra note 14, at 56-57; and Reagan, supra note 17, 173-181.

30. See Guttmacher, supra note 1, at 6; and supra note 6, at 761.


33. See Guttmacher, supra note 1, at 7.

34. Id., at 6.


36. Id.

37. See Guttmacher, supra note 1, at 6-7. But see Luker, supra note 14, at 94 (“by late 1970, of all women who applied for an abortion [in California] 99.2 percent received one”).

38. See Guttmacher, supra note 6; and supra note 16.


52. Id., at 75.
53. See Guttmacher, supra note 1, at 5.
54. See Guttmacher, supra note 51, at 75. As his confidence in the easy success of donor insemination increased, Guttmacher began to recommend a three month trial before making the invasive tests necessary to show female fertility if the woman was “apparently fertile.” Only if a woman failed to conceive with donor sperm would he then begin to look for an additional cause of the couple’s childlessness in her physiology. A. F. Guttmacher, “The Role of Artificial Insemination in the Treatment of Human Sterility,” Bulletin of the New York Academy of Medicine (August 1943): 573-591, at 585-586.
55. See Guttmacher, supra note 51, at 75-76.
57. See, e.g., Beardsley, supra note 56, at 95.
58. See Guttmacher and Pipel, supra note 19, at 583.
60. See Cohen and Cannon, Life in the Crosshairs [full cite needed] C. Joffe, Doctors of Conscience: The Struggle to Provide Abortion before and after Roe v. Wade (Boston: Beacon Press, 1995) at 145-208. These trends have also been documented in the reports of the Guttmacher Institute, an independent research institute, renamed in honor of Guttmacher after his death. See Jaffe, supra note 13, at 1-2.
62. See Swanson, supra note 44, at 592-593.
64. See Seymour and Koerner, supra note 61, at 1532.
66. These forms were thus similar to forms used to evidence patient consent to surgery during this period in order to reduce medical malpractice liability, although the focus was less on avoiding medical liability than on preventing family law problems. P. A. Lombardo, “Phantom Tumors and Hysterical Women: Revising Our View of the Schoenдорf Case,” Journal of Law, Medicine & Ethics 33, no. 4 (2005): 791-801, at 797-798.
67. See Seymour and Koerner, supra note 61, at 1532.
69. See Seymour and Koerner, supra note 61, at 1533; and Swanson, supra note 44, at 622-623.
70. See Guttmacher, supra note 51, at 77; and supra note 54 (1943), at 590.
71. See Guttmacher, supra note 51, at 75.
73. Guttmacher gave a paper at the Second Congress on Obstetrics and Gynecology on April 9, 1942, which was published both in the Journal of the American Medical Association, and in summary form, in the Western Journal of Surgery, Obstetrics and Gynecology. Guttmacher (1942), supra note 72 at 443, 445 (listing 4 rules) and Guttmacher (1942), supra note 72 at 358 (listing 6 rules).
79. Id., at 16.
83. Id., at 1640.
85. Letter from M. Edward Davis, M.D., Chairman, Department of Obstetrics and Gynecology, University of Chicago, to Dr. Wilfred Finegold, dated Dec. 11, 1963, copy in Folder 16, Box 11, Guttmacher Papers.
89. Uniform Laws Annotated, Uniform Act on Parentage (1973) Section 5A.
90. See, for example, W. J. Finegold, Artificial Insemination, 1st ed. (Springfield, IL: Charles C. Thomas, 1964): at 51 (describing unmarried woman seeking insemination as mentally ill).
91. See Guttmacher, supra note 2, at 583.
93. See Guttmacher, supra note 2, at 571.
97. See Swanson, supra note 80, at 227-228.


