



American Medical **Women's** Association

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American Medical Women's Association

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The American Medical Women's Association and the role of the woman physician, 1915–1990

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Nineteen fifteen was an eventful year for women in American medicine. Since the 1830s the number of women physicians had grown from a handful to more than 9,000, between 5% and 6% of all physicians. Then, after decades of formal exclusion, in 1915 the American Medical Association formally seated its first woman delegate, a signal to some women physicians that they had finally "arrived." Nevertheless, later that year a small group of leading women physicians established the American Medical Women's Association (founded as the Medical Women's National Association—the MWNA or simply the "National"—and renamed in 1937), the first nationwide organization of women physicians in America. But why, many asked, institutionalize the segregation of women physicians at the very moment when their professional integration seemed assured? Why create a separate national association for women?

AMWA has grappled with these questions throughout its 75-year history. It has attempted nothing less than to balance the distinctive interests and culture of women against the claims of disinterestedness, scientific objectivity, and professionalism of modern medicine. AMWA's history charts the effort to create a workable model of female professionalism, to serve the needs of both women and medicine, and to answer the question, "What does it mean to be a woman physician?"

Women's Medical Societies: The 19th Century Context

From the 1870s onward, women physicians founded more than 30 state, local, and institutional women's medical associations. Such societies sought to bridge the worlds of female social reform and the profession of medicine. Thus, while they were intended to facilitate the professional integration of women physicians, they also reinforced the Victorian conception of gender as "separate male and female spheres." For Victorian women physicians, in fact, medicine was *ideally* practiced in the "woman's sphere." Women gained entry into the hitherto masculine profession of medicine because their distinctively feminine qualities were considered essential to the delicacy and modesty of Victorian women and girls. Whether in private or institutional practice, the work of Victorian women physicians was largely bounded by gender. By providing

a comfortable setting for presentation of case reports and reviews of the medical literature as well as a setting for "sisterly" networking, women's medical societies provided a training ground in collegiality for women physicians. Yet they also provided a forum from which to attend to the traditional "social housekeeping" concerns of Victorian women, particularly the general well-being of women and children. Women's medical societies and hospitals thus were intended to link the values of Victorian social feminism to the increasingly complex culture of modern medicine.¹

World War I

Yet, by 1915 the rationale for all-women's medical associations was weakening. Basic assumptions about the nature and role of women in American society were shifting, a challenge to the women who founded the MWNA. By 1915, the monolithic Victorian notion of gender, a habit of mind dividing all culture into distinctive masculine and feminine spheres, was crumbling. The movements for higher education, coeducation, and suffrage for women were expanding the bounds of "woman's sphere." The majority of women physicians before 1890 attended all-women's medical colleges. By 1900, however, most women medical students were graduating from coeducational medical schools.

In short, the professional niche for women in medicine was eroding on all fronts. Between the 1880s and the 1930s, the theoretical, institutional, and moral underpinnings of the professions were being rapidly transformed. Professionalism, formerly bound up with gender-linked character norms—such as "strength of character" or "tender care"—now was to be measured according to "objective," scientific standards of education and expertise. For physicians, the older tradition of environmental, moralizing, gender-specific medicine was replaced by an ethos of reductive, biomedical science and clinical specialization. Medical practice, formerly structured according to gender, race, and social class, now obscured these phenomena behind an impersonal mask of bureaucracy, technology, and experimental science. Gender-specific institutions of any kind were losing their rationale. An all-women's medical society, even a national association, by 1915 no longer could count on the unquestioned support of its "natural" constituency, women physicians.

"Assimilation" had replaced "integration" as the goal of many women in medicine.

The founding of the MWNA thus coincided with the redefinition of gender norms, professionalism, and medicine itself. The National's early leaders fully grasped their paradoxical position. An all-women's medical society was by no means an inevitability. They were confident that the organization could foster the professional visibility and standing of women in medicine. Yet, as they also realized, many women physicians wished to be *invisible*—or at least inconspicuous. By advancing its cause, the MWNA risked alienating its constituency.

Therefore, when the prominent Chicago obstetrical surgeon, Bertha Van Hoosen, invited a small group of women to meet at the Chicago Women's Club on November 18, 1915, during the week-long 50th anniversary celebration for Mary Thompson Hospital in Chicago, she selected only those whom she knew to be "enthusiastic for organization." Marion Craig Potter, a veteran organizer from Rochester, New York, took the chair. As her first action, she moved that Dr. Van Hoosen be named acting president. By the end of the day concrete plans were laid for a Medical Women's National Association.

Drs. Van Hoosen and Potter had invested many years in advancing the cause of women physicians. Launching "the National" was the culmination of their efforts. Dr. Van Hoosen later recalled the, for women physicians, "dreary" experience of attending annual meetings of the American Medical Association; women who had once stood united outside the institutions of organized medicine, now were on the inside, "sitting alone."² In response, when the AMA met in Chicago in 1908 Dr. Van Hoosen persuaded the Medical Women's Club of Illinois, the Chicago Medical Women's Club, and the Women's Alumnae of the AMA to hold a banquet for women physicians attending the meeting. Marion Craig Potter, a principal founder in 1907 of the Women's Medical Society of New York State and an editor of the *Woman's Medical Journal*, addressed the after-dinner symposium on "Organization." Basing her remarks on her recent organizing successes in New York, she urged her colleagues to establish a national organization for medical women. Her audience, however, was "evenly divided for and against national organization." Between 1908 and 1915, prominent medical women like Dr. Potter used the annual women's banquet to preach the gospel of "organization" to medical women. Yet even Dr. Van Hoosen was skeptical of the need for a national association until she witnessed the crippling divisiveness plaguing women physicians in the absence of one strong, central voice.³

Certainly by 1915 both Drs. Van Hoosen and Potter knew that the future of women in American medicine was far from assured. Between 1904 and 1915, many financially weak medical schools succumbed to external pressures to close their doors, while others—taking their cue from Abraham Flexner—drastically curtailed enrollments. Yet while the total number of medical graduates dropped from 5,574 to 3,536, a decline of 37%, women

graduates declined from 198 to 92, a decline of 54% in the same period. From a steady rise to 6% of all physicians in 1910, the number of women practitioners dropped back to the 5% level by 1920. Never were women in medicine more in need of a powerful, united voice.⁴

Perhaps the strongest plea for unity was offered by the philanthropist Mrs. George Bass of Chicago to the 12 women assembled in Chicago to organize the MWNA. She urged them "not to be afraid of grouping yourselves together, not to antagonize or to fight the men in your profession, but to obtain fuller opportunity, wider recognition, and greater success."⁵ The National's original statement of purpose was couched in positive terms: "to bring Medical Women into communication with each other for their mutual advantage, and to encourage social and harmonious relations within and without the profession." Its theme was harmony, not dissonance, or, in the words of the *Woman's Medical Journal*, "Amalgamation, not Separation."⁶

The original roster of offices included a president, president-elect, three vice-presidents, recording secretary-treasurer, and corresponding secretary. The office of president, of course, went to Dr. Van Hoosen herself. Eliza Mosher, first dean of women at the University of Michigan, became honorary president, and Marion Craig Potter, first vice-president. The *Woman's Medical Journal* (renamed *Medical Woman's Journal* in 1921) was made the MWNA's official publication with Mrs. Margaret Rockhill, editor, as corresponding secretary. Membership was divided into three categories: full, dues-paying members with voting privileges (dues were \$2); associate members; and honorary members.⁷

By the time of the National's first Annual Meeting in June 1916, President Van Hoosen knew it faced an uphill climb. After its first six months, the organization had received only \$306 in dues from—at most—a membership of 153 women. With approximately 6,000 women physicians—active and retired—in 1916, this meant fewer than 3% had chosen to join the National. Low membership might have reflected mere lack of interest, but outright opposition to the organization also surfaced. One woman, chosen to be one of the National's first slate of councillors, asked that her name be removed from the list. At the AMA's annual convention in 1916, some women physicians, notably from California, circulated a petition opposing the MWNA as divisive and retrogressive.⁸

Dr. Van Hoosen's strategy was straightforward: to convince women physicians, first, of the need for cooperative action by women in medicine; and, second, that the National could be a positive force for women in the profession. As a first step she organized committees on women's hospitals, internships, postgraduate work, and scholarships. Beginning in 1917 the Committee on Internship (later renamed the Committee on Medical Opportunities for Women) surveyed hospital internships open to women. The Committee documented for the first time the scarcity and uneven quality of postgraduate training for women. The Committee's sobering findings served a second pur-

pose. They also demonstrated that acting collectively through a national organization, women could increase their effectiveness as lobbyists without sacrificing their credibility as professionals.⁹

Yet without the United States' entry into World War I on April 2, 1917, the MWNA might never have gotten off the ground. The war stimulated an immediate infusion of interest in the MWNA.¹⁰ Many women doctors were eager to join their male colleagues in the military medical corps. Overseas war work offered many opportunities for professional advancement. Physicians were recruited primarily through the Army Medical Reserve Corps, from which, as it turned out, women were legally excluded. Directly after President Woodrow Wilson's declaration of war, however, Dr. Van Hoosen offered the services of the National's membership in the medical reserves as did other women's groups in California and Colorado.¹¹

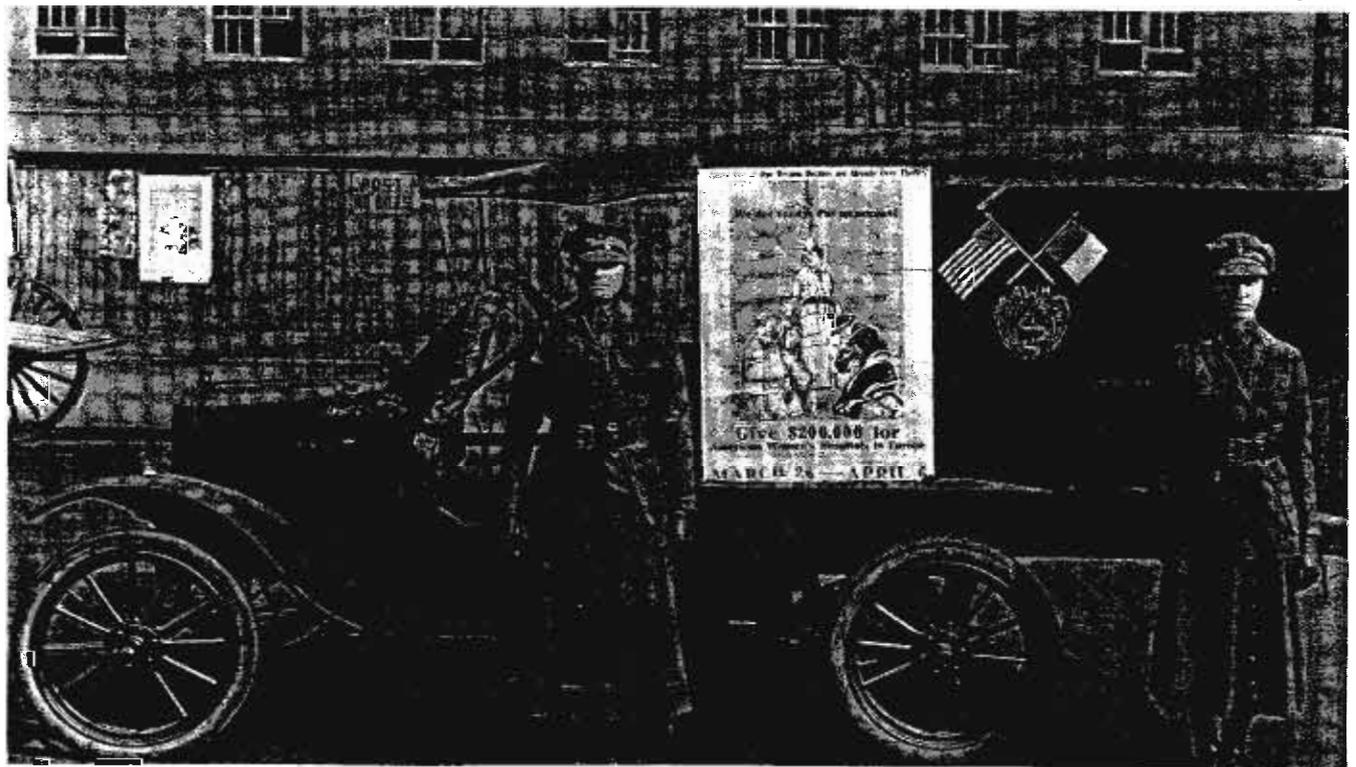
The War Department's refusal to accept women physicians gave the MWNA a chance to justify its claim to the loyalties of all women doctors. By June 1917, when the National held its second Annual Meeting in New York, membership had more than doubled since the previous year. Dr. Van Hoosen fully realized the importance of this meeting for the organization's future.¹² By the end of the meeting, the MWNA agreed to form a War Service Committee chaired by the Virginia-born, New York surgeon Rosalie Slaughter Morton. Its purpose was twofold: to lobby the War Department for military commissions for women physicians, and, in the older tradition of women physicians, to care for civilian war victims, primarily

women and children. Within weeks the War Service Committee renamed itself the American Women's Hospitals Service (AWH).¹³

The AWH could not persuade the War Department to commission women physicians. But by the end of the fighting in November 1918, it launched a spectacularly successful mission to deliver voluntary medical relief throughout the world. By the end of the war the AWH had successfully won Red Cross backing to send women's hospital units overseas and had raised nearly \$200,000 for the purpose.¹⁴ Close to 130 women physicians, dentists, nurses, ambulance drivers, and general purpose assistants, working either directly for the Red Cross or, wearing the AWH insignia and working directly for AWH units, served in France, Serbia, and Greece. By 1920, the AWH was operating 9 hospital units and approximately 20 dispensaries.¹⁵

Thus began work that continues up to the present day: sponsorship of voluntary, all-women's hospitals and clinics, public health and preventive medicine projects, prevention or control of epidemics, nurse training, social welfare programs for needy mothers and children, and professional support for women physicians around the world. By the 1950s, American Women's Hospitals services extended to Asia, Latin America, and, beginning during the Depression, to impoverished Appalachian communities in the United States. From 1959 until 1982 the AWH reincorporated under its own name for tax purposes, but since then it has continued as a constituent part of AMWA. Except during emergencies or war, the AWH

Unless otherwise noted, all photos courtesy, Archives and Special Collections on Women in Medicine, Medical College of Pennsylvania, Philadelphia.



AWH workers with a fund-raising poster during World War I.

nowadays emphasizes preventive medicine, public health, and family planning, rather than the acute care of the modern hospital. By 1969 the AWH was sponsoring medical, health care, and social welfare services in 11 countries. Carrying on the tradition of 19th century women physicians, the AWH retains its commitment to health care, broadly conceived, rather than to the narrowly biomedical approach of much 20th century medical care. The long-term, utterly modern goal of the AWH is the transfer of control over its foreign services into the hands of local women professionals and lay workers—many of whom are trained by the AWH.¹⁶

The work of the American Women's Hospitals during World War I possessed both intrinsic and symbolic value to the MWNA. Yet, its very successes presented the leaders of the National with an unexpected challenge. As the National's War Service Committee, the AWH was conceived as a temporary response to the professional and medical crises produced by the war. Neither Rosalie Slaughter Morton nor Bertha Van Hoosen could have envisioned its future scope. As the accomplishments, the prestige, and the financial basis of AWH operations grew more substantial, however, the AWH threatened to overshadow its parent organization. The *Medical Woman's Journal* in 1921 even claimed that the AWH's success "alone should justify the existence of the National Association."¹⁷ The appointment of Esther Pohl Lovejoy to head the AWH eventually resolved the tensions created by the independence and strong public presence of its "committee." Dr. Lovejoy, MWNA president in 1932–1933 and a veteran wartime organizer for the Red Cross in Europe, directed the AWH from 1919 until her death in 1967. In 1919 she also helped found the Medical Women's International Association. Although Dr. Lovejoy made the AWH her life's work, as her successes mounted she always acknowledged her ties to the Medical Women's National Association.¹⁸

Between the Wars

In 1920, Martha Tracy, dean of the Woman's Medical College of Pennsylvania and president of the MWNA, while addressing the Interim Meeting of the National, articulated what continues to be the organization's agenda. While conceding that women physicians should not be "separated from men in a scientific way," still, she insisted, the National must "live to promote special work for women and children." The postwar decade presented ample opportunities to pursue both goals: professional advancement *and* concern for women's health care. Yet by 1930 the organization's social vision began to fade, finally to reemerge three decades later.¹⁹

The Medical Women's National Association emerged from World War I far stronger than it had been at its outset. In fact, between 1916 and 1926 it could boast a comfortable increase in individual members from about 150 to 450, plus approximately 100 new group members. While this figure—about 8% of all women physicians—could not

compare to the nearly 48% of women physicians who belonged to the AMA in 1925, these were quite respectable gains for a fledgling special interest group such as the MWNA.²⁰

Behind this modest advance lay a combination of factors. For one, the enormous publicity and respect generated by the work of the AWH certainly added to the prestige of its parent organization. In 1924, for example, Esther Pohl Lovejoy announced to the MWNA Annual Meeting that the AWH had raised more than \$2 million since the war for its overseas relief work. An editorial in the *New York Times* praised its work alongside that of the International Red Cross and the Rockefeller Foundation.²¹

Second, under the farsighted guidance of Kate C. Hurd-Mead, MWNA president, a Five-Year Plan was established in 1923 to increase membership, advance the professional interests of women medical students and physicians, and to cement the organization's ties to medical and lay women by promoting affiliations with local women's medical societies and the General Federation of Women's Clubs. In perhaps its most far-reaching initiative, the National explicitly sought to reach out to its traditional constituency—women and children—through public health initiatives in each state.²²

One of the earliest signs of the National's solidifying organizational identity came in 1922 when it voted to end its official ties to the *Medical Woman's Journal*, and began editing and publishing its own official publication, the quarterly *Bulletin of the MWNA*. As the *Bulletin's* first editor, Grace Kimball of San Diego, recalled, the decision resulted from the "unanimous" opinion of the members, "that the affairs and interests of a national Association could be efficiently and satisfactorily handled only by a publication devoted entirely to its own interests and run entirely by its own officers." Financial concerns may have also played a part. By publishing a modest quarterly supported by advertisements, and by raising dues from \$2 to \$3, the Association began to build up a modest endowment.²³

To increase membership, in 1923 the National voted to alter its constitution to create the new category of group membership. Within two years, 15 constituent groups had affiliated with the national association. Likewise in 1925 Dr. Hurd-Mead proposed establishing junior memberships in the National, an innovation, however, that took many years to accomplish. In 1925, the National did offer its first two student scholarships, a result of two initial gifts of \$1,000 and \$500, as a way to create "professional heirs."²⁴

The first consolidated Committee on Medical Opportunities for Women was formed in 1920. Under Dr. Van Hoosen's leadership from 1924 onward, the Committee vigilantly documented the slippage in medical women's professional status by documenting the limited number and mixed quality of internships available to women, the scarcity of women with academic appointments, and the low number of papers presented by women at mixed gen-

der professional meetings. With 180 out of 643 hospitals accepting female interns and the many other institutional positions available, Dr. Van Hoosen believed, "We need an army to fill the positions now open." The problem, as she saw it, was to interest more women in a career in medicine in the first place. Yet a glance at Dr. Van Hoosen's list of job categories suggests that even in her own eyes, women physicians were still expected to work within their own "separate sphere"—like it or not. The "opportunities" she identified, besides internships and scholarships, stressed public health positions, vacancies for women in state institutions for the insane, resident physician appointments in schools and colleges and hospitals, opportunities as medical missionaries, and assistantships to private surgeons and groups—the traditional settings for women in medicine.²⁵

In one respect, however, the 1920s offered great promise for women physicians. The ratification of the woman suffrage amendment in 1920 held the promise of a powerful new feminine electorate. Ever prudent, politicians at first willingly listened to the concerns of their female constituents. Anticipating its own potential strength, the powerful remnant of the suffrage lobby took advantage of this favorable political climate by creating a new vehicle for social feminist reform, the Women's Joint Congressional Committee. The WJCC, founded in 1920 to lobby for progressive style "women's issues," consisted of organizations such as the League of Women Voters, the PTA, the General Federation of Women's Clubs, the National Consumer's League, and, after 1924, the MWNA.

Virtually the first bill the WJCC lobbied for was the pioneering legislation to protect prenatal, maternal, and child health known as the Sheppard-Towner act of 1921. The prominence of MWNA leaders in this effort attests to the continued identification of women physicians with the broad reformism of social feminism.²⁶ Because Sheppard-Towner established prenatal and child health clinics with state and federal funding it was almost immediately opposed by the American Medical Association. The MWNA's own growing detachment from the bill during the 1920s, while never as sharp as the AMA's, reflected an ideological shift by organized women in medicine from progressive social feminism to the individualism of modern professionalism.

Originally introduced as a "baby bill" by Representative Jeanette Rankin of Montana in 1919, the prenatal and child health measure was reintroduced in 1920 and 1921 by Representative Horace Towner of Iowa and Senator Morris Sheppard of Texas. No less than four future presidents of the MWNA, Kate C. Hurd-Mead, Ellen C. Potter, Esther Pohl Lovejoy, and S. Josephine Baker testified on behalf of the bill. Indeed, at the urging of Dr. Hurd-Mead, at its Annual Meeting in June 1921 the National passed a resolution to "urgently recommend" its passage.²⁷ The Sheppard-Towner Act became law on November 23, 1921. Congress permitted its renewal in 1927 after a bitter debate, but only for two years. In 1929 it was allowed to lapse.²⁸



S. Josephine Baker, MD, first director of the Bureau of Child Hygiene of the New York City Health Department and MWNA President, 1935–1936.

The act established prenatal and child health centers emphasizing preventive medicine and public health through maternal education, well-baby exams and instruction (from public health nurses) in personal and child hygiene (broadly interpreted to include nutrition, exercise, proper clothing, as well as disease prevention and cleanliness). Funding was administered to the states through the US Children's Bureau, headed by Miss Grace Abbott, through the Division of Infancy and Maternity. Division Chief Blanche M. Haines was a former secretary of the MWNA. Additionally, matching funds were given to any state putting up \$5,000 of its own money.²⁹ The bill represented the first time federal money was used for a "social welfare" purpose. Perhaps for that reason, and to combat opposition from local private physicians, the Children's Bureau relied heavily on the local organizing and lobbying efforts of the General Federation of Women's Clubs, which initially supported the bill.³⁰

Between 1924 and 1929, when the bill lapsed, 2,978 prenatal and child health centers were established at least in part using Sheppard-Towner money. During its final 4 years, 4 million infants and expectant mothers were reached. Perhaps most significant was the law's educational function. Almost 20,000 classes were held, often taught by public health nurses, to instruct midwives, mothers, and girls in child health and hygiene.³¹ Sheppard-Towner also benefited women physicians, as MWNA leaders fully understood. In 1927, of the 43 participating states, 16 had women physicians as directors. Forty-three of the 89 full-time physicians employed by the program were women. Seventeen others worked directly for the Infant and Maternity Division of the Women's Bureau.³²

Despite these accomplishments, as the decade progressed, opposition to the bill grew stronger as a general political shift to the right took hold in America. One senator labeled it the "Bill to Organize a Board of Spinsters

to Teach Mothers How to Raise Babies." Primarily, though, opposition to "state medicine" by the AMA, conservative political groups, and several influential state medical societies, arose from a growing hostility to anything smacking of "communism." As in the debate over compulsory health insurance during the previous decade, conservatives within and without the profession accused supporters of "tending to promote communism." In the words of the rabidly conservative Illinois State Medical Society, "the beast [compulsory health insurance] gave birth to a litter answering to the name of . . . the Sheppard-Towner bill." Although it was a close vote, in June 1921 the AMA endorsed "all proper activities and policies of state and federal governments directed to the prevention of disease and the preservation of the public health." That was the last favorable action on "state medicine" to come out of the House of Delegates for decades to come. In the words of an angered supporter, any suggestion of government participation brought "howls from the extreme Right and induces, as sequelae, editorials in the *JAMA* eulogizing the tender economic relation between the physician and his patient, a very intimately personal relation."³³

Yet the AMA's position was more complex than this. It valued both the merits of preventive medicine and its usefulness in building up the practices of the still too abundant general practitioner. Nor did it wish to be seen by the public as opposing medical care for the poor. Thus alongside its negative campaign against the maternal-child health act, it also set forth its own positive approach to preventive medicine, including launching a new magazine, *Hygiae*, aimed at the laity. The AMA also began promoting the presumed benefits of a "periodic health exam," better known today as the yearly "physical."³⁴

During the mid-1920s, the MWNA's ideological center also seems to have changed focus. Until then it identified strongly with the traditional social housekeeping goals of the progressive era. In this context, it is hardly surprising that the MWNA chose not to support the National Woman's Party in 1924 when it first proposed the Equal Rights Amendment. Taking the advice of Alice Hamilton, Hull House resident and pioneer industrial toxicologist, MWNA delegates voted down the ERA as a potential threat to the protective legislation for working women long sought by progressive reformers. The National's leaders still saw the primary social identity of the woman physician as the protector of the sick and powerless. By the end of the decade, however, the organization began to identify less with the obligations of the social reformer than with the rights of the professional physician. Not unlike the AMA, its promotion of "positive health" was aimed at a private, not a public, constituency.³⁵

Thus although historians have contrasted the AMA's hostility toward the Sheppard-Towner Act with the uncompromising support given by the MWNA, the National's position was both more complex and less unchanging than has often been reported. For S. Josephine Baker, it is true, the prospect of what she called "state medicine"

held no terrors. Rather, as she later wrote, "State medicine is to my mind an ideal, and the sooner it changes from an ideal to a practical reality, the better off the human race will be." Louise Tayler-Jones, chair of the MWNA's Committee on Legislation, also supported the bill to the end. But Drs. Baker and Tayler-Jones occupied only one end of the continuum of opinions held by MWNA leaders.³⁶

In reality, as organized medicine's opposition to government intervention grew more pronounced, the MWNA's position also shifted. Faithful as ever to the principles of health education and preventive medicine, it nevertheless began to align itself with the values of the private physician. In short, it actively promoted "positive health," but through the combined auspices of women's clubs, medical societies, and public health departments. As the Public Health Education Committee chair reported as early as 1921, positive health promotion was "consistent with the ideals and standards of medical practice [and] furnishes the basis for promotion of positive health education by physicians in accordance with the ethical and economic requirements of the medical profession." Thus the National's 1923 Five-Year Plan included a section on public health calling for coordinated work with both the AMA and the Women's Foundation for Health. By 1925 the updated Plan called on medical women to introduce the public health programs of the AMA and the Women's Foundation to "all organizations and clubs of Lay Women." As the National bowed to the conservative political realities of the 1920s, state funded programs targeted at the poor began to take a back seat to private medical care for the middle class.³⁷

More and more as the decade wore on, the National looked to alliances with state and local women's clubs to introduce programs of preventive medicine. (And, in fact, by 1928 the Federated Women's Clubs had resigned from the WJCC.) Sheppard-Towner thus became the vehicle by which the MWNA cemented its ties to the private sector, in keeping with the goals of its Five-Year Plan. Lena K. Sadler, chair of the MWNA Committee on Public Health in 1927, articulated the newly emerging position at the 1925 Annual Meeting: "I wish to say that the Sheppard-Towner Bill, fortunately or unfortunately is not functioning in the State of Illinois . . . Personally it is nothing to me, whether it functions or not, because I believe my record is behind me . . . I believe in every educational feature of that Bill, but when organized medicine is against it in my state, I must do something with the clubs to take its place." Working together, Dr. Sadler, the Illinois Department of Public Health, the Federated Women's Clubs, and the state medical and dental societies began a jointly sponsored program of examinations of the preschool child. "It is a five-year program," Dr. Sadler commented, "and by that time we hope to make it the custom for parents to have their children examined before entering school." Dr. Sadler was too tactful to say so, but surely she envisioned these future examinations in the offices of private physicians.³⁸

Thus, by 1926 when the fight to renew Sheppard-Towner beyond its initial appropriation was underway, MWNA support had already been deflected into other channels. At the Annual Meeting in 1926, the National's representative on the WJCC, Louise Tayler-Jones, proposed a new resolution of support for Sheppard-Towner, but no action was taken that year. In fact in October 1926, the MWNA *Bulletin* published an anonymous attack on the bill. Arguing that "Maternity education should be directed only by physicians," it insisted that the government has no more right to subsidize health care with tax money than "it has the right to make Rockefeller 'divide up' with Eugene V. Debs." (A signed rebuttal by Dr. Tayler-Jones appeared in the next issue.) By the Annual Meeting of 1927, when a resolution supporting Sheppard-Towner was presented to the meeting, it was decided to table the matter since it was "not at issue at present, having been already settled by Congress." That settlement, however, was not a victory for reformers; the Sheppard-Towner bill was renewed in 1927, but for a maximum of only two years.³⁹

Nevertheless, whether working through government clinics or public health committees of state and local women's clubs, the Sheppard-Towner initiative played a significant role in revitalizing the MWNA in this postwar decade. For one thing, it provided the impetus for creation of new constituent women's medical societies. As Belle Wood-Comstock, president of the three-year-old Women's Medical Society of Los Angeles County, reported in 1926, their success in breaking down the "prejudice" against a women's medical society was due to its larger goal, "to band medical women together for the purpose of doing a definite work along health educational lines." By joining California's Federation of Women's Clubs, women doctors were breaking down the "barriers" between "the

profession and the people."⁴⁰ By 1928, the MWNA's membership had doubled to more than 500 individual members, plus several hundred group members, largely due to its organizational efforts in connection with public health education through public clinics and private women's clubs.⁴¹

Yet the outlook for the coming decade of the 1930s was not as rosy as it may have appeared. Even before the onset of the Great Depression, the percentage of women admitted to American medical schools was beginning to decline again, from about 6% in 1923 to 4.5% in 1928. With the approach of hard times in the 1930s, advertising for the *Bulletin* steeply declined. The National's membership also declined, despite replacing "group" memberships with "branch" societies. While in 1931 membership totaled about 750 (with about 6,300 women in active practice at that time), in 1933 it was down to about 600.⁴²

Thus, the 1930s were years of retrenchment for the National. Although the organization came out in favor of birth control in 1929 (albeit only with supervision by a physician), nearly a decade before the AMA, it lost much of its momentum in the field of public health. The White House Conference on Child Health and Protection in 1930, unlike its predecessors, was dominated by male pediatricians, not by women physicians in the field of public health as in the past. Hardly a health department in the 1930s was headed by a woman, as S. Josephine Baker sadly observed. But Dr. Baker felt obliged to lay some of the blame on women physicians themselves. Her 1932 report on public health to the MWNA was an attempt to reinvigorate women physicians' own sense of responsibility for work that, traditionally, had been theirs for the taking.⁴³

The political tenor of the Association had changed considerably during the previous decade. Even during the



One of the last meetings of the Medical Women's National Association before the name was changed to AMWA.

hard times of the mid-1930s, AMWA delegates rejected measures for wider provision of health care as inroads to "socialism." Bertha Van Hoosen found it necessary to remind them that "the only way women physicians got a foothold [in the early days of women in medicine] was through charity work until they had gained the confidence of the public." Nevertheless, for the next 30 years, the Association's leadership retreated from its vanguard position on Sheppard-Towner; in 1944 it went on record as "opposing that part of the Wagner-Murray-Dingle Bill which specifically refers to compulsory health insurance." It did endorse medical society supported "medical plans" (such as Blue Cross-Blue Shield), but only to prevent further "socialization" of medicine.⁴⁴

The percentage of practicing women physicians declined during the 1930s to 4.4% of all physicians. Moreover, AMWA's own membership was a cause of great worry to its leaders. Of particular concern was an "appalling annual turnover," undermining their success in bringing in new members. In the words of President Nelle S. Noble, "It is like giving repeated blood transfusions to a patient whose hemorrhage remains unchecked." Dr. Noble also criticized a "system of choosing officers by arranging withdrawals back and forth in a small privileged group." (Moreover, AMWA continued its policy of rejecting membership applications from "colored" women physicians as late as 1939.⁴⁵)

In 1935, at the 20th anniversary of the MWNNA, the Association voted to reincorporate as the American Medical Women's Association, an action completed in 1937. Both because of the group's increasing frustration with the lack of progress of women in the profession during the 1930s, and in keeping with the trend toward conservative individualism, it now publicly supported the ERA. Although the institution of junior memberships for medical students was again rejected by the membership, junior and senior medical students were accorded nonvoting, associate member status if sponsored by two full members of the association.⁴⁶

Women Physicians and World War II

The war years brought AMWA face to face with two difficult issues: finding a way to assist embattled women colleagues trying to escape from Europe and persuading the US War Department to commission women physicians in the armed forces. In 1938 a Committee on Aid to Medical Women in Distress was founded under the direction of Rita Finkler of New Jersey. Until the war's conclusion it helped secure affidavits to enable women physicians and their families to emigrate to America and raised funds to assist them to relocate.

Well before the outbreak of World War II, AMWA renewed its campaign, suspended since 1918, to win commissions for women physicians in the medical reserves. A resolution protesting discrimination against women physicians in the Army was passed at the Annual Meeting of 1932.⁴⁷ In 1939 two AMWA representatives interviewed the Army surgeon general about the question. They

learned that a change in the laws pertaining to military service probably would be necessary before women could be commissioned. When Emily Dunning Barringer, a veteran of the AWH Executive Board and a delegate to the AMA from the Medical Society of New York State, became president-elect of AMWA for 1940-1941, she took charge of the renewed campaign for commissions. In 1940 AMWA petitioned the AMA for support in changing the law regarding the medical reserves. During a chance encounter with the AMA's Morris Fishbein, Dr. Barringer asked him why the AMA held a different position toward nurses—given military rank since World War I—and women physicians. Dr. Fishbein replied that, "Nurses are well supervised." Dr. Barringer mildly asked him to put his comment in writing, but Dr. Fishbein prudently declined.⁴⁸

Undeterred, the Association cabled President Roosevelt to volunteer its services if needed, sending a copy to the surgeon general, too. Surgeon General James C. Magee politely replied with thanks and the tepid assurance that the Army likely would need only "a small number of women physicians as civilians on a contract basis."⁴⁹

Nevertheless, AMWA kept up its effort to gain AMA and War Department backing and, in 1943, the AMA withdrew its opposition to women in the medical reserves. Since Frank Lahey, AMA president, was also the head of the government's Procurement and Assignment Service for Physicians, the AMA's change of heart was an important signal. In fact, by the end of 1942, even the surgeons general of the Army and Navy had withdrawn their objections to amending the laws governing the medical reserves in favor of female physicians.

What had happened to change their minds? Essentially this was a case of supply and demand. In the words of James Burrow, "the problem of military medical care often stood perilously close to the crisis stage." Between 1940 and 1945 new draftees swelled the Army's ranks from 267,000 to 8,266,000, a more than thirtyfold increase. Physician supply simply could not keep up with this gigantic demand. Even the American Legion was becoming alarmed at the possibility that American soldiers might not receive adequate care. AMWA, too, began an active campaign to win over public opinion. In December 1941, AMWA President Barringer hired noted judge and lobbyist Dorothy Kenyon of New York, one of the few women members of the New York City Bar Association, to assist AMWA in Washington.⁵⁰ Throughout the winter and spring of 1942, Kenyon and Dr. Barringer were in close contact. Kenyon lobbied in Washington, while Dr. Barringer wrote requesting support from a wide variety of women's business and professional groups. Public opinion was moving in their direction. When, in June, the AMA once again rejected AMWA's petition for support, the *New York Herald Tribune* wrote an editorial supporting AMWA. As Kenyon observed, "We have at last got our case out into the Court of Public Opinion."⁵¹

In an address to the AMWA inaugural banquet in June 1942, Kenyon unveiled the argument she would success-

fully employ over the next six months. First, she argued from the simple justice of the women's case: Physicians should be used on the basis of qualifications, not sex. "A male obstetrician for instance had better stay at home and bring babies into the world rather than take care of wounded soldiers at the front while a woman surgeon had better do just the opposite." Second, she argued on legal grounds: "Army regulations state that persons, com-



Emily Dunning Barringer, MD, was AMWA president during the struggle to commission women physicians during World War II.

petently trained and qualified are eligible to the Medical Reserve Corps." "Simple and unambiguous" words such as "person" are legally understood according to their "plain and natural meaning," she argued, "and must therefore be assumed to refer to both men and women."⁵²

By December 1942, Congressman Emmanuel Celler of New York introduced legislation to permit commissioning women in the military. John Sparkman, congressman from Alabama, introduced a narrower bill, at the request of the American Legion, specifically aimed at commissioning women physicians. Hearings were held before the House Committee on Military Affairs in March 1943. Dr. Barringer, Kenyon, and representatives of the medical procurement board and the military all testified in favor of commissions for medical women. Congressman Celler, borrowing from Kenyon's testimony, explained, "I think women doctors have reached a situation where they should not be judged by sex; they should be judged by accomplishments and skill." Besides, as he also remarked, the military was beginning to "scrape the bottom of the barrel" to find sufficient physicians to meet its needs. The Sparkman bill was approved unanimously by the House. After passage in the Senate, President Roosevelt signed it into law on April 16, 1943. Four days later, Margaret D. Craighill, former dean of the Woman's Medical College of Pennsylvania, was given the rank of major, the first woman physician to be commissioned into the Army Medical Corps. Ultimately, 119 women received commissions in the Army, Navy, and Public Health Service.⁵³

AMWA vs the Feminine Mystique: The 1950s

During the war years, as the numbers of women in medicine rose and as AMWA's campaign for commissions put its goals squarely before the public, membership in the organization rose to 1,225 active members, doubling between 1933 and 1943. In 1945 AMWA voted to acknowledge its heightened professional presence by establishing

its own monthly journal, *JAMWA*.⁵⁴

Despite the gains made during the war, the culture of postwar America, the America of the 1950s, contained the ingredients for a subtle but undeniable letdown for professional women. Even women physicians found themselves at a disadvantage against the insinuations of what Betty Freidan has called "the feminine mystique." The 1957 Annual Meeting in Dallas was fairly representative of the privatized, apolitical concerns of the period. It featured a keynote address on "Woman's Greatest Enemy—Fatigue" and workshops on "The Emotional Health of the Family." Subtopics included "Education for Marriage," for "Homemaking," and for "Parenthood." An evening session was devoted to "Today's Teenagers—Tomorrow's Homemakers."

Yet even in the midst of such determined domesticity, AMWA was beginning to acknowledge its need to attract young women into medical school and, once there, to win them over as AMWA members. (Between 1950 and 1960, women as a percent of practicing physicians remained almost unchanged at about 6%. AMWA membership, 1,181 in 1951, actually had declined since 1943.) For this reason, in a revised constitution written in 1957, AMWA established junior branches and a director of junior membership. Junior members could not vote, but they could participate in every other way at annual meetings. In 1953, in addition to its program of scholarships, AMWA began offering \$100 prizes to all women medical students graduating first in their classes. A pamphlet for use by high school guidance counselors, *So You Want to Be a Doctor?* was created in 1959.⁵⁵

Nevertheless, in the conservative political climate of the 1950s, when the broader reformist ideals of the turn-of-the-century woman movement had been forgotten, women physicians had few conceptual tools with which to address the precarious position of women in medicine. Still clinging to the conservative individualism of the 1930s, they continued to oppose government subsidized medical insurance for social security recipients, a measure they identified with the "ultra-liberals." Such subsidies, they believed, would "make the aged wards of the government with health care handouts."⁵⁶

Locked into a conception of professionalism that equated "objectivity" and legitimacy, they were constrained from pleading a "special case" for women based on unequal opportunity. Moreover, lacking at that time the analytical tools to understand the construction of gender in modern society, they could only wonder why so few women pursued their theoretically "equal" opportunity for a career in medicine.⁵⁷ Some idea of what the Association was up against can be gleaned from the recollections of Bertha Offenbach, president of Branch 39 in 1962 and the "moving spirit" in its rejuvenation. Dr. Offenbach recalled her early efforts in the 1950s to drum up interest in the branch. Consistently she was told by women colleagues on the staff of Massachusetts General Hospital, "I have *no* interest in joining . . . a women's medical association; there is no sex in medicine" (June 28, 1989 interview).

Medical "Manpower" and the Woman Physician

The fear of a medical "manpower" shortage in the early 1960s produced a fundamental change in AMWA's perspective on the place of women in American medicine. Prior to World War II, this nation faced only one medical "manpower" problem, an *oversupply* of physicians. In 1932, for example, the final report of the AAMC's Commission on Medical Education, begun in 1925, concluded that the number of physicians in America was increasing at a rate faster than that of the general population.⁵⁸

Three factors, however, quickly transformed a century-long surplus into what was predicted to be a catastrophic physician shortage. The first was the postwar population increase. The second factor, a boom in hospital construction fueled by postwar government subsidies, quickly expanded the need for medical graduates to fill internships and residencies. By 1957, in fact, while medical schools were graduating just under 7,000 physicians a year, hospitals were seeking to fill 12,000 vacant internships annually. Finally, the gradual aging of the population accompanied by the replacement of acute, infectious with sub-acute, chronic illnesses, seemed to be creating heavier and heavier demand for physician services.⁵⁹

As a result, the surgeon general commissioned a report on health care manpower published in 1959. It created a shock wave throughout the health care system when it predicted a drastic physician shortfall. Only by increasing the supply of new medical graduates by an average of 3,600 per year over the next 15 years, the report concluded, could calamitous pressures on the health care system be avoided. This would require, in the words of the report, that "present medical school facilities be increased substantially and new schools be established... at once."⁶⁰

The impact of the "manpower" scare in the early 1960s, although rarely discussed today, was of great significance for the movement of women into the medical profession in recent times. AMWA's leadership was first alerted to the problem when Medical Education Committee Chair Mary K. Helz attended, at the request of the National Health Council, a "National Health Council Meeting on Manpower Shortages in the Field of Health" in October 1959. AMWA delegates also attended the AAMC annual meeting in November on the theme of "Physicians for a Growing America." The delegates were given information packets including "startling predictions of the future," especially indications of future health care shortages.⁶¹

The issue of physician shortages influenced the direction taken by AMWA's leadership during the 1960s, for three main reasons: First, because it alerted them to the problems of married women medical students and physicians, problems that frequently interfered with their ability to complete their training, to practice their profession to the fullest, or even to practice at all. Second, the identification of social rather than strictly individual deterrents to women's success as physicians slowly moved AMWA's policy makers from a position of conservative

individualism to an acceptance of the need for underlying structural changes in the organization of health care and medical education. Third, the fear of a physician shortage provided the impetus to increase enrollments at existing medical colleges and to construct 41 new medical schools between 1960 and 1980. As the surgeon general's report, *Physicians for a Growing America*, had made clear in 1959, increasing the supply of physicians required both increasing and "equalizing opportunity" (emphasis added) through expanded facilities and more abundant scholarship money.⁶²

For the first time, national policy makers were countering organized medicine's longstanding goal of keeping the number of physicians as *low* as possible. This decreasingly restrictive climate proved to be a powerful magnet to prospective applicants and a significant factor in the increasing numbers of women entering medicine. Twenty-two new schools enrolled their first classes between 1961 and 1971, the decade during which the number of women students finally began to climb. Between 1960 and 1970, the combined "push" of the women's movement and "pull" of increased enrollment opportunities resulted in a tripling of the number of women applicants, while the number of male applicants only doubled. The number of women medical students rose from 1,745 in 1961-1962 to 4,733 in 1971-1972. As a percentage of students, women increased from 5.8% to 10.86%, nearly doubling their percentage in ten years. Even more startling, the AAMC has shown that of the first-year slots opened in the new schools between 1970 and 1980, women filled 65%.⁶³

AMWA's Response to the "Manpower" Challenge

Paradoxically, the physician shortage produced both calls for greater utilization of women and the publication of studies criticizing women physicians' lower practice rates. For example, a study by Roscoe A. Dykman and John M. Stalnaker, "Survey of Women Physicians Graduating from Medical School 1925-1940," was initiated by the AAMC in June 1953 and published in 1957, possibly as a response to the slight rise in women graduates in the aftermath of World War II. In the authors' somewhat sensationalized opinion, "The most conspicuous difference between women and men [was] the number of women not in practice." Thirty three percent of the female respondents had been out of practice at some point in their careers, the average figure being 4.5 years. Of this subset, 71.5% were married and most had "terminated their medical practice for a few years to rear their children." At the time of the study, 87.5% of the female respondents were engaged in either full- or part-time practice. Only .4% had *never* practiced since graduation. (But, 10% of the male physicians had curtailed their practices an average of 2.1 years during the same period, due primarily to physical disability.)⁶⁴

Results of the Dykman and Stalnaker study were widely used in the ensuing discussions of how to better use American medical personnel. In a 1961 editorial in *Medical Economics* titled "The Case Against the Female

MD," for example, the author began, "I get sick and tired of ridiculous statements about helping solve the alleged physician shortage by having more women physicians . . . Why not solve the problem at hand more efficiently by having more *men* physicians?" Referring to the Dykman and Stalnaker study, he claimed that "women gave much less time to practice than the men."⁶⁵

AMWA's leadership attempted to respond to this criticism of women physicians by sponsoring a panel discussion at a "Summer Convention" in June 1962 on "medical womanpower." AMWA wanted to know, "Are female MD's as useful in society as male MD's, or are they poor social investments?" Thus the problem AMWA was attempting to address at this conference on medical womanpower was whether women were dropping out of medicine with disturbing frequency, as charged, and whether it was possible to successfully combine medicine with what "we, in our culture, consider a successful marriage." One young woman participant complained, "I think you must make a lot of personal sacrifices. I think you miss a lot of personal time with your family: When the kids come home from school, the little times when you should be together, seeing after your husband, being rested when he comes home from work, getting the house cleaned up."⁶⁶

Immediately, however, from the floor came a request for a "rebuttal" from Lillian P. Seitsive, a graduate of WMCP and the wife, partner, and, recently, widow of a general practitioner. Her comments reflected the "other" side of the coin, the view held by many married women who entered practice as she had, 30 years before: "I was married to a physician for 26 years. I practiced medicine all [that time] except two weeks apiece for each of two children when I was confined to the hospital . . . because they didn't let you out before that. You can be a wonderful wife and a wonderful mother and a very good doctor, but you must have qualities for all three. [Applause.]"⁶⁷

Yet again and again, the issue raised by the younger women physicians in attendance was the question of "mothers' guilt." As Rosa Lee Nemir observed, "women everywhere, who are college educated have listened to the psychologists who have told us for a long time that we must be with our children . . . I think that too often the standards that women hold themselves to are too high. They are much too hard on themselves . . . they are apt to feel guilt when anything goes wrong."⁶⁸ Many solutions were offered, such as federal subsidies for child care, day care centers at hospitals, and creation of residencies with flexible hours for physician-mothers. But not even the example of an overwhelmingly successful wife/mother/full-time practitioner like Dr. Nemir dispelled the atmosphere of frustration at this conference.

In January 1964, still attempting to counter the implication that women physicians functioned below optimal levels, AMWA President Rosa Lee Nemir attempted to forge some kind of cooperative agreement with the AAMC and the AMA to conduct an in-depth study of women physicians' practice patterns.⁶⁹ Planning for the "Survey of Women Physicians Graduating from Medical

School 1935-1960" was begun in July 1965. Present were Dr. Nemir and AMWA President-Elect Bernice C. Sachs as well as representatives from the AMA, the AAMC, and the US Department of Health Education and Welfare. Of greater significance in the long run, the Josiah Macy, Jr. Foundation agreed to sponsor a study of "1. Factors influencing the entry of women into medicine; 2. The attitudes of medical faculties toward the admission of women to medical schools; 3. The career choices and influence of medical schools on a woman's attitude toward medicine."⁷⁰ The Macy Foundation also agreed to host a 1966 "Conference on Women for Medicine," the first of many contributions made by the Foundation in the interest of women and minorities in medicine.

Preliminary results of these studies were released in time for the Macy conference. The findings of the AMWA/AAMC combined study clarified, rather than contradicted, the conclusions of the Dykman and Stalnaker research. The study found, for example, that twice as many men *and* women graduating in 1956 married before completion of training than in 1931. More than a third of these women in 1956 had had children before completion of training. Second, when counting 2,000 hours per year as full-time practice for 1964, 55% of female physicians worked full time and 31% part time; the figures for male physicians were 90% and 7%, respectively. The influence of family responsibilities on the number of hours in practice, however, was clearly highlighted by this study. In 1964, 39% of women with 3+ children worked full time while 86% of single women (presumably without children) worked full time. Indeed "family responsibilities" were the major reason given for curtailment of professional activities by married women physicians. Likewise women physicians saw fewer patients and earned, on average, substantially less than their male colleagues. Finally, regarding specialization and type of practice, women specialized most frequently in pediatrics (33.6%), psychiatry (13.7%), internal medicine (10%), anesthesiology (9.1%), preventive medicine (8.6%), and obstetrics/gynecology (8%).⁷¹

Participants at the Macy Conference, however, were not content to look simply at the statistical profile of women's participation rates. John Z. Bowers, Macy Foundation president, derived his interest in medical "womanpower" from his exposure to the much higher utilization rates of women physicians in other countries and from an "acute awareness of the medical shortage in our country." His interest, like that of AMWA's leaders, focused more on the cultural factors discouraging women from entering the profession than those factors limiting their participation once they completed their training. Radcliffe College President Mary Bunting, another conferee, understood the problem both as a conflict between profession and family and as a structural phenomenon through which women with children were marginalized in the profession. "Increasing the interest of women in medicine will not of itself bring more physicians into the profession . . . The average woman physician practices some-

what fewer hours than the average man . . . This calls for more medical schools and better organization of health care delivery systems." As the words of one physician-mother indicated, women's situation in the profession could be summed up as follows: "Women have something of their own to give the profession." It is in the interest of society to organize its health care in ways that make use of those special contributions.⁷²

Thus in 1966, as feminists were beginning to analyze the place of women in the modern workforce, AMWA's leadership was confronting the social/structural factors affecting the role of the woman physician. At the AMWA Annual Meeting that year, these issues were taken up again through the theme of "Medicine, Marriage, and Motherhood." Echoing the concerns of President Johnson's National Advisory Commission on Health Manpower, AMWA sought to determine "the factors which interfered with women entering the medical profession." Referring to the Macy conference, Rosa Lee Nemir pointed to the "discouragement" doled out by guidance counselors, "primarily based on the difficulty of combining marriage and a career and on the problem of finances."⁷³

Thus AMWA's leadership began to link issues of broad social policy to the specific circumstances of women in medicine. Among the far-reaching resolutions adopted at the 1966 Annual Meeting as means to enhance the participation of women in medicine were: income tax deductions for child care, support of the American College of Obstetricians and Gynecologists' recommendation of legalized therapeutic abortion "at licensed hospitals if at least two physicians agree there is substantial danger to the mother's physical or mental health;" hospital-centered child care for health care personnel, and development of part-time programs for women residents and physicians.⁷⁴ Still, it would be another few years before AMWA's leadership fundamentally broadened its political vision.

AMWA in the Era of Modern Feminism, 1968–1990

In 1968, Carol Lopate published *Women in Medicine*, a book based on the 1966 Macy conference, a pathbreaking analysis of the discriminatory culture in which women were discouraged from pursuing medicine as a career. By 1968, AMWA, too, had begun to confront the issue of discrimination directly. For one thing, the age structure of the Association was beginning to shift. In 1967, for example, AMWA consisted of 1,935 full members and 1,498 junior members. The latter represented 43.6% of the total number; by 1969 junior members accounted for 46%. Although they could not vote, their presence was beginning to be felt.⁷⁵

Lopate accurately assessed the inadequacy of AMWA's position on the minority status of women in medicine. Although she believed that AMWA justly could be proud of its history, she also believed that the Association's lack of leadership was partly responsible for its fairly low membership. In Lopate's view, women physicians as individuals would not risk the prestige of their minority status by

acknowledging it directly; yet she also faulted AMWA/JAMWA for being just a "special interest group" rather than "an intellectually vital center for medical ideas." If a separate association for women physicians was still professionally essential, she seemed to ask, why not make a virtue of that very necessity?⁷⁶

AMWA's leaders, largely educated before World War II, however, were not yet ready to abandon an older conception of women physicians as a minority in medicine. They continued to search for ways to accommodate the new generation of women, but found it difficult to imagine innovative structural changes in the medical profession as a whole. The leadership continued to see women's problems as matters for women to overcome by themselves. In 1967, for example, AMWA decided to sponsor a research survey on "household help," a problem they believed to be at the core of the professional difficulties of medical women. In "Household Help—The Woman Doctor's Gordian Knot," Camille Mermod communicated the unexpectedly widespread response the journal had received to a questionnaire about household help and/or child care. She opened with this anonymous quotation: "Household help is, in my opinion, a woman physician's greatest problem. All the rest are miniscule by comparison."⁷⁷

On July 17, 1970, the husband of the woman so quoted wrote privately to Dr. Mermod to declare his disagreement and profound frustration with this analysis. "It is my impression that the opinions set forth in your article (my wife's included) are essentially erroneous . . . That there is a problem for the woman intending to become a physician I would be the last to deny. But . . . [t]he problem that women physicians face is essentially the problem that all women suffer from: the masculine orientation of our society. If society could be made to recognize the right of women to a career, provision on a general scale would be made for the daily care of children in tax-subsidized centers—the children of housekeepers together with the children of physicians . . . [I]t is most curious that women physicians are not in the vanguard . . . storming the barricades of male privilege. They are grouching about household help, like so many suburban matrons."⁷⁸

What was needed from a new generation of leaders was a response to the structural inequities of the workplace through which women were expected to carry the full burden of both career and family and in which the professions themselves remained impervious to the underutilization of women. In short, AMWA was being called on to advocate the positive *advantages* to society of making an equitable place for the woman physician.

AMWA's achievement, beginning in the late 1960s and extending to our own day, has been its ability to accomplish this essential task of revision. For example, at a conference on "Meeting Medical Manpower Needs: The Fuller Utilization of the Woman Physician," sponsored by AMWA, the Women's Bureau, the President's Study Group on Careers for Women, and the US Department of Labor in 1968, AMWA President Alice D. Chenoweth

began to formulate a response to the canard that educating women physicians is a "waste" of national resources. Challenging the statement that women physicians work only half as much as men, she asked, "Are there adequate data to support such a statement? Can the amount of time spent be equated with the physician's effectiveness? What is the true measure of a physician's worth to society?" Building on the position articulated in 1966, the conference concluded that "talented women are needed in medicine, that their contribution is valuable and unique."⁷⁹

The beginnings of a newly liberalized political agenda could also be seen in the resolutions adopted at the Annual Meeting of 1968. The membership acknowledged its common cause with all women in American society in several ways: it pledged its commitment to demonstrating medicine's commitment to family life, sex education, and federal tax credits for the domestic and/or child care expenses of all working women, not just the woman physician. A second Josiah Macy, Jr. Foundation conference on "The Future of Women in Medicine," also in December 1968, again pursued the question of increasing the number of women physicians. Significantly, the AAMC that year had also focused on the issues of widening access to medical care and increasing opportunities for minority, low-income, and women medical students. The flurry of activities aimed at increasing the visibility of women in medicine may have had a collateral effect on AMWA. Between 1967 and 1969, its active membership jumped 22%, from 1,426 to 1,745, almost twice the increase in active female physicians nationwide between 1967 and 1970.⁸⁰

Nothing could have been of greater importance to the position of women in American medicine and to the evolution of AMWA than the striking increase in the number of women admitted to medical schools after 1970. During the decade of the 1960s, first-year enrollments for women nearly doubled, to 9.1% of the first year class in 1969–1970. Between 1969–1970 and 1979–1980, the percentage of female first-year students more than tripled, rising to 28% of all students.⁸¹ Women students were beginning to make themselves heard in the student associations of the AAMC and the AMA. As for AMWA, by 1979 students made up 48% of the membership. Therefore AMWA enhanced student involvement by amending the bylaws. After 1973, every student branch was entitled to send one delegate per eight members to sit as voting members of the House of Delegates.⁸²

On the local level, too, student interests were beginning to be felt in ways that would eventually be directed upward toward AMWA's national leadership. Interviews with prominent participants in these events during the 1970s in both the Boston and New York City branches clearly revealed the importance of student concern with issues of medical education, sexual harassment, access to top residencies, abortion and other women's health issues, and—particularly for residents—the availability of child care. Such issues brought women faculty and students together

in an effort to reform their local medical communities. Oddly, AMWA's lobbying activities during the "manpower shortage" deliberations of the 1960s apparently were unknown to these younger women. And, undoubtedly, the younger generations's more directly assertive political style seemed painfully different from the genteel lobbying of their elders. Yet some older AMWA members such as Bertha Offenbach (June 28, 1989 interview) in Boston and Rosa Lee Nemir (July 5, 1989 interview) in New York successfully persuaded these younger women physicians to work for change through AMWA.

Thus, physicians such as Leah Lowenstein, Carol C. Nadelson, and Eugenia Marcus in Boston, Lila A. Wallis in New York, and Leah J. Dickstein in Louisville—to name only a few—emerged as a new generation of leaders and especially as AMWA's link to the new generation of women students entering medical schools in the 1970s, the height of the feminist movement in medicine. As interviews with Drs. Nadelson (June 28, 1989), Marcus (June 27, 1989), Wallis (March 30, 1989), and Dickstein (September 8, 1989) made clear, AMWA was the beneficiary of an essentially reciprocal process, the mutual politicization of women students and physicians during these years.

As one of the early effects of these changing political styles, in 1974 AMWA member Marlys Witte and the staff of the AMWA Professional Resources and Research Center at the University of Arizona pioneered a research project on medical women in academia. As she and her colleagues discovered, women were still on the ground floor of the medical faculty hierarchy ten years after their number had begun to rise in the profession.⁸³ In 1979, in cooperation with Cornell University Medical College, the Women's Medical Associations of New York City and State, New Jersey, and Connecticut organized the first AMWA Regional Conference and Workshop on Women in Medicine, "outlining the goals and delineating the constraints which limit the expansion of the role of women in medicine [as well as] plans and strategies to overcome the restraints."⁸⁴ Further, with the encouragement of Eugenia Marcus as Branch 39 president and director of AMWA's student membership, women students began to organize themselves into regional directors who made their interests known to the leadership and facilitated communication between local student branches and the National Office.

Rapid changes are never easy to endure, especially in an Association whose leaders have served it faithfully for many, many years. The rapid rise in the number and political awareness of medical women was both exhilarating and, as Mary Bunting has written, at times confusing. Between 1970 and 1980, the percentage of women first-year students had more than tripled. Suddenly, it seemed, the pace of change was accelerating. AMWA, too, experienced growth pangs as younger members vied with more traditional leaders to set their stamp on the Association—in substance as well as style. At the 1980 Annual Meeting in Cambridge, Massachusetts, for example, an alternate

slate of candidates was offered from the floor, an unprecedented event. (Delegates received the list of the new names on the tabs of Lipton tea bags—an update of the Boston Tea Party.) Although the original slate was duly elected, AMWA responded to the insurgents' demands for increased access to the leadership process and greater organizational visibility on issues of importance to women in medicine. In 1981, a major restructuring of the organization and a clarification of its goals were begun in earnest. Significantly, its amended constitution of 1981 now included in AMWA's stated objectives, "to encourage women to study medicine" and "to ensure equal opportunity to do so."⁸⁵

Today AMWA strives for a stronger voice for women in organized medicine and in national policy making for health care. By 1986 women represented 35% of first-year medical students. In 1988 women constituted more than 16% of all physicians. By 2000 they are expected to represent 20%. The past 20 years have brought a younger, straightforwardly political voice to the forefront in AMWA policy making and particularly in its attention to leadership training for women physicians. AMWA's dual commitment to the needs of women physicians and women patients through issues such as family planning, breast cancer prevention, improved child care, and the reduction of cigarette smoking, is bringing to fruition the goals of AMWA's founders—the articulation of what it means to be a woman physician. In the words of Lila A. Wallis, AMWA president in 1988–1989, "Every woman physician is a leader. She had to be a leader to get where she is. She will be an even more effective leader if she belongs to AMWA."⁸⁶

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The American Medical Women's Association as the Vision and Voice of Women in Medicine 1990-2010

By Eliza Lo Chin, MD, MPH and Laurel Waters, MD, FCAP, FASCP

More than 600 AMWA members gathered in Philadelphia in the fall of 1990 and celebrated the Association's 75th Anniversary in style. Of historical significance was the inauguration of AMWA's first African-American president, Dr. Roselyn Payne Epps. Keynote speaker, Dr. Antonia Novello, the first woman physician to serve as Surgeon General of the United States, was welcomed with a standing ovation and sense of pride that was palpable. It was a moment for all women in medicine to cherish.

The next two decades marked impressive growth and expansion of the organization.

Healthcare Advocacy

In the early 1990's, AMWA was actively involved in healthcare advocacy at all levels within the organization, including legislative days on the hill, press briefings at the White House, and student internships. Among the issues that AMWA championed during these years were the *Family and Medical Leave Act* which was passed in 1993, the smoking cessation *Tobacco Product Education and Health Promotion Act*, pro-choice legislation, and the acceptance of RU-486 as a medical abortifacient. Year after year, AMWA continued to be an indefatigable champion for women's health rights.

1992: On April 5, an AMWA delegation marched in Washington DC with the National Organization for Women (NOW) in support for reproductive choice. Their proclamation, "We Won't Go Back...March for Women's Lives," reflected the widespread fear at the time that the Supreme Court was poised to overturn *Roe v. Wade*.

1993: When Dr. David Gunn, a physician who provided abortion services in Pensacola, FL, was killed on March 10, 1993, AMWA immediately denounced the violence and reaffirmed its commitment to end the harassment and isolation of abortion providers.

AMWA and other organizations urged Congress to overturn the gag rule, a federal regulation that prevented Title X funded family planning facilities from counseling or referring patients for abortions. When President Clinton finally signed the order overturning the gag rule, AMWA was among the three medical associations invited to the White House.

During the health reform years of the Clinton Administration, AMWA representatives were invited to be part of the White House Health Care Reform Task Force, the working group chaired by First Lady Hillary Clinton. In December of that same year, seven AMWA leaders attended the press briefing in support of President Clinton's Healthcare Reform Plan.

1994: AMWA members urged the passage of the *Violence Against Women Act (VAWA)*, which upheld victims' rights and increased funds for battered women's shelters, rape education, prevention programs, and the training of police, prosecutors, and judges. The bill also provided funding for a national family violence hotline and required all states to honor restraining orders issued in other states. The Los Angeles AMWA Branch awarded the "Outstanding Legislator Award" to Senator Barbara Boxer (D-CA) who authored VAWA.

1999: During the President's retreat, AMWA leaders met with Janet Luray, the new director of the White House Women's Office. In just half a day, AMWA leaders met with approximately 30 congressional staffers.

2008: *Conversations with the Candidates* was spearheaded by Dr. Claudia Morrissey. During the primary season for the 2008 U. S. Presidential Race, AMWA-doc.org was a website where Hillary Clinton shared her plans for Healthcare reform. Conference calls, engaging AMWA members and supporters around the country, featured conversations with Hillary Clinton, John Edwards and Dennis Kucinich or their representatives.

2009: AMWA was represented in a White House meeting with physicians to discuss healthcare reform strategies on prevention and cost containment. This discussion was led by Drs. Zeke Emanuel, Dora Hughes, Kavita Patel, and Bob Kocher.

2010: AMWA participated in White House conference calls regarding healthcare reform, Haiti earthquake relief efforts, and the First Lady's *Let's Move* Initiative to eradicate childhood obesity. AMWA leaders were invited to the White House for the launch of the First Lady's Initiative as well as a White House press briefing by President Obama as he urged Congress to pass healthcare reform legislation. In support of healthcare reform, AMWA students embarked on the Woven Word Quilt project to express their collective goals for this country. On the eve of International Women's Day, AMWA leaders sent a letter of support to President Obama to applaud his efforts to pass healthcare reform. AMWA members campaigned for the passage of the Affordable Care Act and Dr. Eliza Chin represented AMWA at the event with President Barack Obama and Vice-President Joe Biden following the signing of the bill into law.

Position Papers

Many position papers have been written by AMWA covering the following areas: Career and Education, Ethical Issues, Health and Wellness, Policy and Legislation, and Reproductive Health. Recent position papers include: Sex and Gender Specific Medicine, Cervical Cancer Prevention, Osteoporosis, and Healthcare for All.

Gender Equity

In 1991, AMWA co-sponsored the report, "Empowering Women in Medicine," which exposed the disheartening statistics that women physicians earned only 63% of what their male colleagues earned. Their penetration within the ranks of academic medicine was also limited. At that time, only 21% of medical school faculty and 2% of department heads were women. These statistics were reported through national media outlets including CNN, The New York Times, and Associated Press. Dr. Deborah Judelson and others appeared on the nationally televised Home Show to share these statistics.

Beginning in 1992, AMWA provided a Sexual Harassment and Gender Discrimination Resource and Information Line – a hotline for AMWA student and physician members.

In 2000, AMWA organized and began development of the Institute for the Advancement of Women in Medicine and Healthcare with George Washington, Howard, Johns Hopkins and Maryland Universities.

In 2009, President Obama signed into law the *Lilly Ledbetter Fair Pay Act* of 2009, which helped restore protection against employee pay discrimination.

AMWA is a partner in Drexel University's VISION 2020, a decade-long national project focused on promoting gender equality by engaging new generations of women and men to finish the work of the suffragists, who championed women's right to vote as fundamental to social and economic justice. VISION 2020 will culminate in the centennial celebration of the 19th Amendment to the Constitution.

AMWA Leaders attend the launch of UN Women in February 2011 during the meetings of the UN Commission on the Status of Women.

Annual Meeting Highlights

1990	Philadelphia, PA	2002	San Antonio, TX
1991	Dallas, TX	2003	Atlanta, GA
1992	San Francisco, CA	2004	San Diego, CA
1993	New York, NY	2005	Washington, DC
1994	Lake Buena Vista, FL	2006	Tucson, AZ
1995	Seattle, WA	2007	Orlando, FL
1996	Boston, MA	2008	Anaheim, CA
1997	Chicago, IL	2009	Williamsburg, VA
1998	New Orleans, LA	2010	Washington DC
1999	San Francisco, CA	2011	Washington DC
2000	Colorado Springs, CO	2012	Miami, FL

- The 1992 Annual Meeting in San Francisco featured keynote speaker Dr. Nancy Snyderman, an AMWA member and the Medical Correspondent for ABC-TV's "Good Morning America." Plenary session speakers included Dr. Molly Coye, Director of Health Services for the State of California; Dr. Frances Conley, Stanford Professor of Surgery; Senator Dianne Feinstein; Dr. Jane Hodgson, Clinical Associate Professor in Obstetrics and Gynecology; and Dr. Vivian Pinn, Director of the NIH Office of Research on Women's Health.
- In 1995, AMWA co-sponsored the Third Annual Congress on Women's Health in Washington DC. First Lady Hillary Rodham Clinton addressed attendees, urging women leaders to continue fighting for equal rights and women's health.
- The 1996 Annual Meeting in Boston featured keynote speaker Dr. May Jameson who was the first woman of color to go into space when she flew as a mission specialist astronaut aboard the Space Shuttle Endeavor. In partnership with Simmons College, AMWA hosted a 12 hour Institute of Career Development, discussing topics such as business strategies, negotiating skills, and real gender equity.
- AMWA's 2002 Interim Meeting, "Physicians Adapting to a Changing Environment" was held at Tyson's Corner in McLean, VA and featured the International Women in Medicine Hall of Fame Gala. Honored on that occasion were the two women who had been Surgeons General: Dr. Antonio Novello and Dr. Joycelyn Elders who both gave excellent rousing speeches.
- AMWA's 2003 Annual Meeting in Georgia featured Dr. Julie Gerberding, Director of the CDC as a keynote speaker.
- AMWA's 2007 Annual Meeting was held in conjunction with the First North American Congress of Women in Medicine in Orlando, Florida. The Annual Banquet that year featured singer Christine Baze, a cervical cancer survivor, who inspired the audience with her story and music.
- AMWA's 2008 Annual Meeting was held in conjunction with the Women's Healthcare Forum. The Annual Banquet featured singer, songwriter, and activist, Holly Near.
- AMWA's 2009 Annual Meeting was held in conjunction with The 17th Annual Women's Health Congress.
- AMWA's 2010 Annual Meeting was held in conjunction with the 18th Annual Women's Health Congress. Dr. Vivian Pinn delivered the keynote address at AMWA's Awards Banquet.
- AMWA's 2011 Annual Meeting was held in conjunction with the 19th Annual Women's Health Congress and celebrated the 95th Anniversary of AMWA. Surgeon General, Dr. Regina Benjamin, was a keynote speaker. Both Dr. Benjamin and Dr. Margaret Hamburg, Commissioner of the FDA, were awarded AMWA Presidential Awards.
- AMWA's 2012 Annual Meeting, the first stand-alone meeting in several years, featured keynote speakers, Gloria Steinem and Dr. Rachel Naomi Remen.
- During the annual meetings, AMWA often hosted the famed "Bob Oaks Tours," a tradition started by Mr. Bob Oaks who would accompany his wife, Dr. Mathilda Vaschak, to annual AMWA meetings. Year after year, Bob organized tours of the various cities for the other husbands and friends of the AMWA members attending the meeting. He was recognized for his loving support of his wife and AMWA, by having future city tours named after him. One of the more memorable excursions was the Halloween night trip to Salem, Massachusetts.
- The Nancy C. Binder Memorial Lectures and Programs, founded by AMWA President Dr. Lynn Epstein, were a tribute to past AMWA leader, Dr. Nancy Binder. The 2003 performance by a dance troupe led by a physician who had suffered from breast cancer was deeply moving and unforgettable.
- AMWA Presidents traditionally invited members to attend an overseas presidential trip during their tenure to observe healthcare systems or join international meetings. Notable excursions included Scotland, Japan, Alaska, Cuba, Spain, and Belgium.

American Women's Hospitals Service (AWHS)

During these years, the American Women's Hospitals Service (AWHS) continued to support clinics and hospitals around the globe. In addition to its regular clinic support, periodic emergency funds were awarded during times of need. In 1992, AWHS sent desperately needed funds to war-torn Bosnia, symbolically 75 years after the founding of AWHS, which began with aid to the Balkans after World War I. Similar grants were sent to support the Tsunami victims of Thailand in 2004, the Burma Cyclone in 2008, and to the Hospital Bon Samaritan in Haiti in 2010 in the aftermath of the devastating earthquake.

Over time, some clinics have faded away and have been replaced by new ones referred by AMWA members. As Dr. Morani, former AWHS leader used to say "We do not do bricks and mortar." The aim has always been to provide salary for a local worker so that the funds get magnified as they extend to an ever widening ripples system on a small scale. AWHS has built a lasting legacy of humanitarian aid, which will endure in the years to come.

Current recipients of AWHS funds include:

Bread for the City and Zacchaeus Free Medical Clinic (Washington DC)
Dayspring Family Health Center (Tennessee)
Dover Community Clinic (New Jersey)
Harbor Free Clinic (California)
HealthCare Network (Wisconsin)
Hospital Bon Samaritan (Haiti)
Marian Clinic (Kansas)
South African Development Fund (South Africa)
Clinic Nepal (Nepal)
Engeye Clinic in Uganda (Uganda)

Of these, the latest addition is the Engeye Clinic in Uganda, founded by AMWA member, Dr. Stephanie Van Dyke while she was still a medical student. Impressed by the lack of basic medical care in Uganda, she used her Grandmother's \$30,000 bequest as seed money to fund the building of the clinic. Upon completion of her training, Dr. Van Dyke plans to return to Uganda on a full time basis.

The AMWA Foundation

The AMWA Foundation, which was established in 1990, supported educational, research, scholarship, and service projects during its 15 year tenure. Some of the Foundation's notable projects included:

- support for the American Women's Hospital Service (AWHS)
- support for the Student Loan Program
- development of a Model Day Care Manual in collaboration with the National Association of Hospital-Affiliated Child Care Providers
- development of the Women's Health Curriculum, a continuing medical education program to promote a comprehensive, coordinated approach to women's healthcare
- an updated edition of the medical student resource, "Career Choices for Women in Medicine"
- The Women's Smoking Cessation Project.

AMWA Product Acceptance Program

During its tenure, the AMWA Product Acceptance Program endorsed non-prescription products approved by the Food and Drug Administration (FDA) related to women's health. The products underwent extensive review by AMWA's Scientific Evaluation Council and those approved received the AMWA Seal of Acceptance and Acceptance Statement. Products endorsed in 1991 included Gyne-Lotrimin® and Stay Free Ultra Plus®

The Reproductive Health Initiative (RHI)

In 1993, AMWA launched The Reproductive Health Initiative (RHI) – a program to improve reproductive health training, including family planning and abortion, in medical schools and to train physicians in the latest reproductive health developments. The program included:

- (1) Review of current medical school curricula in reproductive health
- (2) Identification of a model curriculum
- (3) A one-day reproductive health program at medical schools with encouragement that they adopt the program into their own curricula
- (4) Development of a one-month, fourth-year student elective in reproductive health
- (5) AMWA grant awards in reproductive health to honor outstanding abortion providers
- (6) Publication of a special JAMWA issue on reproductive health

RHI continued to flourish under AMWA until 2005 when it was transferred to the auspices of the Association of Reproductive Health Physicians (ARHP).

Medical Education

- AMWA collaborated with the Medical College of Pennsylvania to create the National Academy on Women's Health Medical Education (NAWHME), to focus on women's health in medical education.
- The Centers for Disease Control (CDC) awarded AMWA a three-year \$450,000 grant for educational programs on the early detection and control of breast and cervical cancer. This project was led by Dr. Diana Dell and Dr. Janet Osuch.
- A number of educational programs were developed in the 1990's, most notably, the Master Faculty for AMWA's Education Project on Coronary Heart Disease to Women chaired by Dr. Debra Judelson.
- From 1993 – 1996, AMWA's Breast & Cervical Cancer Education Project for Primary Care Providers held 35 workshops across the country. Jointly sponsored by the CDC, over 1000 healthcare providers were trained.
- In 1997, AMWA was awarded a substantial grant from the Department of Defense to provide breast cancer training to more than 6000 primary care managers in the US and abroad.
- "Advancing Women's Health" is an on-line digital library created by AMWA and the American College of Women's Health Physicians (ACWHP). The goal of this initiative was to create a repository of educational materials addressing sex- and gender-specific issues in women's health based on medical evidence.

Public Health

In keeping with tradition, AMWA continued to focus efforts on health education

- In 1993, Dr. Leah Dickstein was one of 7 prominent women's health experts asked to deliver comments to representatives from the Dept of Health and Human Services about the progress on the women's health objectives of Healthy People 2000, a comprehensive strategic plan for health promotion among the American public.
- In 1994, AMWA was one of 9 organizations chosen for a \$3.6 million grant project funded by the CDC to reduce tobacco use and fight smoking-related disease and death. AMWA fought against smoking ads targeted towards women and issued its own propaganda with the slogans, "Tobacco Industry Beware: Sisterhood is powerful. Targeting women may be hazardous to your health." and "Virginia Slime...It's a Cancer Thing."
- In 1996, AMWA published the guide, *Developing a Child Care Program: A Health System Decision-Making Guide*, which provided information, tools and a model for developing and implementing a quality child care program.
- *Your Thyroid Gland Central* was a nationwide campaign that included featured Olympic Gold Medalist, Gail Devers, and offered free thyroid screening and raised awareness of thyroid disease.
- In 1999, AMWA spearheaded the first National Summit on Cervical Cancer with the National Cervical Cancer Public Education Campaign in Washington DC in January. The purpose of this initiative was to educate women about the link between human papilloma virus (HPV) and cervical cancer as well as improved detection techniques.
- In 2002, AMWA partnered with the US Department of Health and Human Services' Office on Women's Health to hold the first National Town Hall on Menopause. The half-day conference, moderated by AMWA President, Dr. Omega Silva addressed current and new advances in menopause, its symptoms and related conditions, and the implications for public policy.
- 2003: Dr. Omega Silva testified at the FDA's Endocrinology and Metabolic Drugs' Advisory Committee on the Women's Health Initiative on Osteoporosis and Hormone Replacement Therapy (HRT)
- 2007: Dr. Omega Silva participated in the NIH Consultation Meeting on Peer Review with Professional Societies in Washington, DC with Dr. Elias Zerhouni, Director, NIH, and Lawrence Tabak and Keith Yamamoto, co-chairs of the Working Group of the Advisory committee to the NIH Director on NIH Peer Review.
- In 2006-2007, AMWA President Dr. Susan Ivey worked with a coalition of organizations on improving awareness of cervical cancer prevention and detection. A key partner in the organization was Women in Government, a non-profit bipartisan group that advocates for a number of women's health issues. They founded the Challenge to Eliminate Cervical Cancer campaign in January 2004, in which AMWA participated. An outgrowth of Dr. Ivey's cervical cancer work in California resulted in a number cervical cancer prevention tools and messages that reach young women throughout California.

- In 2007, AMWA partnered with Women in Government to create materials for the preventive care for older adults.
- In 2008, AMWA launched its campaign, *Strong to the Bone*, to promote osteoporosis awareness by creating an informational website for screening women.
- AMWA's 2010 public health initiatives include
 - Childhood Obesity Initiative, in alliance with the First Lady's Let's Move Initiative
 - Cervical cancer prevention, in partnership with the Pearl of Wisdom Campaign
 - Prevention of underage drinking
 - Vitamin D Education

AMWA Organizational Structure

AMWA Executive Director, Eileen McGrath, JD led the organization for nearly 14 years until 2002. During this time, the executive offices were strategically moved from New York City to Alexandria, VA to be closer to the Capitol and facilitate AMWA's advocacy work. AMWA branches continued to expand, and by 1992, there were 75 active physician branches and 109 student branches. In 2002, Linda Hallman became the new Executive Director. The Foundation and the Association merged into a single 501c3 non-profit charitable organization.

In 2006, AMWA faced significant economic challenges and some feared that it might close down. Thanks to the strong leadership of Dr. Susan Ivey, AMWA was able to achieve financial security under a new executive management model. The services of an association management company, Fernley and Fernley based in Philadelphia, were enlisted, and the Alexandria office was closed.

AMWA is comprised of a physician division, a student division founded in the mid 20th Century, and a resident division, established in 2010.

AMWA Legacy and Archives

In 2003, AMWA co-sponsored the National Library of Medicine's exhibition, *Changing the Face of Medicine: Celebrating America's Women Physicians*, an online exhibit that profiles hundreds of women physicians, past and present (<http://www.nlm.nih.gov/changingthefaceofmedicine>). A companion gallery to that exhibition was *Local Legends: Celebrating America's Local Physicians*, which featured women physicians nominated by their Congressional representatives. These women were honored at the 2004 Annual Meeting in San Diego, CA.

AMWA's historical documents dating back to 1915 are housed at the Archives and Special Collections of Women in Medicine, Drexel University in a new, state of the art building completed in 2009. The materials are cataloged and available for researchers to access. Through the efforts of Dr. Eliza Chin and generous donations by AMWA members, AMWA now has a permanent Legacy Exhibit at Drexel University to showcase historic documents and photos.

Currently being developed is an on-line exhibit honoring the achievements of AMWA members, entitled, *Faces of AMWA*. This exhibit will profile the diverse and extraordinary lives of AMWA members from 1915 to the present day.

AMWA Publications

AMWA continued to publish the *Journal of the American Medical Women's Association* until the year 2005. Wendy Chavkin, MD, served as editor-in-chief of the journal from 1994-2002. In 2008, the *Journal of Women's Health* became AMWA's official journal.

A separate publication, *What's Happening in AMWA*, kept members up-to-date on the latest news within the organization. The name of this newsletter was later changed to *AMWA Connections* in 1999.

Also, during the 1990's, AMWA published several books, including the *Women's Complete Healthbook*, a 720 page comprehensive health book written by 58 multispecialty authors – all women - for women consumers. *The Women's Complete Wellness Book* was edited by Dr. Debra Judelson and Dr. Diana Dell. There was also a book series on different health topics such as the AMWA Guide to Cancer and Pain Management and the

AMWA Guide to Contraception and Fertility. Currently work is underway to publish a compendium of AMWA's history in preparation for the 100th year anniversary in 2015.

Looking Ahead

Like any professional organization AMWA has weathered economic challenges and evolved with the times. While the battle for representation and admission into medical schools may be over, challenges of gender equity, health disparity, women's health rights, and career-life balance still remain. And of utmost importance is the mentorship of the new generation of women physicians.

For the past 95 years, AMWA has been the vision and voice of women in medicine. Now poised to begin the Countdown to a Century, AMWA leaders have maintained their commitment to women's health, student mentorship, leadership, and healthcare advocacy, and education while still forging ahead to break new ground.

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Current AMWA Programs

Strong to the Bone - A program that promotes osteoporosis awareness through an informational website for screening women.

Advancing Women's Health - An on-line digital library created by AMWA and the American College of Women's Health Physicians (ACWHP). The goal of this initiative is to create a repository of educational materials addressing sex- and gender-specific issues in women's health based on medical evidence.

Obesity Initiative - In alliance with First Lady Michelle Obama's Let's Move Initiative to eradicate childhood obesity through improved nutritional intake and maintenance of regular physical activity among youth. AMWA has recently launched a similar initiative in adults to educate patients about their body mass index.

Cervical Cancer Prevention - In partnership with the Pearl of Wisdom campaign, this program aims to raise awareness about cervical cancer prevention.

Healthcare Advocacy - To continue advocating for health care that provides for a Healthier America with expanded access to high quality care without discrimination. We support initiatives that advance women's health, including women's wellness programs and the right to choose.

Faces of AMWA - An on-line exhibit highlighting the accomplishments of AMWA members and leaders.

Underage Drinking Initiative - A program to increase awareness of alcohol poisoning and extreme drinking on University campuses and to provide interventions to reduce these behaviors.

AMWA Legacy Exhibit - A permanent lobby exhibit at Drexel University's Archives and Special Collections on Women in Medicine that celebrates the AMWA's 95 year legacy through the display of rare documents, photos, and artifacts.

American Women's Hospitals Service - AMWA's charitable program that provides desperately needed funds to hospitals and clinics around the globe that provide care to economically disadvantaged communities. Student travel grants provide support for students who work in 3rd world countries.

Gender Equity Committee – A committee within AMWA that addresses issues of gender equity in medicine. In process are plans for a large-scale national study to assess the work habits of women physicians.

Patient Education literature produced in conjunction with HealthyWomen.

AMWA Committees and Working Groups

AWHS Committee
Awards Committee

Gender Equity Committee
Global Outreach Committee
Governance Committee
Membership Committee
Policy and Advocacy Committee
Finance Committee
Program Committee
Senior Physicians Committee
Student Affairs Committee
Women's Health Working Group

To join one of these committees or help out with one of the AMWA initiatives, e-mail associatedirector@amwa-doc.org.

Medical Women's International Association

The Medical Women's International Association (MWIA) is an international non-governmental organization (NGO) representing women doctors from all five continents. The association was founded in 1919 and is therefore one of the oldest professional bodies at the international level. It is non-political, non-sectarian and non-profit making.

In 1919, the first international congress of women doctors was held in New York from 15 September to 26 October. The American Women's Hospitals Service Committee (a committee of the American Medical Women's Association) took this opportunity and organized a dinner in honor of distinguished medical women from different countries who had just returned from medical relief work in France. 140 guests from 16 nations attended the festivities. Some woman doctors sensed the opportunity of forming an international association of medical women. Their suggestion was enthusiastically welcomed by the participants of the dinner. Within a few days a Committee of Twelve was chosen by ballot and empowered to organize the Medical Women's International Association and to nominate Executive Officers. The Committee met on October 25, 1919 and an Executive Committee was elected. The first MWIA President was Dr. Esther P. Lovejoy, U.S.A. Three Vice-Presidents, a treasurer, a recording secretary, and a corresponding secretary were also elected. A provisional constitution was adopted and provisional aims and objectives were laid down – to exchange ideas and unite efforts for the benefit of mankind.

Today, MWIA members represent 90 countries in all five continents. The MWIA International Congress continues to be held every 3 years. All members of AMWA are members of MWIA. The

Information adopted from the MWIA website, <http://mwia.webtop.de>.

American Women's Hospitals Service (AWHS)

By Anne Barlow, Chair AWHS

In July 1915, at the second annual meeting of the Medical Women's National Association (MWNA, later to become the American Medical Women's Association (AMWA)), 300 women physicians heard from Dr. Rosalie Morton who gave an illustrated lecture on the work of women physicians in world War 1. It was the norm in the United States, as in the allied countries, to deny medical women any active role in the war effort. Dr. Morton's lecture sparked a flame which would see the birth of the American Women's Hospitals Committee. The name was adapted from the Scottish Women's Hospitals, a successful organization working with military sick and wounded in France. The Committee had a two-fold mission at that time - the relief of suffering through medical care and the advancement of women in the medical profession.

Dr. Morton was the first Chair of the new committee, and in 1917, Dr. Esther Pohl Lovejoy offered to try to determine whether the American Women's Hospitals (AWH) then planned to be sent abroad, should be for maternity or general service. Dr. Lovejoy went to Paris in August of that year and joined

the staff of the American Red Cross, working there with the American Fund for French wounded. When she came back to report to the MWNA, money had been raised and a cohort of volunteer women physicians had been registered and the first hospital of the AWH was opened in the village of Neufmotiers, Seine -et-Marne, France on July 28, 1918, immediately followed by a second one.

However, the Armistice in November threw plans in disarray and funds dried up.

Many founders of AWH realized that sickness did not end with the cessation of hostilities. They declared "The war has been won: now the peace must be won." So, more money was raised and during the immediate post-war years American women physicians under the auspices of AWH met medical emergencies, established public health services, did their best with typhoid fever, influenza, malaria, tuberculosis, venereal diseases, pneumonia, smallpox, cholera and the many eye and skin diseases which were rife in Europe and no more so in what was then called the Balkans. In many areas, AWH provided the only medical care in the immediate post-war years.

By 1922, AWH had not only provided service, but had established a number of projects and institutions which local personnel, trained by AWH could continue. At this juncture plans for termination of AWH were being considered. Then the Turkish government displaced to Greece the entire Christian population, burning Smyrna where refugees were waiting for transport and marching the males into the interior for slave labor or execution. This changed the course of AWH. With logistical help from the American Red Cross and under the aegis of the Greek government, AWH established services on the quarantine island of Macronissi, an eleven mile barren rock. Here three AWH women cared for 12,000 refugees, training and recruiting helpers from among the refugees.

Meanwhile, Dr. Lovejoy, having used her considerable abilities to raise private money, was made president of the Medical Women's International Association, which she helped found in 1919. In addition she was made chair of AWH the same year and set about almost single-handedly to raise more money and then oversee the spending of it. In 1922, she was able to attend the founding of an AWH pediatric hospital in Scutari, staffed by American women physicians. Under her leadership, the general principles under which the work continues were formulated.

Although continuing for some time under the auspices of AMWA, the organization was incorporated separately in 1959 as the American Women's Hospitals Service, Inc. (AWHS), but the principles remain the same. AWHS gives small grants to clinics ignored by the large charitable groups. The grants are given, where possible, after visitation by one of the committee members or referred to AWHS by friends who have visited. Originally, all were overseas, at different times in France, Great Britain, Holland, Norway, Finland, Austria, Greece, the former Yugoslavia, Albania, Japan, Taiwan, Philippines, Armenia, Russia, India, Thailand, Chile, Bolivia and Haiti. During the years of the Great Depression, AWHS was also immunizing children in Kentucky, supporting a midwife there and helping a clinic for miners in Tennessee, which continues to this day, although now not exclusively for miners and their families.

"AWHS does not buy bricks and mortar" as Dr. Alma dea Morani always said. She assumed the chair of AWHS in 1967, when Dr. Lovejoy, at 90, resigned. Indeed, the grants from AWHS are targeted at providing staff for clinics already in operation. For instance, for many years AWHS, starting in 1961, supplied both money and medicines to Dr. Ruth Tischauer for assistance in running her remarkable roadside clinics for the Aymara Indians in Bolivia. This allowed her to hire a nurse from the local population. Several members of the Committee have visited Dr. Tischauer, now sadly no more. A documentary, called "Doctora" was made some years ago and may still be available.

From 1967, AWHHS operated from a one- room office in New York City, with a full time secretary. When the secretary was retiring, Dr. Morani came to AMWA to see if there was interest in again joining the two entities. This occurred in 1983 and is still in force today.

AWHHS Today

In 2010, AWHHS has grantees in Haiti, Uganda, Vietnam, India, Barbados, South Africa and Nepal. In the US, we help out clinics in Wisconsin, Tennessee and Washington, DC. Obviously the economic climate has hurt our loyal donors. For many years we were able to fund half our budget from donations and half from endowment investments. Both these sources are drying up. We will however, continue as best we can as even our small grants enable desperately needed medical care for women and children, according to our mission.

An AWHHS program that is very popular with the medical student members of AMWA is the travel grant. Awarded to students who have been accepted into a medical school sponsored overseas clinic program, AWHHS provides help in paying the travel costs to get the students to their overseas destination. Students must fill out a lengthy application, have approval of their school's Dean and write a report, if possible with pictures, on return. Two to three students are usually chosen each year.

If you would like to help you can donate today. We have projects that are waiting for funding in Ethiopia, Angola and Cape Town.

From 1917 to 2009 this small group has sought to make a difference and we believe that we have.