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INTELIGENCE

RELATIONS, DIPLOMACY AND

HISTORY OF INTERNATIONAL

WOMEN AND TRANSNATIONAL

HISTORICAL PERSPECTIVE
The American Women's Hospital Association
International Health: The Medical Feminist
Transnational Activism and
empowered by these transnational networks could then strengthen their policymaking roles in their home nations and, assisted by enfranchised women across the globe, promote legislative and policy measures conducive to healthy communities.1

Figure 1. Esther Pohl Lovejoy, center, Medical Women's International Association Geneva Conference 1922. Courtesy of Medical Women's International Association.

Sven Beckert suggests that transnational history considers “a whole range of connections that transcend politically bounded territories” including institutions, ideas, and processes.2 Lovejoy and members of the MWIA and AWH created transnational professional medical and relief organizations based on the concept that women physicians working together above and across nation-states could best develop ideas and take action to resolve global problems of disease, war, and inequality. Because the politics and policies of nations created such problems, medical women organized outside of their home nations to create collective alternatives. These broad programs, what Lovejoy called action for international health, would benefit all women regardless of their nation of residence. Women physicians worked across national and political boundaries in organizations dedicated to the theory and practice of a healthy and peaceful world for all, a “without borders” challenge to traditional state politics. Many women

facilitation and coordination of programs and work with the MWIA and the AWH. An analysis of the importance of medical women’s shared identity and approaches to activism, and an understanding of the results establishes the contribution of these medical women to twentieth century transnational activism and to feminist theory and practice.

Esther Clayson Pohl Lovejoy was born in a logging camp in Seabeck, Washington Territory, in 1890. She worked at a department store to help pay for her studies at the University of Oregon Medical School in Portland. Three weeks after her graduation in 1894 Esther married her classmate Emil Pohl and after the birth of their son Freddie in 1901 Esther’s mother Annie Clayson came to live with the family in Portland and assisted with child care as both physicians continued their work. Freddie died in September 1908 from septic peritonitis, and Emil died in May 1911 from spinal meningitis. In 1912 Esther married Portland business leader and suffrage supporter George A. Lovejoy; they divorced in 1920. In Portland Lovejoy was active in public health, community, and women’s organizations, worked to gain suffrage for women, held appointed office, and ran for Congress. In the first two decades of the twentieth century Lovejoy and other women physicians were important participants in reform movements, part of what historian Regina Morantz-Sanchez has called the ascendance of “social medicine.” They linked medical and public health issues with social and cultural reform and the women’s movement in the progressive era. Portland mayor Harry Lane, M.D. appointed Lovejoy to the Portland health board in 1905 and she served as Portland city health officer from 1907-1909, the first woman to hold such a position in a major U.S. city. Lovejoy was also active in many progressive era organizations that sought to bring about change to local and national policies, including the Portland Woman’s Club and the Consumer’s League. A strong suffragist, she had a key role in the Oregon state woman suffrage victory of 1912, and continued to work with the National American Woman Suffrage Association until the achievement of the federal suffrage amendment in 1920. And she gained an impressive 44% of the vote in her run as the Democratic candidate for Oregon’s Third Congressional District seat in 1920. For Lovejoy the First World War highlighted the importance of social medicine and underscored new possibilities for activism at the transnational level. Lovejoy went to France from September 1917 to February 1918 as a representative of American women’s organizations, including the Medical Women’s National Association and the Women’s Committee of the U.S. Council of National Defense. The purpose of her work was to assess the needs of women and children in France and to prepare for specific ways in which American medical women might provide assistance. Working at a Paris settlement house, visiting hospitals and clinics, and surveying health care conditions for refugees, Lovejoy came to know French women medical colleagues and praised the work of French midwives. Her observations confirmed the importance of public health and the social medicine agenda with which she had been involved prior to the conflict, and demonstrated that women physicians in other nations had been working for similar goals. In turn, they suggested a wider field of activism across national boundaries. Lovejoy recalled that while in wartime France she “sensed the importance of women doctors working together, and from that time forward never lost an opportunity of promoting the idea.” After the conflict she took leadership positions in two transnational medical women’s organizations. In 1919 she assumed the chair of the American Women’s Hospitals (AWH), a medical relief organization established by the U.S. Medical Women’s National Association during the war to support all-female medical units in France. Under Lovejoy’s direction the organization would expand to provide...

medical relief in the postwar climate of civil wars and economic and refugee crises. Lovejoy was also an organizer and first president of the Medical Women's International Association (MWIA) during its foundation years 1919-1924 and helped to establish its transnational activist program.

Lovejoy was not alone. For many medical women involvement in social medicine before the war and their wartime experiences would be a catalyst for their participation in postwar transnational organizations and for a strong degree of shared identity and purpose. During the war, women physicians on both sides of the conflict formed all-female medical units and provided medical care in hospitals and clinics and with voluntary organizations. One result of this shared identity and experience was the five-week International Conference of Women Physicians attended by more than one hundred medical women from over sixteen nations. They convened in New York City from September 15 - October 24, 1919 to discuss a range of topics relating to women's health including conditions for working women, birth control, and sexuality. Wartime experiences and over a month together sharing common concerns for women's health and debating ideas and programs emphasized the "importance of conferring together regarding matters affecting national and international health" and the possibility of an "international association of women physicians." During the war years women in the United States (1915) and Great Britain (1917) had organized national women's medical associations.¹¹ Now at the close of the conference the assembled women doctors organized the Medical Women's International Association as an "outgrowth of the war and reconstruction activities of medical women of different nationalities" to provide the structure to continue their shared work.¹² Members selected Esther Lovejoy to serve as the first president of the Association and the Executive Board included nine members from Europe (England, France, Holland, Italy, Norway, Scotland, Serbia, Sweden, Switzerland), two from South America (Argentina and Uruguay), two from East Asia (China and Japan), one from Canada, and four from the United States.¹³ The early leaders of the MWIA shared a common identity as women physicians, common experiences with organizing and activism before the war, and many engaged in wartime medical activities. As Leilu Rupp has found for other groups of women working across borders, "identity politics of such organizations sometimes served as an alternative— or at least a complement—to national identity, in that way contributing to the construction of internationalism."¹⁴ Members from Great Britain included Jane Walker, a founder and first president of the Medical Women's Federation of Great Britain who had campaigned for officer rank


¹³ Lovejoy et al., "Medical Women's International Association," p. 3-6; Lovejoy, Women Physicians and Surgeons, pp. 15-24; The Executive Board included Lovejoy (United States), Christine Murrell (England), Lucie Thuiller-Landy (France), Kristine Munch (Norway), Marie Feyler (Switzerland), Martha Whelpson (United States), Ellen Potter (United States), Radmila Lazarevich (Serbia), Alicia Moreau (Argentina), Daisy Robinson (United States), and Tomo Imou (Japan). National Representatives included Alicia Moreau (Argentina), Grace Riehl (England), Idah Kain (China), Christine Murrell (England), Lucie Thuiller-Landy (France), Ada Potter (Holland), Nelia Lollini (Italy), Tomo Imou (Japan), Kristine Munch (Norway), Frances S. Johnston (Scotland), Radmila Lazarevich (Serbia), Alois Sandquist (Swedland), Marie Feyler (Switzerland), Esther Lovejoy (United States), and Alice Armand Ugon (Uruguay).

for British women physicians during the war. Louisa Martindale served on the Executive Committee of the National Union of Suffrage Societies and worked to open medical education and practice for women in Britain. She was a founder of the Medical Women’s Federation of Great Britain, and during the war provided medical care at the Scottish Women’s Hospitals at the Royaumont Abbey outside of Paris. Christine Murrell was active in the Women’s Social and Political Union for suffrage, provided medical care to suffragists on hunger strikes, and chaired the postwar Women’s Election Committee to advocate for the election of women to the House of Commons. During the war she was a medical officer of the Women’s Emergency Corps, a voluntary aid organization established by the National Union of Suffrage Societies.

15 Jane Walker (1859-1938) attended the London School of Medicine for Women, received the LRCP (Licentiate of the Royal College of Physicians) in Dublin in 1884, a LRCs (Licentiate of the Royal College of Surgeons) in Edinburgh in 1888, and an M.D. in Brussels in 1890 and thereafter attended clinics in Vienna. She was an expert in tuberculosis care and president of the Medical Women’s Federation from 1917-1920. See “Jane Walker,” Lancet 235 (November 26, 1938): 1299-1301.

16 Eleanor Rath Coats (1859-1944) was a surgeon who worked at the Stockholm Free Clinic and helped to develop Sweden’s sex education program for public schools. She was a founding member of the International Woman Suffrage Alliance.

17 Lucie Thibult-Landry (1879-1962) was a French physician and one of the founders of the Union Française pour le Suffrage des Femmes. She was a delegate to the International Woman Suffrage Alliance and served as president of the American Woman Suffrage Association. See “Lucie Thibult-Landry,” Women and History 25 (1991): 235-249.

18 Germaine Montreuil-Stauss was a pioneer in sex education in France and a member of the Conseil National des Femmes Françaises (National Council of French Women, CNFF) and the International Woman Suffrage Alliance. See “Germaine Montreuil-Stauss,” Modern Women 19 (1919): 1-10.

19 Alma Sandqvist was an expert in venereal disease who worked at the Stockholm Free Clinic and helped to develop Sweden’s sex education program for public schools.

20 Founding members outside of Western Europe and the United States included Grace Ritchie England of Canada, suffragist and public health activist, provincial vice president of the National Council of Women, and a Canadian representative to the International Congress of Women. Paulina Luisi, the first woman in Uruguay to receive a medical degree and a pioneer in sex education and working women’s rights, was organizer of the Alianza Uruguay de Mujeres para el Sufragio Femenino. Luisi was the president of Montevideo’s Women’s Suffrage Alliance in 1919 and a delegate to the International Woman Suffrage Alliance. See “Luisi, Paulina,” Women Scientists from South America, ed. Roberta Dreyfus, pp. 157-160.

21 Alicia Moreau was a leading Argentinean

22 Lucie Thibult-Landry (1879-1962) was a French physician and one of the founders of the Union Française pour le Suffrage des Femmes. She was a delegate to the International Woman Suffrage Alliance and served as president of the American Woman Suffrage Association. See “Lucie Thibult-Landry,” Women and History 25 (1991): 235-249.
socialist feminist, suffragist, and public health activist, author of *Feminism in Social Evolution* (1911) and *The Civil Emancipation of Women* (1919). Tomo Inouye, a 1901 graduate of the University of Michigan, was medical director for girls in the Tokyo public schools and a founder of the Japanese Medical Women’s Society.

For Lovejoy and other MWIA members, the concept of international health defined freedom from disease as a paramount goal of the postwar world. This view was caused by the poor state policies and international relationships that led to social and economic injustice and war. To address this, they designed the MWIA to support three major transnational goals: to promote medical education and careers for women, to provide opportunities for women physicians to form collegial partnerships for action across national boundaries, and to formulate health policies that would promote and support healthy, safe and secure communities for all women. In the process they created what Nitsa


involvement. The postwar period presented many transnational health crises including care of refugees, epidemics, and natural disasters. The League of Nations formed a permanent Health Committee in 1923 with commissions to investigate and assist in medical emergencies such as epidemics, to keep statistics and issue reports, and to hold conferences and interchange visits for medical specialists. A number of women physicians participated in these interchange visits. Two MWIA members, Swedish physician Alma Sundquist and Danish physician Estrid Hansen-Hein, served on the League Commission for the Control of Traffic in Women and Children and Narcotics. In the interwar period the MWIA took steps to strengthen women physicians’ roles in other organizations by creating liaison officers who would represent the MWIA at meetings of the League, the International Labor Organization, and the International Red Cross. The MWIA exchanged publications with international health organizations, publicized employment opportunities in its journal and other venues and encouraged women physicians to prepare themselves in local work for a future in transnational service.

As a transnational organization the MWIA provided a structure for women physicians that enabled them to consult with and support one another so that they could take on strong policymaking roles in their communities and home nations, and so that they might contribute to international organizations that were setting health policies among nations. The MWIA had a dual membership structure that included physicians who were members of an established national association such as in the United States and also individual members from nations that did not have an organized medical women’s association. Membership grew from several hundred in the early 1920s to 2,000 in 1924 and over 3,600 by 1929. MWIA conferences in these years featured topics such as women and cancer, working women and health, birth control, sex education, and physical education, and provided a forum for women to share research, strategies, and information. The MWIA journal featured reports on women physicians’ activities in their respective nations, information on international organizations and global health issues and the editors reprinted conference papers. Thus while MWIA members continued to work for a larger role in national and transnational policymaking they were also achieving results by assisting in the development and professionalization of women physicians in a variety of nations. Because the MWIA was a professional organization as well as a potential policymaking one, members counted solid accomplishments in strengthening women physicians’ roles and networks as a foundation for future achievement in the transnational policy arena.

From the beginning Esther Lovejoy hoped to enhance the power of the MWIA through cooperative work with the medical relief efforts of the AWH. While continuing to work for women’s inclusion at the League of Nations and other international organizations, she also worked to connect medical women through the MWIA and AWH for transnational action. This was not a new strategy for Lovejoy and other medical women who, as we have seen, were used to working to gain inclusion in traditional institutions at the same time that they worked to achieve goals in separate women’s institutions. In the period of revolution, nationalist conflicts, the redrawing of national boundaries and refugee crises after the First World War Lovejoy expanded the scope and purpose of the AWH and worked to shape policy outside of traditional institutions. The AWH provided medical relief in Greece and Turkey during and after the Greco-Turkish War in 1922-1923, established clinics and dispensaries in Yugoslavia and Albania, provided medical support in Russia and Soviet Armenia after the
revolution, and sent assistance after earthquakes shattered Tokyo in 1923. Lovejoy and the AWH also drew upon transnational networks among women physicians to provide vital relief during the Second World War in Europe, China, and the U.S.S.R. and in other areas after the conflict.\textsuperscript{18}

Lovejoy facilitated transnational activism through cooperation between the AWH and the MWIA to create a feminist "without borders" philosophy for international health. The "without borders" approach was similar to the ideologies of later medical relief organizations such as Doctors Without Borders that, according to medical sociologist Renée Fox, link "medical humanitarian and human rights action, within the larger framework of what has been termed a "without borders" movement." This involves challenging state policies and politics with programs "premised on the conviction that medical care, service, and relief is a humane form of moral action, with the capacity to bind up wounds that are more than physical, to 'heal the body politic' as well as the human body."\textsuperscript{30}

Lovejoy's "without borders" activism through the AWH and MWIA was also strengthened by a feminist vision of the role of medical women in international health and a commitment to social medicine as a method to effect change in international affairs to create strong and healthy communities. Medical women shared many elements of a common identity and program, what Lovejoy called the "friendly and practical relations of women doctors in different countries."\textsuperscript{31} Members of the MWIA and AWH could therefore challenge state structures and traditional international relations by promoting their vision of international health. Women physicians were "writing treaties of peace," Lovejoy noted, "not on scraps of paper, but in the hearts of thousands of children, the men and women of tomorrow."\textsuperscript{41}

Lovejoy's work with Soviet public health pioneer Vera Lebedeva is one notable example of her facilitation of effective connections between the AWH and the MWIA and the potential that a shared identity as women physicians held for a feminist "without borders" philosophy and practice. This is particularly significant given that Allied nations, including the United States, had participated in military operations against the Bolsheviks in Russia in 1918-1919 and that a virulent Red Scare raged in the United States and other Western nations in the 1920s. In public, Lovejoy could use medical relief as a political tool by the relationship between Soviet medical women and AWH/MWIA and as some protection from criticism. Work with the Soviet Union was not the political concern of medical personnel, Lovejoy asserted. "We were there," she said, "to care for the sick."\textsuperscript{42}

Vera Pavlova Lebedeva combined medical and revolutionary activism throughout her life. Born in poverty in 1881 in Izhmii Nizhgorod, Russia, she secured a place for her education in the gymnasium with the assistance of a charitable organization, worked as a rural schoolteacher, and in 1901 enrolled at the Women's Medical Institute in St. Petersburg. Expelled for distributing revolutionary materials, she returned home to Nizhgorod and worked for the Bolshevik party by assisting political prisoners during the 1905 revolution. Here she met and married the revolutionary author Pavel Lebedev-Polinisky. They worked in exile in Finland and Switzerland and she returned to her medical studies in St. Petersburg, graduating in 1910. Fired from her first position as a zemstvo (local district) physician for revolutionary activity, Lebedeva joined Pavel in Geneva where she combined work in a women's clinic with activism in association with Vladimir Lenin and other Russian exiles.\textsuperscript{43}


\textsuperscript{41} "American Medical Women's Overseas Service," Medical Woman's Journal 51, no. 10 (1944): 20.


\textsuperscript{43} Lovejoy, Women Physicians and Surgeons, p. 97.

Lebedeva returned to Russia in May 1917 and following the October Revolution in 1917 that brought the Bolsheviks to power became the director of the new Soviet Department for the Protection of Maternity and Infancy (OMM). As director of the OMM, Lebedeva combined her medical training and public health concerns with her views about women's roles and her ideological identification with the new Soviet state to develop a comprehensive program of state services. Women would no longer be lone individuals who needed to find medical and child care in isolation and who bore the double burden of wage work and domestic work. Women would achieve liberation as workers who were also mothers. Lebedeva's goal was to establish women's clinics and childcare centers and to provide prenatal and pediatric health education across the new nation. These were “based on the picture of woman in the work process,” she asserted, “which we keep constantly before our minds eye.”

In 1922 Lebedeva began to work with Esther Lovejoy and other medical women in the AWH and was soon involved in the MWIA. The Soviet Union was emerging from severe famine and the ravages of civil war, and beginning in 1921 the AWH provided salaries for Dr. Effie Graff and Mabelle Philips in their work with the American Friends Service Committee at Buzuluk, Samara. As part of a discussion about possible AWH work in Moscow Lebedeva extended an invitation to Lovejoy to visit in the spring of 1923. Visa delays postponed Lovejoy's plans to travel to meet with Lebedeva directly, but the two corresponded about ways that the AWH might work with the OMM. Lovejoy also sent information and materials about the MWIA, including a copy of her 1922 Geneva presidential address. The “fraternal spirit engendered” at the Geneva conference, she wrote, “gave us all new hope for a closer union for international service in the future... There are only a few thousand medical women in the world, but united for action they might render a comparatively large service in their chosen field.”

The following year Lebedeva accepted an invitation to represent the Soviet Union as a councillor to the 1924 London meeting of the MWIA and to present a paper about her work. This was at a time when conflict between her nation and the West severely hampered most other transnational relations. In her paper “Mothers’ and Children’s Welfare in Soviet Russia,” Lebedeva articulated her theory of public health and reported on Soviet accomplishments. First, she said, “we consider Mothers’ and Infants’ Welfare as a task of the state” and a “social function,” and “absolutely exclude from our work any suggestion of philanthropy.” In the Soviet state women were first workers, then mothers. “In organizing institutions to alleviate the burden of motherhood, we consider the woman always as a working force in the process of work,” she noted. Lebedeva presented her colleagues with information on the development of institutions and services within her department. These included crèches (nurseries and day-care centers), consultation centers, homes of Mother and Child to support women during the two-month maternity leave, milk camps, and legal services, some 1,350 institutions in all. She also highlighted the establishment of the Scientific Institute of Mothers’ and Infants’ Welfare in Moscow, a teaching hospital that trained “physicians, pediatricians, midwives, and nurses” with the latest developments in obstetrics, gynecology, pediatrics, diet and nutrition and a center for the development of public health educational resources and dispensary services. The work, Lebedeva noted, combined the “experience gained by Western scientific thought” with Soviet “social principles.”

Yet even as Lebedeva shared her hopes and accomplishments with colleagues in London in 1924 her vision of a new society based on the liberation of women and a redefinition of motherhood and the family in the Soviet Union was disintegrating. As Wendy Goldman demonstrates, the period from 1917 to 1936 in Soviet politics saw a “complete reversal” from a commitment to women’s liberation and the “withering away” of the family to restrictions on and reversals of progressive policies and a “repressive strengthening of the family unit.” The Soviet Women’s Party, the Zhenotdel, which provided vital advocacy for women’s issues, was...
severely weakened in the 1920s and abolished in 1930. The Soviet adoption of the New Economic Policy in 1921 shifted support for Lebedeva’s clinics, homes, and creches to the local districts that had little if any financial support to spare. It also caused grave unemployment for many women, further eroding their own ability to support themselves and families. In the middle of the 1920s women earned 65% of what men earned because they were “concentrated in unskilled, menial jobs at the bottom of the pay scale.” Lebedeva provided a strong voice of opposition to these changes and insisted that the dismal economic situation, combined with the decrease in state funding, challenged women’s very survival.

As a result, both Soviet state policies and international fears of the U.S.S.R. were strong barriers to women’s transnational medical work and to the achievement of the goals of social medicine. In these challenging years following the London conference, however, Lebedeva continued to work with Lovejoy and other medical women outside of the Soviet Union. The AWH provided some $1,000 to fund public health publications and for educational work.

Lebedeva left the OMM in 1931, but the foundation for cooperative work had been established. There was little contact during the 1930s given that Lebedeva was no longer in the OMM. Stalinism increased many barriers, and economic depression hampered fund-raising for relief. But during the Second World War Soviet women physicians worked with the AWH to provide vital sulfapyridine and other medicines for wartime medical relief work in the U.S.S.R.

Thus the cooperative work established with Soviet medical women through AWH and MWIA networks stood as an important transnational achievement across the interwar and wartime years.

The power of transnational medical women’s networks is also apparent in the case of the Austrian physician Dora Teleky. Born in Vienna in 1879, Teleky graduated from the University of Vienna Medical School as one of the first women graduates and one of Sigmund Freud’s first female students.

In the years before the First World War Vienna was an international center for postgraduate clinical studies and Teleky served as assistant in gynecology and obstetrics in the two leading women’s clinics in the city. It was in this context that she first met and worked with women physicians who came to Vienna’s postgraduate clinics from many nations, including Esther Lovejoy. Following the war Teleky organized and directed a birth control clinic in Vienna and continued her medical and surgical work. Her research and scholarship in gynecology and urology led to her election as the first woman in the Austrian medical scientific society, the Gesellschaft der Aerzte.

Teleky shared the transnational impulse of many women physicians following the First World War, but her Austrian nationality and her wartime service in an Austrian military hospital made her a former “enemy” of the Allied nations. In 1922 Esther Lovejoy, president of the MWIA, challenged such notions. She invited her colleague from their Vienna clinic days to the Geneva conference and introduced Teleky personally to her colleagues at the banquet that marked the close of the gathering. In her response Teleky said that “she had not hoped ever again to be received so warmly” and that the reception she received at the conference “would give heart to her colleagues in Vienna.” Lovejoy responded that “if women had a larger place in the affairs of nations,” she believed that “the world war would never have come.”

Teleky emerged as a dedicated transnationalist after this conference. In 1924 the one hundred members of the five-year-old Austrian Women’s Medical Society who had founded elected Teleky as a delegate to the MWIA meeting in London. Teleky became the MWIA’s corresponding secretary and board member for Austria, a post that she held until 1938. She joined the editorial board of the Medical Women’s Journal in 1923 and...
continued to serve through the Second World War. Teley and the Austrian Women’s Medical Society hosted the fifth council meeting of the MWIA in Vienna in 1931 and she presented a report on birth control at the eighth general meeting of the MWIA in Stockholm in 1934.

In the interwar years Austrian state policies challenged Teley’s status as a woman physician and, ultimately, threatened her life as a Jewish woman. Following the annexation of Austria by Germany in 1938, Teley wrote that the Austrian medical women’s association had been dissolved and that she could no longer serve as MWIA corresponding secretary. She was proud to have collaborated with her colleagues from other nations, she wrote, “all of whom were so capable and so devoted to our common work.” As Austria became an increasingly dangerous place for Jewish citizens, Teley and her husband Ernst von Brücke worked with international colleagues to find ways to leave the country. Von Brücke, also of Jewish descent, lost his position as a prominent faculty member at the University of Innsbruck in 1938. He secured a position as research associate at Harvard University through the effective support and lobbying efforts of his colleague Alexander Forbes, and arrived in Boston in August 1939 just two weeks before the Nazi invasion of Poland. Teley drew upon her transnational relationships with women physicians to leave Austria. In July 1938 when her assets as a Jewish woman were claimed by the Reich she found refuge for some months with her British MWIA colleagues, staying first in London and then south of the city in Surrey. She arrived in New York on September 15, 1939. Esther Lovejoy visited Teley upon her arrival in New York and by November 1939 Teley was in Boston, where her husband was conducting laboratory research at Harvard Medical School.

After Ernst von Brücke’s death in June 1941 Teley remained in Boston, secured her state medical license, pieced together medical work and eventually built a practice. She retired to Switzerland in 1950 at the age of 71 and lived in retirement until her death in 1963.

Women physicians worked to assist Teley and other refugee colleagues and coordinated their activities with other women’s and refugee groups. The MWIA formed a joint committee with the International Federation of University Women to provide support for medical and professional women and former MWIA president Lucie Thuillier-Landry was the organization’s liaison to the International Committee for the Assistance of Refugees in Geneva.

Esther Lovejoy and the AHW provided funds for refugee medical women and worked with Thuillier-Landry, Louisa Martindale, president of the MWIA, the French Association of Medical Women, and the French Association of University Women.

The Danish and Swedish medical women’s associations raised funds to assist refugee colleagues. MWIA honorary secretary Germaine Montreuil-Straus “kept an up-to-date list of all these women doctors of whom they were notified, and made contact with those countries where it was believed, able to accept them.” The American Medical Women’s Association formed a refugee committee in July 1938 directed by Rita S. Finkler, who was herself a 1915 refugee from Russian pogroms. And women’s medical associations of various U.S. states also formed committees. Initial efforts involved individual sponsorship of medical colleagues from Austria and Germany, including Dora Teley. Many groups then expanded to fundraising. Montreuil-Straus characterized the

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36 Medical Women’s International Association, Report of 1924 Meeting pp. 5, 10; Board member list, Medical Women’s International Journal 1 no. 1 (1925): 1; “Medical Women of Today – Brücke-Teley,” and see Editorial Board list, Medical Women’s Journal 49 no. 6 (1942): ii.


39 Seyfarth, “Transatlantic Friendship.”

process: “England and France were for some of the refugees mainly transit countries from which they made their way to the U.S.A. where a Committee of Welcome, headed by Dr. Finkler, helped them to re-establish themselves.” This transnational work to support refugee women physicians, Montreuil-Straus believed, demonstrated that “solidarity was not an empty display of words.”

Refugee women physicians encountered many challenges in relocation and the reestablishment of their careers that underscored the importance of support from transnational medical women’s networks. Nativism, anti-Semitism, and fears of competition in a decade of international economic depression operated against male and female physician refugees. But as Atina Grossmann has noted, women physicians faced added burdens and a situation “highly complicated by gender.” Grossmann’s research on German women suggests that “the general committees set up to help refugee physicians” were “unsympathetic to the substantial number of women who hoped to reestablish their medical careers.” Immigration laws in many European nations and in the United States were restrictive before the conflict and, combined with adverse bureaucratic practices, created a “world of barriers” as persecution and war came. The MWIA’s Germaine Montreuil-Straus noted “in actual fact.


66 “Report of the Honorary Secretary,” December 1946, p. 2. Rita Finkler reported the arrival of the following refugee women physicians in the States by December 1939: from Austria, Drs. Marianne Baker-Johol, Ida Bredike-Telesky, Gertrude Gerlerland, and Pauline Feldman “expected to arrive any day;” from Germany, Anita DeLomone, Toni Engel, Hedwig Fischer, Dr. Julius, Greta Gugino, and Dr. Greta Gugino; from Turkey, Erika Bruck. Rita Finkler to Lousia Martindale, December 23, 1939, Folder B, L.M. Rumford Correspondence, 1939, Box 8, GC 25, Martindale Correspondence.


69 Grossmann, “German Women Doctors,” p. 232. Grossmann does not include a discussion of the support from the Medical Women’s International Association, the American Women’s Hospitals, or other women physicians for their colleagues.

70 David H. Peppet, “International Aid to German Refugees,” Foreign Policy Reports 14, no. 6 (1938): 196. For the United States see David S. Wyman, Paper Walls: America and (continued)
in France, with the cooperation of Germaine Montreuil-Straus and the Women's Medical Service-Committee, the AWH sent $200 per month until the fall of Paris and then contributed $300 per month for reconstruction and refugee services in France in 1945. At Montreuil-Straus's instigation the AWH worked with COSOR (Committee of Social Work of Resistant Organizations), formed as part of the resistance to Nazi occupation, in cooperation with the French Medical Women's Association.87

Medical women working with the MWIA and the AWH were able to transcend state and international policies and events from 1919 to 1948 and beyond as a result of their shared identities and shared feminist program. But there were still many challenges to their activism. Women physicians were not a representative group although they hoped to reach out to all women through the common link of health care. Medical women faced continuing social, cultural, and economic barriers to women's study, and practice of medicine and to women's roles as policymakers both nationally and internationally. The class and cultural conditions necessary for women to attain a medical education meant that women physicians were an elite group with some 10,000 women practicing globally in the interwar years. Most of the women were from Europe and North America, with some few physicians from Asia and Latin America participating. The costs of travel, communication, and the administration of international organizations also limited participation. In addition, economic crises in nations and across the globe in the interwar years pressured heavily on transnational organizations.

Yet within the scope of their organizations Esther Lovejoy and other women physicians in the MWIA and the AWH used the power of their shared identities, experiences, and common involvement with medicine and public health to take action across national boundaries in the years from the First to the Second World Wars. By defining and acting on feminist goals for international health Lovejoy and her colleagues challenged traditional diplomatic and military goals in international affairs and instead a "without borders" philosophy echoed by subsequent medical relief and non-governmental organizations and other social justice advocates. Their experiences in working simultaneously within and outside organizations, and the links they forged among medical women, the

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79 See Tomo Inouye to Esther Lovejoy, August 17, 1920, Box 6, Folder 20, Lovejoy Collection.

80 See, for example, Janet Campbell to Esther Lovejoy, August 10, 1940; and Esther Lovejoy to Louisa Martincl, January 10, 1940, GC/25/folder B4, LM's Correspondence 1940, Martincl Correspondence; Minutes, AWH Executive Board, January 22, 1946, p. 2, Box 31, Folder 298, Minutes, Executive Board Meetings, 1928-1948, AWH Collection; and Letter to the editor from Janet Campbell, President, Medical Women's Federation, "Help from Women Doctors," The Lancet, June 30, 1945, pp. 834-35, copy in S/A/MWF Box 97 K8/5, MWIA London Meeting 1946, MWF/MWIA Collection; and Janet Campbell, "Medical Women in the Bombing of Britain," Journal of the American Medical Women's Association 1, no. 9 (1946): 309-18.


Medical Women’s International Association, and the American Women’s Hospitals, meant that they created transnational networks to support international health and that women physicians could take action even when challenged by state and international policies and events. Their feminist theory and practice of international health started with the health and well being of women and children and moved from the local to the global in formulating policy and action. The work of Lovejoy and her colleagues in the MWIA and the AWH, therefore, stands as an important chapter in the development of transnational feminist activism.

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HOW TO “MAKE THIS PAN AMERICAN THING GO?” INTERWAR DEBATES ON U.S. WOMEN’S ACTIVISM IN THE WESTERN HEMISPHERE

Megan Threlkeld

In March 1923, former U.S. suffragist Carrie Chapman Catt wrote to Maud Wood Park, president of the U.S. National League of Women Voters, about the importance of inter-American cooperation among women. Catt had been traveling throughout South America, where she became convinced that despite the challenges of different languages, cultures, and religions, women in the Western Hemisphere had to join forces, not only to promote women’s rights but also to secure peace. “It is desperately important that we make this Pan American thing go,” she concluded. “I am convinced that if we women fail, one day [we] will repeat in the western world what Europe has been doing ....” Catt was not alone in her commitment to hemispheric solidarity. Since 1916 various organizations and groups of U.S. women had dedicated themselves to reaching out to Latin American women and to furthering peaceful relations among all American nations. Despite common goals, however, different women promoted inter-American cooperation in different ways and for different reasons. In fact, as Catt quickly discovered, these myriad efforts were frequently at odds with each other.

International and transnational activism were popular among U.S. women in the wake of World War I. For the purposes of this essay, “internationalism” assumes the primacy of nationality and of the nation-state as an organizing principle, while “transnationalism” conveys the primacy of an organization’s subjects, objects, or goals and methods. International groups worked among nations, transnational groups worked across them. According to this model, the League of Nations falls into the former category, the Women’s International League for Peace and Freedom into the latter. The distinction between the two categories is not absolute.

The author would like to thank Kimberly Jensen, Erika Kuhlman, and Diana Williams for their thoughtful feedback on this essay.