

Medical Women's International Association – a space for generating international knowledge and an international medical identity?¹

And what do we want? (...) we want to know and help one another, and we want an instrument wherewith we can make our corporate intelligence and medical training available for service in matters pertaining to international health. (...)

And what does international health mean? It means pestilence which passes from country to country, and all the causes of pestilence, chief among which stands war; it means prostitution and all the causes and results of prostitution; it means traffic in women, traffic in narcotic drugs, or any other evil which may spread from country to country, causing suffering, sickness and death. Briefly, it means the prevention of disease which is due in large measure to destitution resulting from social and economic injustice and war between nations.²

During the First World War, medical women had shown that they could make a valuable and appreciated contribution to health, both inside national borders and in foreign countries. Medical women had applied their skills in the strengthening of recruits, the healing of wounded soldiers and experienced that threats to health and women's medical expertise were not limited to national borders. Motivated by the experiences of the war, in 1919 medical women from seventeen countries participated in a six-week conference in New York, to present and discuss measures of hygiene and social health that could better the moral condition, well-being and health of humanity.³ By the end of that conference, the American Women's Hospitals Committee and the War and Reconstruction Committee of

¹ This paper is a first result of the M. Louis Gloeckner M.D. Summer Research Fellowship, granted from the Archives and Special Collections on Women in Medicine, Drexel University College of Medicine, Hagerty Library, Philadelphia. I am very grateful that the fellowship enabled me to use the comprehensive archive of the Medical Women's International Association (MWIA).

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² Esther P. Lovejoy, 1923, The Possibilities of the Medical Women's International Association, in: The Medical Woman's Journal, 30 (1923), no.1, pp. 14-18. here 16-17.

³ Proceedings of the International Conference of Women Physicians, 1919, Conference held in New York City, Sept. 15-Okt. 24, 1919, 6 Vol. New York: The Woman's Press.

the American Medical Women's Association invited the delegates to join a dinner in honor of the medical women, who had volunteered in France during and after World War I. At that dinner, the present medical women had founded the Medical Women's International Association (MWIA). Several reports of this event state that the founding had happened without prior planning and intention; it was the result of a shared desire to continue the freshly started common work.⁴

The MWIA was a special example in the history of internationalization: it was seldom that a female international organization existed before a gender-neutral was founded, which quite often meant a men's organization. Specialized medical associations did exist, for example, the international association for surgeons, which, together with the International Council of Women served as a role model for MWIA's first organizational steps.⁵ However, the World Medical Association had first been established after the war in 1947. In addition, the timing for founding the MWIA seemed to be unusual. In a perspective of internationalism, the interwar period has been described as a time-period of decline for internationalism.⁶ Yet, not by chance did MWIA's first regular meeting in 1922 take place in Geneva, at the same time when the League of Nations had its annual assembly. The MWIA's participants listened to the inaugural lecture of the League of Nations and the first president of the MWIA, Esther P. Lovejoy, expressed high hopes and expectations for the sake of internationalism. Lovejoy formulated a moral and an intellectual obligation for medical women to cooperate on an international level: Medical women "*possess enormous power for good,*"⁷ they are "*a chosen class of women,*" who had to use their special

⁴ Compare: Lore Antoine, 1970, The Medical Women's International Association, History 1919-1970. Unpublished, without page numbers. In MWIA Accession 271, Box 58, file: History of MWIA 1919-1970. and: Esther P. Lovejoy, 1946, Historical Sketch of the Medical Women's International Association, in: Journal of the American Medical Women's Association, 1 (1946), no. 8, pp. 245-251, here: 245.

⁵ Letter from Esther Lovejoy to Dr. Landry, January 3rd. 1921, in: MWIA, Accession 271, Box 7, file Council Meeting Geneva, 1922. And: Lore Antoine, *ibid.*

⁶ See: Sangster, Joan, 2007, Crossing Boundaries: Women's Organizing in Europe and the Americas, 1880s-1940s, in: Jonsson, Pernilla / Silke Neunsinger / Joan Sangster (Eds.), Crossing Boundaries. Women's Organizing in Europe and the Americas, 1880s-1940s, Acta Universitatis Upsaliensis. Uppsala Studies in Economic History 80m Uppsala, pp. 9-19, here: 12.

⁷ Circular letter from Esther Lovejoy, President to the National Corresponding Secretaries, 28.2.1924, in: *ibid.*

abilities and skills for the good of humanity.

Our privileges and responsibilities are very great. (...) United for action, 10.000 strong, we may greatly influence the health and social status of humanity during this generation, leaving our work with all its possibilities of future development to those who will surely follow after us as we followed after the pioneer medical women of the world.⁸

Before women could influence the health of humanity, they had to overcome professional marginalization. Most of the medical women joining the MWIA stressed that they were discriminated against and marginalized in their national contexts. Forming an international association, co-operating with women from other countries, could strengthen their position on a national level. Another explicit goal of the MWIA was to promote the inclusion of medical women in international bodies such as the health committees of the League of Nations.⁹ The importance of including and promoting medical women was not only a question of equality and career opportunities. The MWIA ascribed medical women distinct abilities and capacities different from their male colleagues. In areas of specialization, the MWIA emphasized social medicine: improving health and preventing diseases meant to better the social and economic life conditions. As women, medical women ascribed to themselves a special medical expertise and ability to solve problems of social health. Thus, the MWIA was a platform for knowledge for topics concerning medical women. At their regular scientific conferences, the MWIA took up difficult work situation for medical women - women in exotic countries, women police surgeons - and topics that were considered of special importance for women: venereal diseases, abortion, birth control, cancer in women, women and the effect of physical exercise.¹⁰

Medical women had built an international association in order to empower themselves, both on a national and international level and to produce and implement knowledge on social medicine and preventive health that would better the health and well-being of

⁸ Esther P. Lovejoy, 1923, The Possibilities of the Medical Women's International Association, in: The Medical Woman's Journal, 30:1, January 1923, pp. 14-18, here 14.

⁹ Esther P. Lovejoy, 1923, The Possibilities of the Medical Women's International Association, in: The Medical Woman's Journal, 30:1, January 1923, pp. 14-18. here 18. And: The Medical Women's Journal, 29:10, October 1922, pp. 236-238.

¹⁰ For a complete list of the conference topics until 1970 see Lore Antoine, *ibid.*

humanity.¹¹

The formulated goals of the MWIA lead me to the following overarching questions for this paper: From the founding years to World War II, how did the MWIA negotiate, organize and achieve internationalism, in terms of administration, medical knowledge and medical identity?

A. FORMING, LOCALIZING AND ADMINISTRATING INTERNATIONALISM

One important and controversial topic inside the MWIA was the question of membership and representation. Should individual medical doctors be eligible for membership, representing their individual medical skills, or should only medical associations become members, representing different nations? The MWIA decided for national representation, following the regulation and practice of the League of Nations. The constitution declared that “*any of the seventy-three sovereign states of the world (reckoned as such according to the Constitution of the League of Nations) shall be eligible to participate.*”¹²

In addition, the MWIA allowed individual membership, if the forming of a national association was too difficult to achieve. However, individual members could only attend scientific conferences, and did not have the right to vote or to attain a seat in the decision making body. Eligible for full membership were associations located in a sovereign state, consisting of medical women only, who were qualified according to the accepted standard of the medical profession in their own country. Thus, associations including men, students, nurses and other health workers were not accepted as member associations. This ruled out the full participation of many medical women. When the MWIA was founded in 1919, only Great Britain and the U.S. had national medical women’s associations that were eligible for full membership. In Russia for example, only an association for all health workers, including women physicians and nurses, existed. Other countries like Sweden and Denmark were reluctant to form a women’s organization, since they did not feel the need

¹¹ The Constitution of Medical Women’s International Association, 1924, in: WMIA, Accession 271, Box 33, file Statutes 1919-1929.

¹² Ibid.

to do so; they experienced equal working possibilities for male and female medical doctors in their countries and did not want to confront and provoke their male colleagues by forming a separate organization.

The MWIA chose national gender-segregated associations as its form of membership because the UK, the biggest national branch, had practiced this solution, but also because many women, even from small nations like Norway, agreed upon the desirability to push medical women to form national associations. A primary task of the first years was to write letters to individual medical women in several countries, encouraging them to form national branches of MWIA. By 1921, 7 nations had formed national associations and in 1928 the MWIA already had 21 affiliated national branches.¹³ Despite initial skepticism, both Denmark and Sweden organized national branches in the beginning of the 1920s, became active members of the MWIA and started to perceive a gender-segregated medical organization as important. Thus, the MWIA is an example of the power of an international organization to shape national processes.

Yet, deciding on national representation did not provide equality among nations. The principle was not one vote per country, but the vote on the Council was proportionate to the amount of national members an association was able to organize.¹⁴ Smaller associations like the Norwegian one, who had managed to organize a comparatively large number of the medical women in their country, but had a limited total amount of medical doctors,

¹³ Until 1945 the following nations were affiliated: United Kingdom 1919, United States 1919, Norway 1921, New Zealand 1922, Italy 1922, Switzerland 1922, France 1923, Austria 1924, Canada 1924, Germany 1924, India 1924, Yugoslavia 1926, Hungary 1926, Denmark 1927, Sweden 1928, Mexico 1928, Belgium 1929, Bolivia 1929, Japan 1930, Czechoslovakia 1931 Finland 1932, Australia 1936, Netherlands 1937. In addition, contact existed with medical women from Argentina, China, Scotland, Serbia, Uruguay, Greece, Turkey, Russia and single doctors working in (former) colonies.

¹⁴ For every 200 delegates, a country got an extra vote in the council, with a maximum amount of 5 votes. In 1929 MWIA had a total of 3500 members belonging to their respective national branches; 1250 from Great Britain, 600 from Germany, 400 from the United States, 270 from India, 130 Australia, 110 France, 65 Norway, 40 Sweden, 30 Denmark. (and others). Secretary Report Council Meeting, in: Medical Women's International Association, no. 1, 1929, pp.25-27.

explicitly criticized this regulation.¹⁵

Closely connected to this problem was the question of where to localize an international organization. The association's work had to take place in specific locations: women had to meet for congresses, council and executive meetings. Whom to elect as presidents and vice-presidents, where to locate a secretary were among others questions of available local infrastructure, geographical centrality – seen from a European perspective – and language.

The first presidents and secretaries were located in the US (1919-1924).¹⁶ There, MWIA's secretary was located together with Medical Women's Hospital in New York and could use the already available administrative infrastructure. The next president and secretary were located in London (1924- 1929), followed by leaders in Paris (1929-1934). Even if presidents from other countries were elected after 1934, from 1924 onwards until 1947, MWIA took place in and between London and Paris.

When in 1934 MWIA's council elected a Swedish medical doctor, Alma Sundquist as president, for the first time the honorary secretary and the secretary did not move to the president's country but remained in Paris. The election of Alma Sundquist rekindled a critical discussion of how to solve the problem of representation: Did the medical doctors elect Alma Sundquist in order to honor a worthy medical doctor and woman, or to grant Sweden due representation? The latter case would be an argument for moving the secretary to Sweden as well. The final decision to let the secretary remain in Paris was justified in terms of continuity of work, but also by pointing to the difficulties for Sweden to provide the necessary infrastructure, among others a secretary that could communicate in the two official languages English and France. Another argument was the huge travel expenses to Sweden, a country in the periphery of Europe.¹⁷ The decision of locating the secretary in

¹⁵ Letter from Kristine Munch to Dr. Murrell, 9.9.1923, MS-100 Accession 271, Box 27, File Statutes: 1919-1929.

¹⁶ The first council consisted of medical doctors from the US (president), from Great Britain, France, Norway (Vice-Presidents) and Switzerland. Esther P. Lovejoy, 1923, *The Possibilities of the Medical Women's International Association*, in: *ibid.* 15.

¹⁷ Medical Women's International Association, Stockholm Congress, August 7th to 12, 1934. *Advisability of a Permanent Secretariat*, in: American Medical Women's Association, Accession 37, *Women's Organization, Medical, WMIA*, File: Stockholm-1934 – 3rd Congress. And: Circular letter written June 22nd 1934 by G-

Paris had the practical consequence that the Swedish president Alma Sundquist had only twice attended the monthly meetings in her 4 years of presidency.¹⁸

In order to become active members of the MWIA, medical women had to have sufficient resources. Not every medical woman was able to travel, to cross borders to be part of this international organization. Communication and an exchange of opinions among the members of MWIA took place in letters, but meetings and direct conversation played an important role for the work of the MWIA. Some medical women made this explicit, and discussed the role space and location played for the Association: Did the location of the secretary at one fixed place guarantee a continuation of work that they perceived as universal? Or should the secretary move from country to country, infusing the international association with new approaches to hygiene and social medicine – presupposing that medical knowledge on these topics were linked to specific countries and changed from country to country?

What is under negotiation here is the importance of geographical location and national belonging for generating medical knowledge and practice.

The MWIA was an international organization in the sense that it built its membership from different nations. Although it managed to organize a considerable amount of nations from different continents, it was not a global organization. Its organizational center and focus was in Europe and the US, or even more specifically, in the international cities of London, Paris and New York, which provided the experience and infrastructure to administer internationalism. Location was important, both for administrating the organization, as well as for questions of representation and medical identity.¹⁹

Montreuil-Straus, Honorary Secretary, WMIA, Accession 271, Box 8, File Circular Letters 1930-1939.

¹⁸ Officer's meetings, which comprised the president and three, from 1929 onwards 6, vice-presidents from different countries, the honorary secretary, the treasurer, and the secretary, were held every month, council meetings every other year and scientific congresses every fourth year. However, several vice presidents from countries like Norway, Germany, Italy and Yugoslavia were very seldom present at these meetings.

¹⁹ The question whether the medical doctors elected a person or a country were resumed, but not solved, when the election of vice-presidents has been discussed on the 1937 Edinburgh conference: Minutes of the First Council Meeting held in the New University Buildings Edinburgh, Wednesday July 14th 1937 at 9.30

B. PRODUCING AN INTERNATIONAL MEDICAL KNOWLEDGE?

In the following, I will have a closer look at which kind of medical knowledge the MWIA organized and produced. Is it possible to discern a traveling and transforming of knowledge from a national to an international knowledge? And what happened to the international knowledge when it traveled back to the respective countries?

In regular intervals, the MWIA had organized scientific conferences where at least two topics had been discussed.²⁰ At the Stockholm conference in 1934, for example the chosen topics were physical education and abortion. Papers on these topics were generated in a process involving two to three reporters, who represented specific groups of nations. For example, at the Stockholm conference in 1934 three reporters were talking about physical exercise: One representative for the German Association speaking for the “Nordic countries”: Germany, Finland, Sweden, Norway and Denmark. One medical woman from Poland, presenting the results from Central Europe: Hungary, Italy, Austria, France, Poland and one from the USA presenting the USA, Great Britain and Japan.

In some cases, it was not obvious how criteria of geographic proximity, or language applied to countries. The US, Great Britain and Japan were stable in their grouping-together. Yet, Germany would sometimes belong to “English writing languages”, or in the case of 1934 be included in a concept of “Nordic countries.” Under the label “Scandinavian countries,” only Denmark, Sweden and Norway were grouped together, classifying Germany as “Central-Europe.”

The groupings did have the effect of establishing (in)coherence between nations, and even more, it did affect the scientific knowledge production. In case of the German-authored “Nordic report” at the Stockholm conference in 1934 the procedure of choosing a German reporter resulted in a comparison of Scandinavian findings with the German results, thereby, Germany’s encompassing experiences with physical exercises dominated the report. Whereas German medical doctors had already undertaken a huge amount of

a.m., p. 9-10, Box 7, File: IV. Congress, Edinburgh 1937. And: Third Council Meeting, Saturday 17.7.1937 (Minutes), WMIA, Accession 271, Box 7, file IV. Congress, Edinburgh 1937.

²⁰ London 1924, Paris 1929, Stockholm 1934, Edinburgh 1937, planned but cancelled: Budapest 1940, Amsterdam 1947, Philadelphia 1950. For an overview of the topics see: Lore Antoine, *ibid.*

research on the topic, the MWIA conference served as an incentive for the medical women in Scandinavia to collect data, to exchange their material, and, as a whole, to generate their own knowledge on the topic. The Danish and Norwegian delegates especially stated that until then hardly any medical scientific material on the topics would exist in their countries, and that they were eager to hear the experiences and results of their international colleagues.

The MWIA's international conferences produced knowledge on a national level that got transferred and transformed into international knowledge. One important tool for internationalizing national knowledge was the use of questionnaires. The process of drawing up questionnaires included several steps. After deciding on a scientific topic by a majority vote in the council, two or more reporters were asked to design a questionnaire for the respective topics. The MWIA's officers assembled the major questions of these questionnaires into one single questionnaire (which sometimes lead to protest by some of the reporters, who did not agree with changes), which was then printed in the international journal. As a next step, every country was called upon to use the questionnaire in order to generate data on the topic in their respective countries. The Council distributed the single national results to the reporters, who had to write a comparative summary for their groups of nations.²¹ The group reports, not the national reports were available as a starting point for discussion and resolutions to take during the conference. Even when no far reaching resolutions and conclusions could be reached, as was the case in the discussion of physical exercise and abortion on the Stockholm conference in 1934, the conference participants stressed that the questionnaire alone was an impressive achievement; it was regarded as the materialization of up to date research interests which were available in the international medical community. Moreover, the questionnaire served as a solid methodological base for further investigations into the topic, both on national levels and for purposes of international comparison.

Now, what impact did the international conferences have on the discussions and regulations in the respective countries on a national level?

²¹ Letter from G. Montreuil-Straus to L. Martindale, 16.5.1933, WMIA, Accession 271, Box 32, File (Vice) President's Correspondence, L. Martindale 1929-1934

Taking the Stockholm conference as an example again, the Danish and Norwegian women doctors published articles and held lectures on the topic of physical exercise, communicating the results of the Stockholm conference. The women could refer to an international authority claiming a beneficial effect of physical exercise for women. Thereby they were questioning prevalent restrictions for women's sports. However, this did neither affect the actual decision-making process in their respective countries nor on an international level. Although the League of Nations requested documentation of the conference's result,²² in their own committee on physical education, a sub-committee of the Health Committee of the League of Nations - not a single woman was included. Important research on the topic was either excluded or only partially referred to and the advice given was, in comparison, restrictive. One reason for the lack of impact might be that many medical experts inside the League of Nations were professors, holding high positions in their nations that were not yet in reach for medical women. Moreover, male medical doctors and scientists had already established a network during scientific conferences that reached further back in time than the freshly established links between the medical women. I found very few reviews and reports about the MWIA conferences in German and Scandinavian scientific journals. Conferences organized by special disciplines, like international congresses on hygiene or physical education attracted more attention.²³ The MWIA was not a highly-specialized organization. Stressing hygiene and social medicine, the MWIA had a different approach to certain topics discussed by the other international bodies. When "cancer in women" was chosen as a topic for the 1937 conference in Edinburgh, MWIA's president stressed that this might be a topic that already had been well-discussed by specialists inside the League of Nations and that would be regarded as a topic for scientific experts only. However, MWIA's members could add knowledge to the debate as women doctors and practitioners: they should concentrate on aspects of prophylactics of cancer, precautions of general hygiene as well as questions concerning early diagnostics, and educational propaganda. It was not asked for expert

²² Réunion du Bureau du 14. Janvier. 1935, p. 3, WMIA, Accession 271, Box 13, File Minutes; Executive Committee, 1929-1937.

²³ About the Stockholm conference in 1934, the German and Scandinavian discussion of physical exercise both on a national and international level and a comparison between the reports written by the MWIA and the League of Nations, see my ongoing PhD project at the University of Oslo. Working title: Tracing a Medical Discourse. Women's Sports in Norway, Denmark and Germany during the Interwar Years.

knowledge produced in laboratory research but for the everyday practical experiences of the medical women as practitioners.²⁴ The women themselves perceived their knowledge production as new and valuable knowledge.

The MWIA stimulated the organization and interaction of medical women on different geographical levels. In the case of Sweden, Norway and Denmark—later also Finland—, the MWIA motivated the establishment of a regional level of interaction – a Scandinavian exchange of medical knowledge and action that had until then not existed between the medical women of these three countries. The national branches started to meet and coordinate research and action, which resulted in a more powerful voice inside the MWIA, but did also strengthen the research on national levels. Together they established a “Scandinavian voice” which successfully claimed that the topic of birth control should remain on the MWIA’s agenda, and they presented a common stance on the question of night work for women.²⁵

On the other hand, the grouping together of different countries could also be perceived as disturbing prevalent perceptions of “belonging together” – the Scandinavian countries would rather have liked not to be grouped together with Germany in 1934. In addition, when in 1937 the US reporter complained that Austria was grouped together with the US, the only explanation given was that Austria had always been included in English written reports.²⁶

Being an international association, and having the production of medical knowledge as one objective, the MWIA did both confirm and dismiss the different spatial levels of the national, the regional and the international. MWIA stimulated the traversal of national borders, both in terms of research and – more and more important – medical doctors

²⁴ Lettre envoyée à: Miss Martindale, Dr. Odlum, Dr. Tayler Jones, Dr. Dagny-Bang, Dr. Balfour, Dr. Sadler (for information), from G, Montreuil-Straus, February 22, 1935, in: MWIA Accession 271, Box 8, File Circular Letters 1930-1939. (The French version is sent to Dr. Sundquist, Dr. Bauer, Dr. Thuillier-Landry, Dr. Montreuil-Straus, Dr. Denis-Géré)

²⁵ Svedberg, Andrea, 1932, in: Association Internationale des Femmes Médecins, no. 6 (1932), in: MWIA, Accession 271, Box 24a.

²⁶ Letter from Napier-Ford to E. Hurdon, 23.4.1937, MWIA. Accession 271, Box 48, File United States 1934-1939.

themselves.

C. REFUGEES: DEALING WITH TRANSNATIONAL MEDICAL EXISTENCES

When the German medical association changed its constitution and banned “Non-Aryan women” from their Association in April 1933, and when the Austrian association had to merge with the German medical women in 1938, the MWIA was confronted with members, who no longer belonged to a national association, and who were no longer able to practice medicine in their home countries and had to cross borders in order to work and to survive. Facing former members who were forced into a denationalized or transnational existence, the MWIA had to re-negotiate questions of representation, of nationality and internationality.

One first official reaction to the exclusion of Jewish medical doctors was to widen the possibilities for individual membership. The MWIA declared every medical doctor who held the qualification of practicing medicine as eligible for membership.²⁷ In doing this, the organization did not follow the decision of their German member branch to exclude Jewish women from the medical community. Even if Jewish medical doctors did not have the opportunity to practice medicine in their national contexts, MWIA did still accept them as medical women. Yet, individual members still did not have a right to vote. The general decision to base the work and representation of the MWIA on national branches was not revised.

Regarding the German national branch, the MWIA claimed a change of the new constitution, if Germany wanted to remain a member of the MWIA. Thereby, the MWIA protested both against the exclusion of Jewish medical doctors and against the inclusion of veterinarians and students. The inclusion of these groups was directly opposed to the first paragraph of the constitution, stating that members need to have a medical diploma in order to become members of the MWIA. The exclusion of Non-Aryans had been

²⁷ Lovejoy, Esther P., 1946, Historical Sketch of the Medical Women’s International Association, in: Journal of the American Medical Women’s Association, 1:8 November 1946 pp. 245-251, here 250-251.

considered a violation of another article stating that the MWIA did not accept religious, political and racial discussions and considerations to enter the MWIA.²⁸ However, it seemed easier to argue with the first violation of the constitution than to criticize too directly the exclusion of Jewish medical doctors.²⁹

Accordingly, when reporting about the Stockholm conference in 1934 the German delegate Edith von Lölhöffel stated that the integration of the new groups of women represents a stumbling block for the MWIA. She did not mention protesting against the exclusion of Jewish medical doctors at all.³⁰ Although the MWIA tried to convince the German branch to change its constitution and to again become a member, the German branch did not reply to official letters sent by the MWIA.³¹ After 1933, the German Association was no longer a member of the International Association, but individual delegates, among them both National Socialists and Jewish refugees, participated in conferences both in 1934 and in 1937.³²

The exclusion of Jewish medical doctors was a topic of discussions, both at the Stockholm conference in 1934, in circular letters and in some national publications.³³ Moreover, the MWIA provided practical help for the refugees, drawing on the international networks MWIA had established so far. Shortly after Jewish medical doctors lost their ability to earn their living in May 1933, among them the former heads of the Austrian and German

²⁸ Teleky, note (without date) Accession 271, Box 53, German Refugees.

²⁹ The official resolution presented on the conference and printed in the newsletter was in accordance with other resolutions, formed by the British Federation of Medical Women and adopted by the Association des Francaises Diplômées des Universités, *Bulletin de l'Association des Francaise Diplômées des Universités*, no. 16, January 1935, pp. 2-3.

³⁰ Lölhöffel, Edith von, 1934, Bericht über den 3. Kongress des Internationalen Aertztinnenbundes, in: *Die Ärztin*, 10 (1934) 9, p. 151.

³¹ Letter from G. Montreuil -Straus, Honorary Secretary to Ruth Schwartzkopf, 17.7.1936, WMIA, Accession 271, Box 37, Federal Republic of Germany 1924-1949.

³² Réunion du Bureau du 16. Décembre 1936, WMIA, Accession 271, Box 13, File Minutes; Executive Committee, 1929-1937. Fourth Congress of the Medical Women's International Association. Edinburgh-July 13th to 18th, 1937. List of Members, in: WMIA Accession 271, Box 7, File IV Congress, Edinburgh, 1937.

³³ For example in the United States: Partymiller, Evalyn, 1934, The Medical Women's International Association. Special Report, in: *The Medical Woman's Journal*. 12 (1934), November, pp. 301-302.

branches, the MWIA received letters inquiring after work in other countries.³⁴ Since the MWIA had already established a cooperative relationship with the International Federation of University Women regarding possible exchanges of medical women, the MWIA could immediately help with information. As early as June 1933, 1,000 copies of the report “notes on the qualifications required for the practice of Medicine in the different countries” was printed and communicated to all Associations and interested persons.³⁵

The MWIA did not stop at that level. In June 1933, the secretary sent a letter to all member organizations and to their individual contacts, inquiring about work for refugees.³⁶ Only very few members saw a possibility for the refugees to take up work in their country. In almost all countries, practicing medicine required a national medical exam, written in the national language.³⁷ Some refugees were able to pass the exams in the US and in England over the years; others found work in health related occupations.³⁸ Massage, beauty treatments, and dermatology were niches some medical women could base a new living on, among others the former head of the German association Elizabeth Hoffa, who opened a massage practice in England.³⁹

³⁴ Compare: Réunion du Bureau du 11.Mai 1933, WMIA Accession 271, Box 13, File: Minutes; Executive Committee, 1929-1937.

³⁵ Medical Women’s International Association. Stockholm Conference, August 7th to 12th 1934. Honorary Secretary’s Report, in: American Medical Women’s Association, Acc. 37, Women’s Organization, Medical, WMIA, File: Stockholm-1934 – 3rd Congress. And: Letter from Ossy Noe to the International Association of medical women in Paris, 27.11.1938, in: Box 50, file: Romania 1930-1962. Answer from Napier-Ford to Ossy Noe, 11.3.1938, *ibid.*

³⁶ Letter Dr. G. Montreuil-Straus. Honorary Secretary, June 19th. 1933, MWIA, Accession 271, Box 53, File: German Refugees Employment Abroad.

³⁷ A medical doctor from Japan was a rare example of encouraging refugees to come to her country. China, Persia, Tanganyika, Siam, British India and Albania did not require exams written inside their borders and in their language. See various Letters, MWIA, Accession 271, Box 53, File: German Refugees: Employment Abroad.

³⁸ An MWIA report published after the war stated that around 50 German and Austrian and 60 Czech medical women managed to pass the national British exams and were able to resume their work in England. However, permanent working possibilities did hardly exist; most of the medical doctors continued their travel to the United States. Council Meeting 21st of September, 1946, WMIA, Accession 271, Box 55, File: Minutes; Council Meetings 1924-1966.

³⁹ The MWIA had planned a workshop on massage for the German refugees in France in 1934 and potential

The MWIA could draw on their established network for providing refugees with information and assistance to find a new living. This happened informally via letters, but also through cooperation with other organizations, for example the International Committee for Securing Employment to Refugee Professional Workers, with which the president of the MWIA as well as a German and Norwegian member had been representatives since 1932.⁴⁰ Thus, without knowing it, in forming an international organization, in establishing networks all over the world and conducting research on working possibilities for medical women, the MWIA provided valuable information for refugees, information that other organizations helping refugees also required.

Since most of the refugees who had contacted the MWIA fled to the US, the MWIA cooperated with other international associations, for example the Council of Jewish Women and the Emergency Committee in Aid of Displaced Foreign Physicians to help Jewish refugees with the immigration process.⁴¹ To encourage their fellow citizens to serve as affidavits, the head of the Welcome committee in the US announced the special qualities of medical women:

(...) Besides, bringing over a woman physician is less of a problem than a man physician. Invariably the women doctors state not only their willingness but their eagerness to act as private instructresses of languages (each physician speaks, reads and writes German, French and English), child nurses, office and laboratory assistants, and even housekeepers, cooks and seamstresses. No occupation is too small to be undertaken by them.⁴²

refugees in Germany, who had written letters to them. However, the workshop had to be cancelled at last minute because of a lack of funding. See: Medical Women's International Association. Stockholm Conference, August 7th to 12th 1934. Honorary Secretary's Report, in: American Medical Women's Association, Acc. 37, Women's Organization, Medical, WMIA, File: Stockholm-1934 – 3rd Congress.

⁴⁰ For the activities of the MWIA and the cooperation with other organizations See: Supplementary Report on the Activities of the International Committee for securing employment to refugees professional workers (Geneva) during the first quarter of 1934, in: MWIA, Accession 271, Box 53, File: German Refugees: Employment Abroad. And Réunion du Bureau du 16 Janvier 1933, WMIA Accession 271, MS-100, Box 13, File Minutes; Executive Committee, 1929-1937 and Reunion du Bureau du 20 Juin 1932, in: Ibid

⁴¹ Council Meeting 21st of September, 1946, WMIA, Accession 271, Box 55, File: Minutes; Council Meetings 1924-1966.

⁴² Rita S. Finkler, Report of the Refugee Committee of the American Medical Women's Association, in: *Women in Medicine*, 62 (1938), pp. 19-20.

The quotation above is a single voice and reference, but I think it generally expresses the medical women's identity from the MWIA's perspective. Besides being medical women, and as such part of a scientific community, entitling them to solidarity by their international colleagues, the medical women are women with special resources. They are educated enough to speak the two official languages of the MWIA, English and French in addition to their mother tongue, German, and they are women with typical gender resources: they can do practical work related to childcare and housework. Bereft of their national context and belonging, Jewish medical women became identified as refugees and most of all, as women. The MWIA would follow this line of thought in the period after World War II, when housework and reconciliation of work and family life became important topics for the scientific conferences.

D. CONCLUDING REMARKS

I have examined how the MWIA negotiated, organized and achieved internationalism. I have on the one hand looked at the effects of localizing the MWIA and, on the other, the attempts and processes of internationalizing medical work, knowledge and identity.

Even while formulating *universal* goals of bettering the health and well-being of humanity, the association had to be located in *specific places*, specific nations were included and were in charge of positions, which affected the research agenda and work of the international association. However, when the MWIA discussed whether members should represent nations or their individual medical and personal abilities; when the MWIA had to take a stance towards the exclusion of Jewish medical doctors; when procedures had to be found to address the question of how to generate, assemble and present national medical knowledge for an international conference, the MWIA was forced to re-think representational and spatial categories. At the same time, the MWIA constituted, affected and blurred the different national, regional and international spatial levels.