
In the Winnipeg Strike Bulletin of 27 May 1919, the poetics of embodiment characterized as “alien” the heart and blood of the ruling class:

But alien is one—of class, not race—he has drawn the line for himself;
His roots drink life from inhuman soil, from garbage of pomp and pelf;
His heart beats not with the common beat, he has changed his life-stream’s hue;
He deems his flesh to be finer flesh, he boasts that his blood is blue;
Politician, aristocrat, tory—whatever his age or name,
To the people’s rights and liberties, a traitor ever the same.

In this, the rhetoric of the Winnipeg General Strike, the working-class body is the body of humanity, true to nature and natural justice. Assuming that such metaphors spoke to the way injustice lived in and through the body, this essay explores linkages between bodily experience and working-class resistance in Winnipeg in the early twentieth century. It seeks to generate a conversation among theories of embodiment, working-class history, and the history of health and dis-
Disease as Embodied Praxis

Working against a lack of serious consideration given to embodiment and disease processes in Canadian working-class history, I argue that crises such as epidemics are not simply reflections of poverty or markers of social inequality, but potential sites of an embodied praxis of resistance and of social transformation. Infectious diseases do not expose underlying social relations so much as they are historical processes central to the political dynamics of working-class consent and resistance in the early twentieth-century West. Bodily experiences of disease such as the 1918–19 influenza pandemic generate the pain of physical misery, yet also enhance communal bonds of solidarity and humanity and serve to challenge the legitimacy of the social order in ways currently unexamined in the literature.

Methodologically, I draw upon theories of “the body” and upon scholarship that explores the dynamic relationships among state formation, infectious disease, and social transformation. Although much of what constitutes these relationships is not restricted or unique to the West, place matters as a point of intersection between nature and politics, like disease itself. Disease processes such the ones I examine here (smallpox and influenza) are embedded in the spatial history of settler colonialism and capitalist expansion in Western Canada, and the spatial management of disease by the state has been a key tenet of both. How did working-class movements in Winnipeg respond to a ruling order in which bodily discipline and control featured so prominently, particularly during moments of epidemic crisis?

What is the history of the body?

The concept of “the body” is by no means new in theory or application. Ten years ago, Mary-Ellen Kelm showed that the bodies of Aboriginal peoples in twentieth-century British Columbia were “literally marked … with the signs of colonization.” Her work argues that Aboriginal bodies “were made, in part, by the colonizing governance of the Canadian state and its allies, the medical profession, the churches, and the provincial government,” and that this was a contested process in which Aboriginals made demands and insisted upon their own views of disease causation. The body has been employed widely in women’s and gender studies, queer studies, and sociology; by the late 1990s, historians of gender, including those whose work examined the lives of working-class women in relation to the state, were often invoking “the body” in their work.

In their recent essay “The Body as a Useful Category of Analysis for Working-Class History,” Ava Baron and Ellen Boris argue that the turn toward bodily studies can and should be usefully employed in working-class history, “through exploring how bodies are both constituted by and constitutive of the workplace and the racialized and gendered class relations that work both expresses and
creates." The body "as a category for historical analysis, ... allows for incorporating difference more fully, for it is one of the most powerful and pervasive cultural symbols that define who and what we are." "The abstract idea of workers" is represented in specific notions about working-class bodies: for example, in state policy and laws that attempt to discipline working bodies, in popular images of the muscle-bound male labourer, or in sexualized constructions of female labouring bodies. Workers' bodies have also been viewed as troublesome and disruptive to the social body as a whole, even as they may be viewed as abject and inferior by dominant society.

For my purposes here, the reciprocal relationship between the corporeal and the social, or the idea of "embodiment," is of interest. Embodiment, suggests Leslie Adelson, is a process "of making and doing the work of bodies—of becoming a body in social space." This making involves an ongoing dialectic between the experience of the body and the social construction of the body; as Kathleen Canning argues, "embodiment encompasses moments of encounter and interpretation, agency and resistance." Within the Marxist tradition, the materiality of the body is essential to human emancipation. As Bryan Turner notes, Marx "approaches the body via a theory of human sensuous practice on nature in which embodiment is social and historical.... A genuine Marxism is thus not simply about social freedom, but must include some account of the liberation of embodied persons from physical misery." However important the post-structuralist critique of bodily regulation, which posits that "the reality of the body is only established by the observing eye that reads it," working-class history must recognize the role of human agency and what Turner calls the "phenomenology of embodiment." Although human beings may not have control over the fate of their bodies, they can exercise "corporeal government," and can act "in, on and through" their bodies. One example of this agency, he argues, is the assertion of individual or social definitions of the meaning of disease. Another example, I argue here, is resistance to public health regimes.

**Bodies in labour and working-class history**

Assumed at the heart of working-class history are the exploited bodies of working men, women, and children. Boris and Baron have referred to "embodiment [as] a foundational assumption rather than a process subjected to historical analysis" within labour and working-class history. Indeed, especially following after the influence of Thompsonian history and the subsequent interventions of feminist gender historians sympathetic to—if in debate with—class, bodies are everywhere. One obvious place to find a notion of the unhealthy body in labour history is in the struggles surrounding occupational health and safety,
workers’ compensation, and the labour of women and children. Scholars including David Rosner, Alan Derickson, and Amy Fairchild have given us a sophisticated understanding of capitalism’s impact upon the health of the labouring body and of worker responses to the state’s interventions and failures to intervene in support of working bodies, particularly the most marginalized of those bodies: immigrant labour.

However, the processes of embodiment cannot be confined to what is traditionally referred to as work or the workplace. To limit our interest to the “working” body is to fail to consider the body at home: in the family, in leisure, in intimacy, in illness, in pleasure. Working-class claims of bodily entitlement have extended considerably beyond the mine, factory, or office. Consider, for example, the early twentieth-century claims of British workers to leisure and enjoyment: men and women argued the right to have a life and do what one wished with one’s body outside of the workplace, like their class superiors. Historians of gender and class have been influential in moving the history of working-class bodily experience into the realm of the family and community. Much of the scholarship of the lived experience of working-class families—in its consideration of issues such as infant mortality, motherhood, and the welfare state—bridges the boundaries between the disciplines of medical and working-class history. Social historians of medicine, while not always committed to class analysis, have long argued the relevance of the material conditions of life in determining disease and mortality rates in society. To be poor, to live in inferior housing conditions, to labour in unsafe and exhausting work is to be unhealthy. Exploitation and social inequality write themselves on the body.

This interdisciplinary engagement between the history of medicine and working-class history is particularly relevant given that medicine and public health have been fundamental venues for the regulation of the modern body, serving to define the contours of citizenship and social rights, gender inequality, immigrant inclusion and exclusion, and colonialism. As sociologist and body theorist Chris Shilling notes, “[T]he social reproduction of society … involves the social reproduction of appropriate bodies.” Indeed, the healing professions (along with others, including educators, for example) “pass judgements on whether certain bodies or bodily practices should even exist.” Working-class bodies have historically been particularly vulnerable to the implications of this “judgement.” As Mona Gleason and Jennifer Stephen illustrate, in the first half of the twentieth century in Canada, health “experts” defined notions of intelligence and “mental hygiene,” introducing regimes of school medical inspection and intelligence testing, for example, that stamped social hierarchy onto working-class and immigrant bodies and minds in profound ways. But this has always been a contested process.
Public health measures such as smallpox vaccination generated controversy, debate, and at times overt resistance. Compulsory vaccination and isolation, as Alison Bashford notes, raised “the crucial question of the sovereignty of individual embodied subjects, both in terms of the suspension of habeas corpus which public health detention powers were increasingly insisting upon, and in terms of incursions into familial and bodily space which vaccination entailed.” Anti-vaccinationism, which sought to defend the autonomy of the citizen body, enjoyed considerable support in many working-class communities in Europe and its colonies, although the level and tenor of opposition varied by locale.

Bodies in place

The history of disease often reflects this intersection between the local and the global. There has also been a recent turn toward region in the Canadian history of medicine. Megan Davies suggests that “the concept of ‘region’ [in medical history] can help us understand the whole in a more nuanced way, demarcating boundaries and marking out potential sites of identity.” She argues for a functional rather than a formal definition of region, stating, “[W]e can consider a multitude of factors that may be shaped by region: state and educational structures, sites of professional identity, routes of agency, and ethnic and cultural groupings.” Although less directly addressing “the West” as a category, new scholars—such as Kristin Burnett, Ryan Eyford, and Mary Jane McCallum—explore space and territoriality, settler-Aboriginal relationships, and a racialized pattern of state formation in which health and disease feature prominently, building upon earlier work by Mary-Ellen Kelm, Maureen Lux, and Carolyn Strange, and international scholarship such as the work of Alison Bashford, Ann Laura Stoler, Claire Hooker, and Warwick Anderson.

In the history of settler colonialism in Western Canada, the spatial management of disease through processes of public health (such as quarantine) play a central role, not only in Aboriginal communities but also among those marginalized groups within settler society that were similarly subjected to discourses of race, civilization, and progress. In his examination of the disease impact upon Aboriginal peoples and Icelandic immigrants to Manitoba, for instance, Eyford argues that the 1876–77 smallpox epidemic on the shores of Lake Winnipeg “demonstrates how Aboriginal dispossession and settler-colonialism were linked through the overlapping governmental apparatuses of territoriality and public health.” Measures such as quarantine asserted the state’s power over individual bodies, but also over the spatial process of colonial transformation in the West.

What is yet missing from this consideration of space, place, and health in the West is the experience of urbanity. Epidemic disease in an urban context
generates heightened anxieties, not just of widespread and rapid contagion, but also of overt social disruption as hierarchies of class, ethnicity, race, and gender shape the disease experience and the epidemic reveals points of fragility in the legitimacy of the social order. The dominant theme of recent histories of immigrant bodies in North America has been the key role played by management of disease in constructing notions of race, ethnicity, and deserving citizenship, largely based in the urban experience. Nayan Shah argues that “the collection and interpretation of knowledge about the incidence of epidemic disease, mortality, and morbidity produced an ethnography of different groups and locations in the city, of their habits, and of their conditions.”

Epidemics and bodily resistance

Through shifting processes of coercion and consent, the state asserted its dominance over Indigenous inhabitants, unruly workers, and immigrants, and structured bodily experiences of disease in urban working-class life. Therefore, as a social relation so central to modern state formation, health was a key site of agency and contestation. The history of epidemic disease suggests a fruitful tension between the now-classic interpretation best represented by Charles Rosenberg—that epidemics “constitute a transverse section through society,” laying bare both the good and bad in social organization—and an alternative formulation that makes space for epidemic disease as a historical contingency that may reshape and transform social relations. Without giving in entirely to a dramaturgical narrative that privileges the disease as biological agent, it is important to consider infectious disease as a site of interaction between human and nature, where people engage their embodiment and employ their agency.

Although not directly applying a theory of embodiment, suggestive here is the work of Marxist health sociologist Evan Stark, who theorizes disease as an “‘event’ with ideological, political, and socioeconomic dimensions”:

To the extent that epidemics can be traced to clearly definable social causes such as “poverty,” overcrowding, or the unequal distribution of services, they can be thought of as in some sense purposive, as done by and with as well as to people. In this context their definition is a dynamic phenomenon constituted politically—as well as “scientifically”—in the struggles that circulate along with physical illness.
His 1977 article “The Epidemic as Social Event” argues that “the coincidence of periodic crises in [capitalist] production and in health ensured that ‘epidemics’ would be occasions for labour to struggle against injustice, not simply sickness.” Stark’s work is unusual in its emphasis upon an embodied resistance to capital expressed during epidemics, upon “epidemics as ‘praxis’ around the labour process.” Stark argues that the same conditions that led to labour struggles and riots—poor living conditions and a relative worsening of material well-being—led to epidemics. The coincidence of epidemics and revolt in the nineteenth century was a reflection of a failure in social and political authority and arose out of workers’ awareness of the social nature of disease. Stark contends that epidemics heighten class-consciousness, sharpening workers’ perception of social power and the state’s illegitimacy; epidemics are also occasions for “mass social invention,” “collective self-help,” and “basic social reorganization.”

He draws a line connecting disasters, epidemics, and labour revolts; all are events that leave the existing order shaken and open up space for social transformation: “Like riots, famines, wars, fires, mass strikes, and rebellions, epidemics are stages for collective self-recognition and for the reconstruction of collective identities normally subordinated in everyday life to publicly acceptable ‘roles.’” Collectivity not only implies that people reach out to one another out of necessity in order to survive. Acts of mutual reliance build bonds, release a “suppressed world” of workers’ culture, and suggest new forms of social relations.

An epidemic holds potential as carnival: the world is turned upside down, and upside down, the possibility of living differently emerges. Here Stark’s work resembles that of Rebecca Solnit, whose essay “The Uses of Disaster: Notes on Bad Weather and Good Government” also draws links between carnival and disaster. She concludes: “[D]isaster makes it clear that our interdependence is not only an inescapable fact but a fact worth celebrating—that the production of civil society is a work of love.… [A]t stake in stories of disaster is what version of human nature we will accept, and at stake in that choice is how will we govern.”

Within Canadian working-class history, bodily health, when mentioned at all, tends to be seen as a functional issue: disease might be another among the litany of indignities to which working people were subjected, but bodily experience of disease is not viewed as integral to working-class movements or ideologies, or as a catalyst in moments of overt challenge to the governing order. Historians have duly noted the impact of the Great War upon labour radicalism, yet have largely ignored the global 1918–19 influenza pandemic. Yet each of these events produced approximately the same number of deaths (fifty-five to sixty thousand) in Canada, both presented new challenges to families because of their impact upon adults (60 percent of those who died from influenza in Winnipeg were between
ages twenty and thirty-nine), and both were arguably experiences that held distinct meanings and consequences for the working-class and racialized minorities.

The history of pandemic influenza in Winnipeg illustrates the severity of epidemic disease for workers and families, and provides evidence of both mutual reliance and overt oppositional struggle against the public health response to disease, suggesting the delegitimization of state authority and social order, and an enhanced space for new forms of social organization. If a carnivalesque world of interdependence and inversion emerged in Winnipeg in 1918–19, however, it did not grow entirely from a vacuum: the diseased body was already a politicized and politicizing issue for working-class movements in the city.

Ethnicity, class and embodiment in Winnipeg

In early twentieth-century Winnipeg, which was simultaneously a frontier town and a particular kind of cosmopolitan metropolis, spatial geographies were critically shaped by the intersection of class and ethnicity, as geographer Daniel Hiebert has shown. Although not unique in its emergence from the profits of industrialization, settler colonization, and the displacement of Aboriginal peoples from the territory, Winnipeg had a relatively distinct trajectory as a Western Canadian city in the period. With a population of approximately 180,000 at the end of World War I, it was significantly larger than other communities in the region.

Although the city was past the peak of its rapid expansionary boom, it was still the most important financial, distribution and transportation, and manufacturing hub in the West. Almost half of Winnipeggers were immigrants; in the early 1930s, more than half could speak a language other than English. Even for the West, which had settled the vast majority of European immigrants to Canada in this era, this was a high level of diversity. It was a city where European immigrants had made a visible impact on the development of large sections of the city centre. The most (in)famous immigrant district was the North End, but immigrants from Germany and Iceland, for example, lived and created social institutions in the west end. Both districts were home to many working-class people of British or Anglo-Canadian backgrounds, not only European immigrants.

The city’s social geography reflected significant economic inequality, intersecting with ethnic segregation. Winnipeg’s labour force had an unusually high number of unskilled workers employed in menial labour creating urban infrastructure; the city also attracted seasonal labourers from the agricultural and railway sectors, mostly single men, seeking work in the city to tide them over through the winter months. Daniel Hiebert estimates that in 1921, 53 percent of the workforce was blue collar, an additional 17 percent worked in clerical/
sales, and 7.6 percent earned their living running small family-based businesses. A growing professional/managerial sector constituted 16 percent of the local labour market, but only 2.4 percent of Winnipeggers owned large businesses. The wealthiest of the city’s population were almost entirely concentrated in two residential enclaves: Fort Rouge, immediately south of the Assiniboine River, and the area, today known as Armstrong’s Point.

Health statistics gathered by the city health department in this era demonstrate not only the very real implications of inequality but also the preoccupation of health officials with ethnicity and economic status as determinants of poor health. The Bureau of Child Hygiene, for example, spatially tracked infant mortality rates and argued that the infants of “British” and “foreign born” populations were susceptible to different disease processes. Wards with high “foreign born” populations had “low death rates during the first month of life, but high mortality from the first to the sixth month, mainly due to improper feeding and pneumonia.” Infant mortality in wards that included working-class “British” families living in rooming houses and cramped conditions “mainly occurred in infants less than one week old and were due to diseases of early infancy.” The highest infant morality rates in Winnipeg in 1919 were in the northern part of the city, on either side of the Red River, in ethnically mixed, working-class wards (wards 5 and 7).

Despite a general awareness of the importance of poor housing, for example, in facilitating the transmission of disease, workers and immigrants were blamed for the spread of diseases such as smallpox, tuberculosis, and typhoid, and became the target of public health reform. Nayan Shah argues that over the first two decades of the twentieth century, public health tactics shifted from compulsion and coercion toward education and processes of self-governance and consent. As many public health practitioners themselves clearly understood, health measures that relied upon compulsion provoked resistance in the population. Nadja Durbach has shown that in nineteenth-century England, opposition to the state’s use of coercive health practices, such as compulsory smallpox vaccination, was deeply held in many working-class communities, and was politicized within a broader opposition to the New Poor Law and the 1832 Anatomy Act, which allowed medical practitioners to dissect the bodies of the poor without consent. The small body of literature dealing with anti-vaccinationism in Canada has discussed the existence of an organized social movement to oppose compulsory vaccination in several Canadian cities. Not exclusively working class, anti-vaccinationists nevertheless argued that “compulsory vaccination was a class based legislation whose function was to exert control over the working classes.” In Ontario, for example, private and separate schools were exempt from legislation mandating compulsory vaccination for school attendance.
Any shift in public health from coercion to consent was fragmentary and subject to retrenchment. Anti-vaccinationism in Winnipeg persisted into the twentieth century and was supported by many within labour and socialist circles. Working-class objection to vaccination was part of a larger discourse that resisted the loss of personal freedom at the hands of health officials and physicians. This opposition was expressed in letters to the editor of the Winnipeg worker paper, *The Voice*; in *The Voice* editorials; and in the “Woman’s Column.” Although it was officially published by the Trades and Labour Council (TLC), *The Voice* represented an eclectic mix of working-class opinion (albeit generally of Anglo-Canadian opinion), including the views of working-class feminists, socialists, trade unionists, social democrats, and single taxers. From the late nineteenth-century through to the Great War, letters from readers concerned with the public health measures taken to control the spread of infectious disease reveal a sense of disenfranchisement from the state. During a smallpox outbreak in Winnipeg in July 1897, a letter to *The Voice* referred positively to a British Royal Commission’s recommendation against compulsory smallpox vaccination, but noted that Winnipeg’s “wise [city] councilors thought it advisable not to put the means in the way of the people instructing themselves in the laws of health. They would rather the people think by proxy.” It is clear from the
labour press that compulsory vaccination was a hotly debated subject in labour circles; The Voice referred to it as "this well worn and contentious subject." 48

Discussion intensified as the city moved toward the closer enforcement of compulsory vaccination for school children, made possible under Manitoba’s Public Health Act (1893). The act gave Winnipeg school boards the authority to prevent unvaccinated children from attending school, an indirect but nonetheless assertive means of ensuring widespread smallpox vaccination, as parents were unlikely to forego their children’s education, however strongly they felt about smallpox vaccination. This authority appears not to have been widely exercised until 1901, when the school board decided to begin stricter monitoring of children’s vaccination. This decision was debated by the TLC, which had appointed a committee to examine the issue. Although there were dissenting voices in the discussion, the TLC passed a condemnation of compulsory vaccination in schools in December 1901. 49 In spring 1902, The Voice announced that an anti-vaccination league had been formed in Winnipeg. In May the league called on the province to repeal the compulsory clause of the Public Health Act. A letter to The Voice written by G.W. Winckler states that compulsory vaccination “is most oppressive and iniquitous, insisted upon an unfounded and exploded idea.” 50

Between 1902 and 1906, the labour press did not report again on the issue. From 1906 to 1912, however, anti-vaccinationism and opposition to mainstream medicine and public health found a voice in Ada Muir, who would regularly discuss health issues in her “Woman’s Column” in The Voice and who played a critical role in the founding and success of several health advocacy groups supported by labour, including the Winnipeg Health League. Ada Muir was born in Britain and trained as a nurse there before emigrating to Canada. The mother of six, she was an active feminist who worked alongside Nellie McClung to change the dower law and gain women’s suffrage. She was also a founding member of the working-class Women’s Labour League, led by Helen Armstrong. 51 She and her family left Winnipeg for Vancouver in 1912, where Ada and her husband, Alan, continued to be active on health issues. In the 1920s, they were vocal opponents of the sterilization of the feeble-minded and the mentally ill. 52

Ada Muir’s overlapping political commitments and oppositional views on a number of issues were not uncommon in health movements of the era. 53 She was a proponent of natural health and an anti-vaccinationist, and she explicitly rejected the germ theory of disease. "The germ scare is only a medical scare craze,” 54 she bluntly argued in 1911. Health was more than the absence of the disease organism: "Health may be said to exist in a proportionately well balanced organism enjoying full vitality…. Whatever causes loss of life force or vitality would produce a condition of depression or anxiety rendering the body unbalanced, and therefore liable to disease at its weakest point.” 55 Illnesses such as tu-
berculosis were caused not by bacilli, in her view, but by “nervous depletion of the chest from worry, poverty, strain, or restraint. It is caused by dirty and unwholesome conditions, and is purely an economic and social disease.” Muir’s view, would best be addressed by an improvement in the material conditions of working-class life: “Give to everyone the right to live. Improve working conditions and remove the cause of the workman’s fear that when old and unfit for employment he will starve, and many a consumptive case will be prevented.”

Muir was consistently hostile to the medical profession and to other professionals such as teachers and social workers who exerted control over working-class parents. In 1906 Muir warned against medical usurpation of citizen control over health. “Instead of the doctor’s calling being legitimate and beneficial,” she cautioned, “it is becoming more and more meddling and despotic, and the government seems unequal to the task of contending with the profession.” She opposed government legislation that gave allopathic medicine a legal monopoly over the provision of medical care by excluding other types of practitioners such as chiropractors and naturopaths, arguing that families should have the right to seek and receive medical help from providers of their own choosing, as well as friends and neighbours.

Muir considered the medical inspection and compulsory vaccination of school children to be violations of working-class freedom without demonstrable cause, as neither would improve the health of working families. Muir disputed the effectiveness of the smallpox vaccine, and like opponents elsewhere in Canada and in Britain, characterized vaccination as defilement of the pure bodies of working-class children. “If a man were to put a rotten apple in the middle of a barrel of good ones and say he did it as a preventive of more rottenness, we should consider him crazy. So in the next generation will the man be judged who introduces a disease into the pure life blood of a little child.”

In 1908 and 1909, Muir urged parents to protest vaccination and medical inspection by withdrawing their children from school when they were to take place. Not only were public health measures autocratic, but they also failed to address the fundamental cause of illness: “How will medical inspection provide a remedy for the thousands of poor who must live on less than a living wage during eight months of the year and on nothing at all the remaining four?” she queried. Muir became the central working-class voice for anti-vaccination after the inauguration of her column in 1906.

Muir’s ideas, which were explicitly oppositional to the state, were not universally held in the labour and socialist community, particularly by Labour parties, which tended to give greater support to the development of state medicine and public health. Her position and her writings exposed the tension within working-class politics between the desire to compel the state to articulate a greater de-
gree of regard and support for the bodies of its citizens and a profound mistrust of state power over those bodies. In February 1908, the Canadian Labour Party organized a lecture by Dr. C.T. Sharpe, a practicing physician in Winnipeg’s North End, entitled “Tuberculosis as It Affects Wage-Earners.” Sharpe began by explaining the germ theory to his audience and appeared to express sympathy for the health implications of poverty and poor housing. He told the story of an immigrant family moving into a rented house whose former resident suffered from tuberculosis. Due to economic hardship—perhaps requiring the sharing of the same bed—two of the family’s children contracted bronchitis, which eventually worsened into tuberculosis. This would have been a familiar scenario for his audience. Yet Sharpe’s discussion of remedies for the situation illustrated the yawning gap between the world views of working families and public health and medical approaches to disease causation and control: his solution was not to increase incomes, improve housing conditions, or even provide better medical care for working-class tuberculosis sufferers but rather to implement a system of compulsory notification of disease, house inspections by health officials, and a public record of the health history of every home. He also called for the appointment of a full-time minister of health in Manitoba, a qualified physician.

Ada Muir and other anti-vaccinationists openly voiced their concern at Sharpe’s suggestions, and, according to The Voice, the audience at the lecture “became demonstrative and plainly sympathetic” to their criticism. Muir was typically scathingly critical of medicine in her defence of the bodily autonomy of “the people”:

The suggestion that the Health Board keep a record of every house, would if carried out create an ideal condition for the doctors, bringing about a medical inquisition similar to the theological inquisition of the middle ages, whereby the profession backed by the laws and the political force would have absolute control of the bodies of the people and incidentally their purses.

In her writings, Muir drew on the discourse of British justice and the right to liberty of the British working man (and woman), drawing upon a rich tradition in working-class rhetoric in Winnipeg. As Chad Reimer has demonstrated, this was the language of the workers’ revolt in 1919. Decrying state power over the health practices of working mothers and fathers, Muir urged her audience to resist:

What are we that we will tamely allow irresponsible practitioners to take our children from our care? Has British pluck died out of the resi-
dent Britishers that they will tolerate such an infringement of their liberty? Remember the mothers of Bristol, who stormed the school doors crying “We won’t have our children undressed,” and the doctor and nurse were afraid…. Remember the mothers of Huddersfield who emptied the schools on medical inspection day…. Do we so bow to the great Winnipeg god, Respectability, that every nobler trait shall be subservient to it?”

Ada Muir’s discussion of health in her “Woman’s Column” drew attention to the fraught and at times conflictual relationship between workers’ bodies and the state. It is difficult to assess to what degree she reflected broader thinking or influenced her readership, but Muir considered health issues central, not peripheral, to labour politics and activism. Her intense and often personal hostility to mainstream medicine may ultimately have resulted in the cancellation of her column, which ended in September 1912 after a series of heated exchanges between Muir and a reader named George Keays, who challenged Muir’s comprehension of medical science, charges against which Muir robustly defended herself. Yet she was not alone in arguing for a class analysis of disease causation and in opposing state and medical control of the working-class body. Her advocacy in *The Voice* was a factor in the establishment of the Winnipeg Health League in 1907, and she contributed to the league until its demise in 1909. The league began after a series of letters to the “Woman’s Column” suggested that anti-vaccinationists and other critics of mainstream medicine organize themselves into a group whose purpose would be to advocate “medical freedom.”

The president of the Winnipeg Health League was Ada’s husband, Alan Muir, and the vice-president was Fred Dixon, an advocate of the single tax and a Labour member of the provincial legislature.

Dixon would (with J.S. Woodsworth) assume the editorship of the *Western Labour News* after the arrest of William Ivens during the Winnipeg General Strike. Ivens, the leader of the Labour Church and a future member of the provincial legislature, also resisted medical orthodoxies and became a chiropractor after the strike. The Health League published articles critical of the city’s health policy, opposing compulsory vaccination and holding public lectures and meetings on a variety of health questions. Although the level of interest in the league’s activities appears to have been fairly high, the group discontinued its lectures in spring 1908. It was followed a few years later by the Manitoba Medical Freedom League, formed in 1914. This organization was also short lived. Dixon himself continued to advocate for improved health conditions for workers through higher wages. In 1911 he criticized the health department for missing the true cause of overcrowding and disease in the city’s North End: poverty.
Despite this economic analysis, health activists whose views were expressed in *The Voice* often shared dominant understandings of “foreign” bodies as potentially diseased and requiring instruction in “a higher standard of domestic and personal life,” as the Winnipeg Health League stated in 1907. In 1908 Muir argued that “the living conditions of non-British immigrants might be improved through a program of modern domestic education and the regular sanitary inspection of immigrant public housing.” At the same time, Muir referred to “the Canadian alien” as “a desirable class,” which would have distinguished her views from those of many in the city’s Anglo-Canadian elite. That year, *The Voice* reported with outrage the use of force against a “foreign” mother who was handcuffed to her bedpost by police in order to remove her child with diphtheria to the hospital. As much as non-British immigrants were viewed as other, they too were entitled to freedom from medical coercion.

**Influenza 1918–19**

This critique of medicine and public health formed the backdrop to the coming confrontation between labour and health officials during the 1918–19 influenza pandemic. Twelve hundred women, men, and their children died of influenza in Winnipeg that season, sometimes in desperately tragic circumstances. A thirty-four-year-old carpenter lost his wife, mother to five children, the youngest of whom was nine months old. A six-year-old boy sat for a day and a half alone with the body of his mother, who had worked at a department store lunch counter while her husband fought overseas. The wife of a Jewish peddler miscarried seven months into her pregnancy and died, leaving her husband and two children in the care of the local nursing mission. Brother Woodcock, a member of the carpenters’ local union of which future General Strike leader George Armstrong was business agent, died in February 1919. His widow was left with two small children and was pregnant. In December 1918, R.B. Russell organized the funeral of his comrade Ray Calhoun, president of the Metal Trades Council, who was married with one child. “The sympathy of all the workers of Winnipeg goes out to all his relatives in their loss,” said his obituary in the *Western Labour News*. Dead, too, was Isabella Duncan, head of the Winnipeg Housemaids’ Union. The labour movement lost, grieved, and raged.

Influenza had arrived in Winnipeg on 30 September 1918 and was soon made a “notifiable disease” by the provincial government. Provincial authority over disease containment was delegated to the municipal governments. Most public health responses to influenza were determined by local government and Winnipeg’s Medical Officer of Health Alexander Douglas. Douglas and his staff preferred to operate according to principles of consent rather than overt coer-
cian. Instead of forcing the infected to be confined in hospital isolation wards, for example, the health department emphasized the importance of educating the public (including “foreign” immigrants) and the reporting of cases. As I have argued elsewhere, although the city did ultimately institute the quarantine and placarding of infected households, Douglas agreed with other health professionals who argued that placarding merely encouraged the public to hide the infected from authorities. The main strategies employed by the health department to fight influenza were mandatory closures of public gathering places, an immunization campaign, and public education about how to prevent the disease and what to do if infected.

Although historians of the influenza pandemic in North America have often argued that the 1918–19 influenza pandemic crossed classes and ethnicities, recent scholarship has challenged this, suggesting that illness and death from influenza was shaped by social inequality. The Winnipeg experience supports this view. While the disease affected all social groups, Winnipeg’s working class and immigrant poor were hardest hit. Between October 1918 and January 1919, the North End of Winnipeg suffered nearly four and a half times as many deaths as did the more prosperous region south of the Assiniboine River: 6.73 deaths per 1,000 population compared with 4.02 per 1,000.

Many of the claims about economic hardship made by labour interests in Winnipeg before and during the 1919 General Strike were highly relevant in the pandemic situation. In the later years of the war, households lost considerable purchasing power relative to wages as inflation undermined income levels. Winnipeg housing in working-class and immigrant districts was of poor quality and overcrowded. Keeping the sick clean, dry, and comfortable could be impossible for working families. The majority of homes in the North End had no baths. In an epidemic disease context, even more than in ordinary life, hygiene was a luxury that the well-off could afford but for which the poor struggled.

In this economic context, household earners could not afford to lose wages, and many would have continued to work even after they developed symptoms of influenza and would have returned to work before they were truly well. While the available evidence is fragmentary, work itself could increase susceptibility to contracting the disease. Those in public service and professional occupations—doctors, nurses, social workers, child welfare workers—who were exposed to high numbers of influenza cases were certainly at high risk. But so too were railway workers, city transportation workers, police, ambulance drivers, and telephone operators, as well as factory workers, probably because of the poor ventilation and close quarters of their workplaces.

During the peak period of the epidemic in mid-November, public health authorities estimated that there were approximately three hundred new cases
of influenza in the city each day; on November 15, forty-three deaths were reported. Although the city had opened emergency hospital beds for flu victims, many were left empty as people remained in their homes. It seems clear that, for a time, the demands of coping with influenza disrupted workers’ everyday lives, and they called upon informal and formal networks of communal solidarity in an extraordinary way. These sources of support included ethnically based mutual aid organizations, unions, the Labour Church, and groups such as the Women’s Labour League, which collected funds to help those widowed during the epidemic. While many working families were assisted by volunteer nurses and missions, others organized themselves into informal support networks to help their neighbours. Family, extended kin, friends, neighbours, comrades—these relationships were crucial to survival, even if they did at times fail. The preservation of life and health moved beyond the private domain, becoming dependent upon bonds between people rather than upon individual behaviour (avoiding crowds, seeking medical attention, observing health quarantines), as the dominant public health paradigm asserted. These bonds formed one crucial element of an embodied praxis that subverted the legitimacy of the social order.

Other elements of this praxis were more overtly defiant. During the epidemic, public health policy and disease containment became directly intertwined with a key demand of Winnipeg’s labour movement: the right to a living wage. Taken as a measure to limit the spread of influenza, the city health department in Winnipeg, like those in many other North American cities, announced on 11 October 1918 a ban on public meetings and the closure of public gathering places. The list of those affected by the meeting ban included “theatres, schools, boarding schools, the university, the medical school, churches, lodges, exhibitions, and all public meetings.” The closure was also extended to places of entertainment, including theatres, billiard parlours, and bowling alleys. The ban lasted forty-six days—the longest in North America, according to the Tribune—and caused “considerable unrest among businessmen” as their incomes and profits were more deeply affected than they had initially expected, particularly those who owned places of entertainment.

The closure of entertainment venues in the city put between three and four hundred theatre, billiard parlour, and bowling alley workers out of work, without financial compensation, for over six weeks. This infuriated the Trades and Labour Council (TLC), which on 1 November 1918 bellowed on the front page of the Western Labour News: “Men cannot be allowed to starve in a time of epidemic.” Labour employed a gendered discourse to emphasize the threat influenza posed to the male wage, and by extension to working families, employing what Elizabeth Faue refers to as “the masculine solidarity of workplace
conflict.” Female workers were not directly visible in this rhetoric; however, women played a role in working-class resistance to public health regulation, claiming their authority as wives and mothers in writing to city council to protest the impact of the public closures upon their families’ well-being.

When the closures were first announced, the business community quietly supported them, although with mixed motives. Owners of places of entertainment feared that the epidemic, regardless of any public health measures, would reduce business and that they would be forced to pay their employees’ wages with reduced revenue coming in. The health department’s decree allowed them, essentially, to lay off their workers without having to bear the responsibility or the wrath of their employees, such as members of the Winnipeg Musicians’ Union. And, indeed, labour did direct its opposition toward the state, not employers. It was not the public closures per se that labour resisted, but rather the failure by health authorities to consider the economic devastation that this would mean for hundreds of working families during a time of economic vulnerability and instability.

The TLC responded immediately to the announcement of public closures and took the workers’ case to two levels of government, provincial and municipal. The public meeting ban had been declared under the authority of the provincial government’s Public Health Act. The Provincial Board of Health was responsible to the provincial Municipal Commissioner, and in 1918 that cabinet post was held by a prominent Manitoba physician, James William Armstrong. Armstrong was socially progressive, an advocate of women’s suffrage and equality rights in the government that gave Manitoba women the right to vote in 1916, but his government did not give a sympathetic hearing to labour’s arguments regarding wage compensation. After hearing the complaints of labour representatives, Armstrong evaded any responsibility and denied any undue suffering on the part of the employees:

Some hardships must be encountered in carrying out any such provision. The board of health had no authority regarding the matter of wages, this being entirely within the province of the employers and employees. At such a time the whole community had to suffer a certain measure of inconvenience.

A few days later, the TLC appealed to the city’s Board of Control for the reimbursement of theatre employees’ lost wages. The workers’ case was presented by T.J. Murray, the solicitor for the Dominion Labour Party. He argued that employees could not find work by leaving the city because theatres were also closed in other nearby cities, such as Minneapolis. On October 21, a deputation
of business owners appeared before the Board in support of their employees.\textsuperscript{99} As a result, the Board agreed to appoint a committee to take up the issue with the provincial government. The mayor and Board of Control were careful to “repudiate any legal liability.” Frank Kerr, the relief commissioner, was asked to help the men find temporary work, and it was suggested that families could be provided with cheap firewood.\textsuperscript{100}

But working men, and their wives, resented the refusal of the city to offer any solution apart from relief. The issue from their point of view was one of basic fairness and community responsibility in a time of crisis. The suggestion that workers laid off as a direct result of public health policy be dealt with by relief authorities was unfair and an affront to values of self-reliance, independence, and British justice.\textsuperscript{101} Labour argued that the loss of wage “was incurred in behalf of the public generally, and that injustice would be done if working men were compelled to suffer for the public good, without at least a portion of the cost being met by the people generally.”\textsuperscript{102}

Letters to the Board of Control document the desperation of those families who lost their main source of income through the implementation of the Public Health Act.\textsuperscript{103} The Provincial Exhibitors Association wrote in support of the Winnipeg Musicians’ Association, pointing out that more than eighty Winnipeg musicians, the majority of whom were married, had lost more than $15,000 in wages; the TLC approximated $23,000 in lost wages overall.\textsuperscript{104} The Board of Control, which met only twice during the epidemic (and full city council not at all), declined to appeal to the provincial government on the workers’ behalf. Since employees had already made their case directly to the province, the Board argued that it “could not add anything further to the representation of the case” and that such a meeting was therefore unnecessary.\textsuperscript{105} The Board referred the issue of compensation to the city solicitor for a legal opinion, and he reassured them that “the City has no authority to grant any such compensation.”\textsuperscript{106} Labour’s vision of governance and social justice confronted a state that did not acknowledge workers’ sense of fairness or entitlement.

**Embodied praxis and labour resistance**

If, as Ian McKay argues, the period 1915–20 witnessed an “organic crisis of liberal order,” resistance to health inequality played an important, if neglected, role in the hegemonic challenge.\textsuperscript{107} The global influenza pandemic of 1918–19 served to emphasize in a compelling and tragic way the health implications of social hierarchy, the longstanding failure of the state to respond to the health needs of the people, and the state’s tendency to discipline the working-class body through health measures that were class-biased and perceived as unjust. Demands for bodily
autonomy and “medical freedom” in Winnipeg in the period before the pandemic reveal an embodied praxis constructed not only around work itself, but also in relation to the perceived social nature of illness. In labour’s discourse, health was less an individual matter than a political one, shaped by class and ethnic relations and state power. Given this already existing critique, labour’s response to the 1918–19 influenza pandemic can be seen not as an isolated reaction but as intricately woven into the context of labour struggle in this period. The epidemic, within a context of broader demands for health equality and freedom from coercion, greatly intensified both mutual reliance and opposition to the state, and created an opening through which an alternate social order could be imagined and lived. In many suggestive ways, then, the influenza pandemic resembles Stark’s epidemic as praxis and Solnit’s “crash course in consciousness,” and sheds new light upon McKay’s argument that Winnipeg in 1919 was a place where “new relations of freedom” were tested.108

This was not a permanent space; it was fleeting. But it is no less important for that. Theories of embodiment urge us to view the working-class body as both historical subject and unfinished project. As Chris Shilling argues,

the shapes, sizes and meanings of the body are not given at birth and neither is the body’s future experience of well-being: the body is an entity which can be “completed” only through human labour…. [S]ocial relations, inequalities and oppressions are manifest not simply in the form of differential access to economic, educational or cultural resources but are embodied.”109

This embodiment is made real and is starkly revealed in the experience of epidemic disease. Diseased working-class bodies are not merely victims of a social order but bodies of resistance and rage. They are, if we like, “real” material bodies that exist in a place, a social landscape constituted by specific, historically constituted power relations: “a landscape for politics.”110

Notes
1 This paper could not have been written without research in the labour press carried out by Desmond Fitzgibbon. I also wish to thank two anonymous readers for their helpful comments and the editors of this volume for their encouragement of this project.

2 Quoted in Norman Penner, ed., Winnipeg 1919: The Strikers’ Own History of the Winnipeg General Strike, 2nd ed. (Toronto: James Lorimer, 1975), 78. This poem is also quoted in Ian McKay, Reasoning Otherwise: Leftists and the People’s Enlightenment in Canada, 1890–1920 (Toronto: Between the Lines, 2008), 478. He refers to it as “drawing on the organic language of parasitism.” I would add that the power of
the metaphor for the paper’s working-class audience lies with their experience of bodily marginalization and resistance. References to flesh and blood operate in and through language but express a bodily experience of inequality.

3 This paper is a fine-tuning of my earlier work on the connection between epidemics and revolt. See Esyllt W. Jones, *Influenza 1918: Disease, Death, and Struggle in Winnipeg* (Toronto: University of Toronto Press, 2007), chaps. 5 and 6.


7 Baron and Boris, “‘Body’ as a Useful Category,” 24.

8 Leslie Adelson, *Making Bodies, Making History: Feminism and German Identity* (Lincoln: University of Nebraska Press, 1993), xiii.

9 Canning, *Gender History in Practice*, 179.


13 Baron and Boris, “‘Body’ as a Useful Category,” 23.


Eyford, “Quarantined,” 57.


32 Ibid.

33 Ibid., 687, 686.

34 Ibid., 687.


42 For Winnipeg, see Marion McKay, “Region, Faith, and Health: The Development of Winnipeg’s Visiting Nursing Agencies, 1897–1926,” in Jane Elliot, Meryn Stuart, and Cynthia Toman, eds., *Place and Practice in Canadian Nursing History* (Vancouver: University of British Columbia Press, 2008), 70–90.


The Voice, 17 July 1897. The British Royal Commission on Vaccination presented its findings in 1896. While the commission did in fact recommend the continuation of compulsory vaccination, it suggested that parliament include a conscientious objector clause. Durbach, “Conscientious Objector,” 68.

The Voice, 27 December 1901.

Ibid.

The Voice, 9 and 16 May 1902.


Ibid., 92.


The Voice, 24 February 1911.

Ibid., 16 February 1906.

Ibid., 2 April 1909.

Ibid., 24 May 1907.

Ibid., 2 March 1906.

Ibid.

Ibid., 7 April 1911.

Ibid., 27 August 1909.
Muir disagreed with the Independent Labour Party’s support for compulsory education, since this would require the vaccination of all school-age children.

A summary of Dr. C.T. Sharpe’s lecture appeared in *The Voice*, 6 March 1908.

Reimer, “War, Nationhood and Working-Class Entitlement.”

*The Voice*, 3 September 1909.

This exchange took place June through August 1912. See *The Voice*, 28 June, 5 July, 19 July, 23 August 1912. Muir’s column ended 20 September 1912.

Fred Dixon first ran for the provincial legislature as a Labour Party candidate in 1910 but was narrowly defeated as a result of a split in the left vote when a Socialist Party candidate entered the race. In 1914 Dixon ran again, with the endorsement of the Labour Representation Committee, a joint venture of the Labour Party and the Social Democratic Party. This time his bid was successful. Doug Smith, *Let Us Rise! An Illustrated History of the Manitoba Labour Movement* (Vancouver: New Star Books, 1985), 29–30.

After the General Strike and during the last year of the Labour Church’s existence, Ivens became a chiropractor, an occupation outside of the allopathic medical mainstream. As a member of the provincial legislature, Ivens often addressed health inequality. Michael Butt, “‘To Each According to His Need, and from Each According to His Ability. Why Cannot the World See This?’: The Politics of William Ivens, 1916–1936” (master’s thesis, University of Manitoba, 1993), 187–200.

84 City of Winnipeg, Annual Health Report, 1918.


86 For a discussion of the relevance of social inequality to hygiene and the prevention of cholera, see Evans, Death in Hamburg, 409–12. The well-off had domestic servants to boil all water and maintain strict hygiene in their households. The poor lacked running water, had to carry water long distances, and lacked the fuel and person-power to boil all of their water. They were therefore were more likely to contract cholera.

87 Manitoba Free Press, 15 November 1918, 11.

88 Winnipeg Tribune, 13 November 1918, 6; 16 November 1918, 3.

89 For a discussion of nursing relief, see Jones, Influenza 1918, chap. 4.

90 Winnipeg Tribune, 12 November 1918, 6.


92 Manitoba Free Press, 11 October 1918, 1.

93 Winnipeg Tribune, 22 November 1918, 1.

94 Western Labour News, 1 November 1918, 1.


96 See the letters written to the Board of Control by Mrs. Lamoreaux, the wife of a theatre employee put out of work by the public closure. Jones, Influenza 1918, 4.111–12.

97 MA, P 2192, file 4, 15, 16. James Armstrong was born into a farming family in Nova Scotia, attended Acadia College, and became a school teacher. He came to Manitoba in 1889 to teach in Brandon, decided the following year to enrol in the...
Manitoba Medical College, and graduated in 1893. After postgraduate study at
Guys Hospital in London, England, he established a practice in Gladstone, a rural
community about a hundred miles west of Winnipeg. Active in politics as a Liberal,
he sat as a member of the legislative assembly from 1907 to 1921. He moved to
Winnipeg in 1915 and was appointed to Tobias Norris’ first cabinet, serving as
provincial secretary and municipal commissioner (responsible for health).

98 Manitoba Free Press, 12 October 1918, 4.

99 City of Winnipeg Archives (hereafter cited as CWA), Board of Control minutes, 16
and 21 October 1918.

100 Winnipeg Tribune, 16 October 1918, 1.

101 Craig Heron argues that the balance between self-reliance and community
responsibility was central to labour politics in this era. See “Labourism and
the Working Class,” Labour/Le Travail 13 (Spring 1984): 62. For a discussion of
demands for British law and justice in Winnipeg’s labour movement in this period,
see Reimer, “War, Nationhood and Working-Class Entitlement,” 228–33.

102 Winnipeg Tribune, 13 December 1918, 2.

103 CWA, Board of Control Correspondence, 014403, 26 October 1918; 0144036
November 1918.

104 CWA, Board of Control Correspondence 014426, 7 December 1918; City Council
minutes, 9 December 1918.

105 CWA, Board of Control Correspondence 014426, 13 November 1918.

106 Ibid., 13 December 1918.

107 McKay, Reasoning Otherwise, 426.

108 Solnit, “Uses of Disaster”; McKay, Reasoning Otherwise, 493. I don’t share McKay’s
critique of the “liberal activists and intellectuals” who have shaped the memory of
the strike as “a sort of natural disaster” (492). The disastrous, the uncanny, might
be, as Leonard Cohen would say, the cracks where the light comes in, albeit not
without those who proclaim it so.

109 Shilling, Body and Social Theory, 109.

110 See Rebecca Solnit, Storming the Gates of Paradise: Landscapes for Politics
(Berkeley, University of California Press, 2007).