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Published in:
International Review of Social History

DOI:
[10.1017/S0020859016000493](https://doi.org/10.1017/S0020859016000493)

Publication date:
2016

Document Version
Peer reviewed version

[Link to publication in ResearchOnline](#)

Citation for published version (Harvard):
Greenlees, J 2016, 'Workplace health and gender among cotton workers in America and Britain, c.1880s–1940s', *International Review of Social History*, vol. 61, no. 3, pp. 459-485.
<https://doi.org/10.1017/S0020859016000493>

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Workplace health and gender among cotton workers in America and Britain, c. 1880s-1940s*

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This article clarifies the differences between occupational health and workplace health and reveals how the two overlap. It unravels a multi-layered narrative about textile workers' understandings and experiences of ill-health at work in both America and Britain, utilizing a combination of oral histories, government documents, company and union records, and the trade press and identifying the multiple influences on debates about health at work. Contrary to current historiography, gender was only occasionally important to such discussions and among workers, gender did not significantly influence responses to unhealthy conditions. Understandings of, and responses to, workplace hazards were individual and related to knowledge about risk, ill-health and socio-economic factors. Consequently, workers' understandings of and responses to the working environment reveals more convergence than divergence, suggesting a universal human response to the health risks of work that is not significantly influenced by national or industrial constraints, or gender.

Cotton textile manufacturing was one of the few trades in both Britain and America where men and women could work alongside each other performing the same tasks for the same rates of pay and experiencing the same workplace health hazards. The two cotton industries, centred in Lancashire and New England, grew rapidly during the nineteenth and early twentieth centuries and subsequently declined, albeit at different rates. While studies of industrial strategy and production choices in cotton textile manufacturing regularly compare Britain and America and relate gender to costs and manual dexterity, industrial health has received limited comparative attention. Analyzing workers' understandings of and responses to an unhealthy working environment provides a multi-layered narrative involving official authorities, employers, medical advertising and workers, where gender's importance depended on the context and discursive level. Working-class social realities influenced understandings of and responses to work-related health disorders, highlighting the similarity of the industrial experience across national and gender boundaries while also broadening understandings of occupational health. Many causes of ill-health relate to both working and living conditions. Hence, workplace health encompasses ill-health experienced at work but not necessarily caused by it and overlaps with occupational health, or ill health caused by specific work processes.

When men and women work alongside each other work-health relationships become entwined with broader histories of women's health and work and occupational health and safety. British histories of women's work-health relationship have followed broader histories of women's health which argues that these issues rose to government interest tangentially through the development of maternal and child welfare policies in the early years of the twentieth century.¹ Industrial work histories have emphasized the dangers that work supposedly posed to women and their unborn children and how the British government introduced legislation to support a broader social agenda.² The health of unmarried girls in the workplace – the future mothers of Britain – became a legislative priority.

In America too, working-class women's silence and maternalist ideology has dominated social policy and historical debates.³ In 1917, Alice Hamilton, physician, factory inspector, professor at the Harvard School of Public Health and the woman who created the field of industrial toxicology, shifted the existing legislative emphasis on purely protecting women's health in factories to include hazards specific to reproductive health.⁴ This marked a shift in workplace health policies which reflected gender and class norms that had previously sought to limit the hours that women could work, partly so that they had the time and energy to be a good mother. Indeed, assumptions about motherhood greatly influenced women's employment regulations,⁵ although policy implications have been prioritized over medical and scientific rationales for sex-specific laws.⁶ This article reveals how for both Lancashire and New England workers, social and environmental factors influenced their conception of work-related disorders and did not necessarily correspond with the middle-class, gendered, social and political priorities.

In both countries, male experiences have dominated occupational health and safety discourses, with risk, cultures of masculinity and the politics of compensation recurrent themes.⁷ Broad labour issues have overshadowed women's experiences of occupational ill-health, particularly legislation and compensation for occupational diseases. Where gender has been addressed, this has been related to women's behavior rather than occupation, overlooked due to wartime necessities, or the ill workers have been removed from the health debates.⁸ For cotton textile manufacturing, trade unions, legislation, medical politics, employers and their organizations, and sanitation have dominated debates,⁹ whereas women's contributions to Trade Unions and indeed, the broader labour movement have been marginalized.¹⁰ Overall, British and American historiography about industrial illness and injury emphasize how capitalist neglect, official indifference and compensation took precedence over better health and safety standards - although the dynamics of each situation varied according to individual case studies.

This article examines the lesser known and often informal actions of individuals and groups of cotton operatives between the 1880s and 1940s when cotton cloth manufacturing in Lancashire and New England shifted from industrial growth to terminal decline after World War I. Throughout, operatives in both regions daily calculated the health risks associated with work and sought to address such risks when the boundary of what they deemed 'acceptable' working conditions was crossed. This boundary was fluid and only sometimes corresponded with trade union or political agendas. It was also entwined with the agendas of employers and official authorities and influenced by medical advertising. In both Lancashire and New England, workers' agency in responding to hazards depended on the relevant constraints, personal, industrial and economic, including the state of the local labour market. When the need to earn a wage dominated priorities, responses included coping strategies. Utilizing a combination of workers' papers, oral history collections, government documents and health reports, this article argues that the importance of gender in workplace health debates depended on the context and the dominant actors, but was never of central importance to workers. Instead, individuals and groups of workers' daily determined the workplace health risks and responded accordingly. Risk was not determined by political and technical processes.¹¹ Rather, in both regions, the social and economic context dominated workers' decision-making and was not overtly gendered.

Firstly, this article provides the health context of the cotton textile manufacturing regions of Lancashire and New England, with the textile mills of the American South excluded from analysis due to differences in industrial structure, labour and the timing of industrial change.¹² The focus is the chronic health risks associated with cotton manufacturing, rather than accidents or compensation campaigns against life-threatening diseases, such as mule-spinners' cancer and byssinosis – the respiratory disease whereby lung capacity is increasingly restricted after prolonged exposure to cotton dust. Because many chronic health problems attributable to textile work had multiple contributing agents, for example pneumonia, bronchitis and hearing loss, these were not high on the political reform agenda. Moreover, as with many health problems, individual and collective responses to the perceived workplace hazards varied depending on context. Secondly, it analyses the changing knowledge and expectations about work-health relationships and responsibilities, revealing contrasting understandings of workplace health between politicians, medical professionals, employers, workers and their representatives. Thirdly, it analyses the formal and informal strategies men and women cotton operatives utilized to address an unhealthy workplace, demonstrating the fluidity of the relationship between the working environment, health and gender. It reveals how throughout periods of industrial growth and subsequent decline, gender was more important to official authorities than it was to workers. The medical market, social reformers and

employers all utilized gender to suit their agendas. Unlike debates about industrial structure and strategy and union activism, workers' understandings of and responses to the working environment in both countries reveals more convergence than divergence, where social and economic realities superseded national and industrial constraints, as well as gender. These contextual relationships at any given point in time determine health priorities and responses – both formal and informal.

Textile regions, occupational health and responsibility

Historically, the cotton industry has been labelled one of the pillars of industrialization in both Britain and America. In eighteenth and nineteenth century Britain, the industry found its ideal location in Lancashire where the humid climate aided the fragile cotton fibres. Towns such as Blackburn, Burnley, Bolton, Preston, Oldham and Nelson became synonymous with cotton textile manufacturing. Both men and women entered the mills, particularly in towns where cotton textile manufacturing dominated the local economy, including Blackburn and Burnley. Towns with more diverse economies, including Bolton and Preston, provided greater employment opportunities for males, while textiles remained a higher paid choice for females. Cotton manufacturing expanded in a largely unregulated manner until the mid-nineteenth century when concerns grew about both mill works impact on operatives' health and the high morbidity and mortality rates in many Lancashire towns.¹³ Even then, regulation was gradual and piecemeal and aimed more at restricting women's labour than reforming conditions.

In nineteenth century America, entrepreneurs found the abundant rivers and available female labour in New England ideal for cotton textile manufacturing. While isolated rural mills survived, the Massachusetts towns of Lowell, Holyoke, Fall River, New Bedford and Lawrence became thriving textile communities, employing men, women and sometimes children. Increased immigration during the latter years of the nineteenth century provided a ready supply of labour for the mills. The low wages paid frequently required more than one family member to work in order to sustain the household, with over half the weavers of cotton goods in the United States being women and young people by 1905.¹⁴ Factory regulation in America was state specific and, similar to British legislation, Massachusetts legislation was gradual and piecemeal, prioritizing restricting the working hour's women and children rather than industrial reform. Indeed, the concentration of cotton textile manufacturing in particular areas of the two countries created a regional component to occupational diseases and their regulation.¹⁵ In both countries, health and safety laws and the evolution of factory inspection were strongly shaped by mill experiences.¹⁶ Consequently, both mill operations

and the labour force were under regular observation by social reformers and politicians, whose priorities were influenced more by factors external to the mill, than internal.

The health risks specific to mill work are well recorded, with causation both occupational and environmental. Long hours and the gruelling pace of work caused fatigue and migraines. Cotton and size dust caused or exacerbated multiple respiratory problems, including bronchitis, pneumonia and tuberculosis. Long-term exposure could also cause byssinosis, which acquired its medical name between 1885 and 1890. Dust was a particular problem in raw cotton processing, while weavers were concerned about both dust inhalation and contagious diseases through the use of the suction shuttle which required weavers to use their mouth to repeatedly draw thread through a tiny hole. Excessive heat and humidity contributed to high levels of respiratory illnesses, including pneumonia and bronchitis, and could cause rheumatism. Poor lighting strained operatives' eyes, while excessive machine noise could eventually cause deafness. And, from 1922, the carcinogenic lubricating oils used on spinning mules were a recognised problem in Lancashire.¹⁷ Indeed, the risks attributable to textile work were such that in 1914 the British government classified working in cotton factories a 'dangerous' trade, despite the comparatively low rate of work injuries and fatalities compared with other industries.¹⁸ By World War I, the government had regulated many workplace hazards, yet employers repeatedly breached the legislation. In 1903 alone, there were 569 recorded breaches of the Cotton Cloth Factories Act which regulated heat and humidity, in addition to those that went unrecorded.¹⁹ Moreover, the factory inspectorate was grossly understaffed and many workers had never known an inspector visit their firm.²⁰

With similar timing to Britain, in 1915, the Massachusetts Industrial Accident Board labelled the cotton manufacturing industry the states' second most dangerous, surpassed only by iron and steel.²¹ Despite Massachusetts' progressive labour legislation and despite the Bureau of Labor's studies about the dusty trades from 1903, *preventive* legislation that would have protected workers' health and safety was absent other than the 1911 ban of the suction shuttle from public health concerns over tuberculosis. While State and Federal officials readily noted the health risks attributable to textile work, Massachusetts legislation prioritized women's and children's working hours (1874), employer's liability for accidents (1887), and Workers' Compensation (1912). Similar to in Lancashire, legislative enforcement was limited, with factory inspections few and the department understaffed and underfunded. While occupational legislation secured limited factory health reforms, responsibility for working conditions and for managing ill-health lay with employers and workers.

Cotton manufacturers blamed workers for accidents and workplace ill-health. In 1920, the *Textile World Journal* neatly summarized the Massachusetts' employers' arguments that had been reiterated in testimony to state inquiries over the previous fifty years and which government officials largely seem to have accepted.

Textile workers are apt to be careless, ignorant of the dangers of infection and disease, not always cleanly, and many of the alien rather prefer to herd together in their habitations. They have borne the ill effects of accident and sickness with a stoicism handed down through several generations. They have accepted these ills as the customary lot of their class, without much thought that they could be alleviated, and without dreaming that in large measure they might be eliminated.²²

Blaming the victim fit the broader ideology of the American legal system through the first two decades of the twentieth century which held workers accountable for accidents and acute diseases under an assumption of risk. Yet consensus about responsibility was lacking. Some Progressive Era employers made the work-health connection, recognizing the production benefits from improved working conditions and linking responsibility with profits, while others did not.

Lancashire employers also blamed workers for their own ill health, bemoaning in 1914 that: "How is it that the factory is always denounced as the only cause of sickness? Overcrowded housing, careless dietary, and habits that make for ill-health never seem to enter the calculations of the [Trade Union] officials."²³ Responsibility for ill-health was placed on the workers, their lifestyles, dietary choices and carelessness.

How much, for instance, have the conditions of the home got to do with sickness, especially the almost always closed bedroom windows. How much is a careless system of dietary responsible for illness? And how much carelessness in other matters that need not be specifically indicated?²⁴

To employers, health problems were the fault and prevention the responsibility of workers. Nevertheless, in both Lancashire and Massachusetts, without firm workplace legislation variations in working conditions between firms remained as employers sought to maximize production.

For their part, workers and their unions needed to balance the health risks attributable to work with those of not working – particularly no income. Yet while documentary and some oral testimony supports Elizabeth Roberts idea of a 'social calm' in Lancashire whereby people accepted their lot, including poverty and poor conditions and which is reflected in the absence of class protest,²⁵ this does not mean operatives were always deferential and submissive or that they left

industrial health to their unions. Similarly, Mary Blewett has argued that in Massachusetts, the female mill workers of Lowell accepted their lot as working-class children, with all that it entailed, from leaving school at a young age to many years in the mills.²⁶ Yet while health did not always dominate workers' priorities, this should not imply worker passivity. Rather, this article suggests that workers' priorities were fluid and dependent on personal and industrial circumstances, particularly because many health issues related to both the working and living environment.

Biomedical knowledge and expectations about health at work

From the late nineteenth century, formal medical knowledge about the workplace causes of ill-health grew alongside developments in biomedicine, while health expectations in mill communities were tempered by living conditions. Levels of understanding about different workplace diseases varied, but in the latter decades of the nineteenth century the leading fear in both Lancashire and Massachusetts was tuberculosis. The medical community raised concerns about the spread of TB into the factory before medical knowledge differentiated byssinosis and tuberculosis. It was 1902 before the British physician Thomas Oliver recognized byssinosis as one of the four recognized types of pneumoconiosis, or industrial lung diseases.²⁷ Nevertheless, distinguishing between industrial and contagious respiratory illnesses remained difficult well into the twentieth century, particularly byssinosis and bronchitis. It was the mid-1950s before the British physician, Richard Shilling, made significant progress in separating the two and 1969 before the American medical community acknowledged that byssinosis was indeed, a disease.²⁸

A different trajectory of understanding followed industrial deafness. In 1911, the Massachusetts' legislature acknowledged that certain occupations associated with loud noises produced permanent injury to the ear, including weaving. Yet deafness was not considered the serious handicap for weavers that it was for other occupations. Rather, weavers' deafness was merely an inconvenience.²⁹ It was the 1920s before audiometric techniques were developed and 1942 before a hearing impairment formula was developed and accepted by the American Medical Association.³⁰ Hence, until the 1940s, medical consensus was lacking about the boundary between hearing loss and deafness, as well as pinpointing the cause.³¹ With similar timing, in the 1930s, the British government's Industrial Health Research Board conducted experiments about the effects of excessive noise on weavers' efficiency, concluding in 1935, that:

it may be doubted whether complete immunity from the inimical effects of excessive noise can ever be acquired so long as normal hearing is retained, and that

the development of partial deafness appears to be the only effective protection which the individual can acquire.³²

The following year, the *British Medical Journal* further deflected attention about hearing loss from the factory, arguing that it was 'by no means easy to define precisely the working conditions which are in themselves calculated to produce partial or total deafness in a given time.'³³ Clearly, well into the twentieth century, both governments and medical communities in Britain and the United States were unable or unwilling to link specific health problems to work, making easier employers' ability to ignore the working environment. Consequently, operatives lacked a formal, medical framework to which to attach any physical symptoms they believed were caused by occupation. Instead, workers' expectations and knowledge about the working environment was based on a personal model of illness, not a medical model, where many health issues translated to both working and living conditions.

While experiences of illness are individual, mill workers noted similarities of symptoms and the work-health connection. However, ill-educated workers focused on their immediate health and did not foresee long-term health hazards from mill work. In the 1840s Lowell operatives complained to family and friends how the dust and noise of the mills made them feel unwell.³⁴ By 1910, the majority of operative admissions to the Lowell Corporation Hospital, owned by the textile employers', were for respiratory problems.³⁵ In the 1920s and 1930s, mill workers still noted how inhaling textile dust made their breathing 'uncomfortable' but did not understand the physiological implications. Some workers stoically commented that 'you get used to it (the dust)',³⁶ while others identified a work-health connection. For example, Valentine Chartrand, who spent over twenty years working in the Lowell mills from World War I noted, "Because in the winter the windows are all closed, you know? And all you get is that lint flying around. And you breathe a lot of that. And I always had a feeling that wasn't good for your lungs...."³⁷ Carder and dye house worker, Sydney Muskowitz, who entered the Merrimack Mills of Lowell in 1937, noted that "And before I got hired, I was told, keep your eyes open, ears open, and your mouth shut [because of the dust and dirt]. The superintendent says....That [carding] is the most miserable, hottest, dangerous job I ever had." Thirty years later, Muskowitz found that, "I couldn't breathe, getting dizzy. Pains in the chest.... I believe it was the heat and the dust that irritated my heart."³⁸ He had never heard of byssinosis, possibly because there were few cases of byssinosis in New England.³⁹ Yet despite lacking the medical language, both male and female operatives clearly recognized the work-health relationship between dust and respiratory problems, but not the longer-term health consequences until too late.

In the mid-twentieth century, Lancashire mill workers knowledge remained limited about biomedical and legislative developments concerning dust inhalation, its regulation and the term byssinosis. They did not realize the potential for cotton dust to permanently damage health. For example, Mona Morgan worked in the cardroom between the 1930s and 1970s and when interviewed, suffered from byssinosis. She claimed that: "If anyone would have told me this would happen, I wouldn't have gone in."⁴⁰ Fellow byssinosis sufferer and ring room worker between the 1940s and 1980s, Ethel Fielding noted, "We were never told anything like that. You never dreamt of work hazards."⁴¹ Cardroom worker May Mitchell, employed in the 1930s and 1940s, confirmed that she had "Never heard the word [byssinosis], never heard the word til years after come out of t' mill."⁴² Yet from before the Great War, trade union campaigns fought to secure compensation for male byssinosis sufferers, succeeding in 1941, suggesting that some men were aware of the health impact from long-term dust exposure. Indeed, the British discourse of byssinosis was predominantly male, comprising trade unions, medics and government officials, not operatives.⁴³ While byssinosis compensation was extended to women from 1948, for years, ignorance of the disease and the law remained amongst women. Gendered understandings of the dust-disease relationship translated to unions and compensation, not reform or education.

Mill-workers could not avoid the deafening noise of machines. Yet, well into the twentieth century they remained unaware of the long term effects of exposure and did not consider industrial noise 'dangerous'.⁴⁴ Massachusetts mill worker Rene Desjardins noted that: "At that time, nobody knew anything about that" (industrial deafness),⁴⁵ while Mabel Mangan remembered that "The noise would drive you out of your mind... but we didn't know it could hurt you."⁴⁶ Instead, the weavers compensated for hearing loss by either shouting directly into another's ear or by communicating with their hands in a crude type of sign language.⁴⁷ Twentieth century Lancashire mill workers also complained about the noise. George Wrigley remembered how "The noise was horrendous. But, like anything else when you're young, you just take it. It's your job. You've gone into it, get on with it."⁴⁸ Weaver Marjory Shaw remembered that:

Oh, it was very noisy. But I knew that. Ahh, I knew it was noisy, but all the family had gone weaving, so I thought, well, it's in the blood. Foolish, you know. Very foolish, but there it is. And, ah, it didn't bother me. Cause everybody was talking with yer lips, you know, lip reading, and you could have a conversation and nobody would know what you were talkin', only you who were eye to eye.⁴⁹

Lancashire weavers were reputed for their lip-reading abilities, which enabled them to communicate. Yet their denial of potential deafness related to hearing loss being gradual. They could

still communicate and friends and neighbours did not react to it. Throughout both regions, deafness was a socially accepted problem for men and women that could be overcome and one in which science, society, labour and politics had little interest.

While operatives in both regions recognized that certain aspects of millwork made them feel unwell, the social context of the living environment tempered their understandings and expectations of health. Overcrowding, poverty and poor sanitation featured in the textile towns of both Lancashire and New England. While direct comparisons are difficult, it is probable that the damp, stone houses of Lancashire were unhealthier than the wooden homes of New England. Even then, the public health initiatives and agendas of different Lancashire town councils and their Medical Officers of Health suggest considerable variations in the living and working conditions between communities.⁵⁰ So too in Massachusetts, did living and working conditions vary within and between communities, with Fall River living conditions reputedly some of the worst; rivaling those in parts of Lancashire.⁵¹ Hence, within each region, and indeed, each town, the importance of both the living and working environment to the public health agenda fluctuated, making difficult any unified campaigns for workplace health reform.

Social factors meant that Lancashire women's health was frequently weaker than men's, more so than their New England counterparts and excluding the universal impact of pregnancy. American wages were higher than those in Lancashire. Nevertheless, diet, the quantity and quality of food varied between towns. Archaeological digs in Lowell revealed that skilled workers on higher pay, unsurprisingly, were more likely to have better quality food than unskilled workers. Yet, the unskilled workers residing in Lowell boardinghouses had sufficient food and did not note gender differences in diet, quantity or quality. During the textile recession of the 1920s and 1930s, families strove to ensure 'three squares a day' for all members.⁵² In contrast, late-nineteenth century Fall River workers had poor diets in both quality and quantity, but the vital contribution of multiple family members to the household budget required all to have a fair share of the available food.⁵³ While family circumstance determined whether American women needed to enter the paid labour force on a short-term, intermittent or long-term basis, society acknowledged women as essential contributors to the economy. In contrast, Lancashire diets were generally more meager than those in New England with cheap, filling foods rather than nutrition being the priority.⁵⁴ When times were hard, women and young girls often had the smallest portion at family mealtimes, lowering their resistance to disease⁵⁵ and making more difficult the long days in the mills. Through the mid-twentieth century, social reformers ignored economic realities and prioritized morality, a male-breadwinner and women's primary role being that of mother and homemaker. These factors,

combined with the longer manufacturing decline than in New England, suggest that Lancashire women textile workers may have been consistently physically weaker than both their American counterparts and their male colleagues in their ability to cope with an unhealthy workplace. Variations aside, urban living conditions in both countries were bleak, with high mortality and morbidity rates, making it unsurprising that textile operatives' tolerated some discomfort in the factory working environment.

Textile workers' expectations about health and the working environment were continuously entwined with social realities. In a life of low wages and substandard housing, with a need to earn money and limited employment opportunities, both Lancashire and Massachusetts textile workers accepted certain health risks attributable to the workplace, including dust, accidents and noise. Yet both men and women operatives did not expect these risks to have long-term health consequences extending outside the factory walls. Such dissonance between means and ends, responsibilities and understandings of workplace hazards, left mill workers to daily address what they understood to be the immediate health risks attributable to work, rather than seeking prevention of long-term health conditions.

Operatives' responses to workplace health hazards

Cotton operatives' responses to what they perceived were the health risks of work were entwined with relationships with their trade unions, employers and governments and influenced by local factors, including available medicines. Moreover, workers' attitudes and reactions to an unhealthy working environment cannot be pigeonholed. Rather, they reveal the multiple attitudes and methods workers adopted to address the workplace health risks, which only grew during the interwar recession as production was speeded up on outdated machines, increasing levels of noise and fatigue.⁵⁶ Throughout, coping strategies were entwined with collective action, including spontaneous protests and strikes, both with and without Trade Union support. At the same time, operatives supported Union reform campaigns. What emerges is a universal picture of cotton operatives who were consistently concerned about the impact poor working conditions had on their immediate health, alongside a gendered commonality of experience and response. The exception is women retaining their traditional familial role as healthcare provider. Individually and collectively workers dealt with whatever life threw at them, rather than merely accepting it, as Hallet, et al., have argued.⁵⁷

The working environment was firm specific which prevented sustained, widespread action for reform. Individual firms earned reputations for their working conditions, making some firms more desirable places to work than others. In the 1880s, the Granite Mills in Fall River began improving their factory environment by tackling the high heat and humidity levels. The firm continued investing in new technologies into the 1920s. While some new machines met legislative requirements, they also earned the firm a good reputation.⁵⁸ So too, did the Merrimack, Hamilton and Bunting Mills in Lowell invest in more modern technologies. By the end of the nineteenth century, these employers recognized the production benefits that translated from reforming the mill environment to improving the health of their workforce, while operatives found these firms more desirable places to work.⁵⁹ In contrast, in 1932, the fire insurance company identified the Boott Mills of Lowell as the dirtiest and dustiest firm in the American textile industry. The Boott also ignored legislation about humidity, child labour and sanitation. Consequently, when possible, Boott operatives sought employment elsewhere.⁶⁰ In Lancashire too, mill workers regularly switched employers when dissatisfied with conditions.⁶¹ Oldham operatives remembered how the working environment in the Bee and Maple Mills was better than at the Borough or Monarch Mills, being cleaner and having newer technology that minimized atmospheric dust.⁶² These employers recognized the production benefits of technological investment, while workers reaped the health benefits.

In both countries, women workers were more likely than men to switch jobs or firms because they were denied access to more highly skilled, better paying jobs like loom fixing. Equally, a poor working environment hastened some operatives' exit from the textile labour market.⁶³ In New England, cotton manufacturing left the region more rapidly than in Lancashire and where in some towns, employment options grew during the twentieth century. From the 1940s, light industry and electronics firms moved into Lowell, providing jobs with better pay and conditions than the mills, especially for women. Nevertheless, in both regions the regular switching of firms and jobs provided women with a sense of empowerment in a powerless environment because the mills offered little opportunity for either advancement or consistent employment. Switching employers demonstrated individual worker agency, yet the form of expression remained locally determined.

Workers developed coping strategies when switching employers was not possible, when the risk of not working was greater than the health risks of working, or when the health risks associated with work were within the boundaries of 'acceptable' risk. Although varied, strategies held industrial commonalities in Lancashire and New England. For example, dust inhalation caused workers to cough and sometimes vomit. To try and remove the dust from their mouth and lungs,

workers spat.⁶⁴ When this did not work, well into the twentieth century both men and women chewed tobacco to induce coughing to try and clear the airways.⁶⁵ Such actions had no direct effect on employers' technological choices, but elicited both social and political responses. Social reformers considered 'spitting' a disgusting habit, particularly by women; while early twentieth century public health officials argued that spitting spread disease.⁶⁶ The emphasis on morality and contagion provided no social or professional support for workers needing causal reforms from employers. To workers, spitting served an immediate, practical, preventive health function.

The public moral priority, combined with legislative indifference, led operatives in both countries to turn to kinship and friendship networks and 'wise women' for advice on managing the ill effects of work, while utilizing patent medicines to alleviate discomfort.⁶⁷ Indeed, the multiple health problems, combined with often a family labour force, made cotton regions a ready market for patent medicines. It is unsurprising that two of the leading patent medicines, Beecham's in Britain and Father John's Medicine in America, were developed in the textile regions. By the 1920s, these firms had clearly identified women as the core purchasers of medicine and targeted her in advertising family remedies.⁶⁸ As both victims of occupational maladies and in charge of the household health, women provided a dual market for patent medicines.

Late nineteenth and twentieth century Beecham's adverts claimed that their pills cured consumption, fatigue and women's problems. In 1918, Beecham's advertised in the operatives' newspaper, the *Cotton Factory Times*, that Beecham's Pills were designed for 'Weary Women Workers'. They could prevent or cure fatigue.⁶⁹ While initially advertised as a cure-all, Beecham's pills also had a positive effect on the digestive system,⁷⁰ which may well have appealed to operatives working in dusty environments. Despite the growing authority of biomedicine in the twentieth century, Lancashire workers continued utilizing traditional and patent medicines, herbal remedies, and consulting wise women.⁷¹ Women learned about such remedies in the mills from listening to conversations of older women or directly seeking their advice in health matters.⁷²

New England mill workers similarly used kinship, friendship and workplace networks for health advice, with women central to such care networks. Yet the multi-ethnic composition of the textile workforce meant makers of patent medicines adopted different marketing strategies to in Lancashire, although women remained the target customer. New immigrants reconstructed their ethnic support networks and traditions from their home country,⁷³ with many coming from Catholic traditions, including French Canadians, Irish and Southern Europeans. Perhaps the most famous patent medicine, Father John's Medicine was named after the Lowell priest, Father John O'Brien in 1855. It targeted Catholic families with Father John's personal, product endorsement. Father John's

Medicine was widely available and claimed to cure: “consumption, grip, croup, whooping cough, and other diseases of the throat.” It was a “A fine tonic: Good for the whole family.”⁷⁴ Unlike another well-known New England patent medicine, Lydia Pinkham’s vegetable compound, which in 1906 was found to contain 15 per cent alcohol, Father John’s medicine contained no alcohol. Initially comprising cod liver oil, with liquorice flavouring, after fifty years, the ingredients remained virtually the same. Hence, the makers of patent medicines in the British and American textile regions recognized a burgeoning market with mill workers, but marked their product within the local gender context.

Another component of the operatives’ mixed economy of healthcare was that offered by employers. Some employers increasingly recognized the production benefits from onsite welfare, in part because it could prevent workers from going home. The 1916 British Factory Act mandated a sick room where workers could rest and return to work when well. By the 1950s, Lancashire workers regularly utilized certain company health initiatives. Welfare Officers, who were occupational nurses or first aiders, provided workers with aspirins or a chance to rest in the sick room. They also supported operatives’ with cases to go home sick. Yet if a firm did not have a Welfare Officer, or if operatives chose to ignore her advice, sick operatives continued to go home – to the employers’ complaints.⁷⁵ The Welfare Officers’ retained their autonomy and resisted management aims for them to serve the employers, rather than the workers. Although employed to support all workers, Welfare Officers particularly catered to women. They allowed tired women to rest, particularly if they had their periods, or listened to domestic troubles, providing a cup of tea and sympathy rather than rushing operatives back to work.⁷⁶ For minor illnesses and fatigue, Welfare Officers bridged the gap between self-help and employer control. Hence, Lancashire operatives expanded their healthcare networks to take advantage of the free healthcare provided, including that offered by employers, while retaining the autonomy of individual choice.

American textile employers also increasingly sought to manage workers’ ill health, particularly after a 1929 U.S. Department of Labor investigation into mill workers’ absences revealed high absentee rates due to illness and accidents, home duties and personal reasons, especially by women who were both workers and the primary care-givers.⁷⁷ The Lowell employers were unique because they operated a hospital between 1840 and 1930 to attend workers’ injuries and illnesses, but with limited success. Workers preferred to manage their own health and avoided the employers’ hospital when possible.⁷⁸ Starting in the interwar years, some employers introduced company nurses to provide minor health services and to determine whether individuals were sick enough to leave. Previously, this had been the managers’ decision.⁷⁹ While little is known about company nurses,

Lawrence operatives remembered them as being kind and resourceful. They dressed wounds, treated burns and advised on pregnancy.⁸⁰ While company nurses were associated with the employer and consulted with caution, generally, mill hands responded favourably to them and the free, professional health advice they provided.⁸¹ Nevertheless, similar to their Lancashire counterparts, Massachusetts working-class mill operatives retained autonomy by seeking health advice from whomever they wished.

Being ill was costly because time off work was unpaid. Hence, cooperative networks played an important role in mill workers management of ill-health. In fact, cooperation was essential for managing the heat, dust, humidity and pace of work. Lancashire and New England operatives watched co-workers machines to enable breaks. They helped struggling colleagues, for example, to lift something heavy, while neighbouring workers might help an individual keep up when sick or pregnant. Twentieth century mill worker Jean Rouses remembered how in Lowell: “We took care of one another. Sometimes you’d say, Would you watch my frame? And you’d take off. They’d watch it. It was pretty good.”⁸² Similarly, Lancashire mill worker Elsie Hansford remembered how “We always used to help one another.”⁸³ Such informal networks secure little written documentation, yet collectively and individually, for short periods, they allowed ill workers to keep earning when unable to afford time off. Mill managers seemingly accepted such arrangements because workers retained their jobs, possibly because production was not impeded. Indeed, there is no consistent narrative surrounding how mill workers coped with an unhealthy workplace or the relationship between workers, employers and health. Managing health at work was simply part of working life. It was primarily informal and not overtly gendered. Rather, gender was entwined with working-class health through custom, including women being responsible for family health care. Co-operation was universal.

Nevertheless, if working conditions became unbearable, operatives were not averse to collective action. Accounts of collective action happening outside those recognised by trade unions paralleled individual responses. New England newspapers record mills voluntarily closing for a few days in the summer due to the heat, as well as operatives walking out and effectively shutting the mills when they considered the weather too hot for work, to take advantage of berry picking season, or to go fishing.⁸⁴ In 1873, women operatives walked out of the Lawrence Mills in Lowell because of poor ventilation.⁸⁵ Unable to assert their authority and prevent walkouts, or because of a local labour shortage, employers seem to have accepted these informal disruptions because the newspapers do not mention workers being dismissed. More formally, in 1903 and again in 1912, Lowell mill workers struck for higher wages and “better, cleaner and healthier conditions in the city

of Lowell".⁸⁶ While strikes and walkouts were mostly mill specific and returned only limited success, they reveal how working-class cooperation prioritized dignity, autonomy, conditions and wages. In protest, as on the shop floor, women worked alongside men to organize strikes and as participants. In fact, of the recorded, spontaneous walkouts in New England, most were started and led by women, including the 1912 strike.⁸⁷ While this does not imply that men were less interested than women in working conditions, it highlights the importance of working conditions to women and their labour leadership in this area. Despite the lack of a strong trade union tradition in New England, working-class collaboration strove to improve industrial life.

In Lancashire, male trade union activity and government priorities have overshadowed spontaneous and non-union collective action about the working environment.⁸⁸ White's study of Lancashire Textile Workers' strikes between 1910 and 1914 found that of 130 weavers' strikes, 24 or 18 percent, related to undefined working conditions.⁸⁹ Yet throughout the first half of the twentieth century, additional, unofficial action went unrecorded in White's union and government sources. Male and female operatives walked out when managers used bad language, including at Marsden in 1900 and Blackburn in 1925,⁹⁰ or when the moisture was excessive, including in 1895 in Burnley and Padiham and in 1913, in both Blackburn and Burnley.⁹¹ While a local labour shortage minimized the long-term risks of such action, the state of the local labour market was not always relevant. When the humidity became too oppressive, workers sometimes left anyway, including at Burnley in 1900 and Preston in the 1930s.⁹² Impromptu strikes were also staged at mills that were too cold or if temperatures were below that required by the Factory Acts, such as in Nelson, Oldham and Burnley in 1918.⁹³ Indeed, working conditions were important to male and female workers and their representatives. In 1910, the Blackburn and District Power-Loom Weavers', Winders' & Warpers' Association argued that weavers':

...are even willing, to receive less wages if they can bring about the abolition of artificial humidity. That to our minds gives us the possibility of arriving at only one conclusion, namely, that the system is considered and believed to be so injurious to their health that the weavers are prepared to face other difficulties rather than carry on their vocation under its operation.⁹⁴

While Lancashire mill workers accepted that working conditions were not always ideal, such non-gendered collective action to improve working conditions helps counter the argument that the Lancashire working-class stoically accepted their lot⁹⁵ and highlights workers' proactive efforts to improve working conditions, with and without union support. Nevertheless, the localized nature of such protests secured little national political attention.

During the interwar years when the textile industries began their long decline, British government investigations into the effect of mill conditions on operatives' health increased. In 1925, an Industrial Fatigue Research Board Report revealed no significant difference in the morbidity rates of weavers who worked in sheds that used steam and those that did not. Shortly afterwards, Home Office Reports in 1927 and 1928 effectively 'confirmed' that humidity did not pose a risk to workers' health.⁹⁶ With similar timing, the workers' newspaper, the *Cotton Factory Times*, placed greater responsibility on operatives for their own health, hinting at the unions shifting priorities to wages and jobs.⁹⁷ Indeed, both government and the unions prioritized industrial survival over workers' health. When a 1935 Industrial Health Research Board investigation revealed that the noise in weaving sheds seriously impaired hearing and impeded production, the government accepted the employers' argument that industrial reforms were prohibitively expensive.⁹⁸ The government demonstrated a similar disinterest in complaints about eyestrain and fatigue and formally ignored workplace health by not including an occupational health service in the original mandate for the National Health Service (NHS).⁹⁹

Despite industrial decline and political disinterest, Lancashire workers continued their sporadic collective action against unhealthy conditions. For example, in August 1932, 150 weavers at Clover Mill in Nelson struck, claiming that the excessive use of steam caused numerous cases of rheumatism. The Nelson Weavers' Association provided little support other than claiming "that the people who work in that atmosphere are the best judges."¹⁰⁰ Instead, the Association prioritized an ongoing wage-battle with employers, the outcome of which held wider implications for all Lancashire weavers.¹⁰¹ The growing government and trade union apathy towards the working environment helps explain the decline in recorded collective action and the preference for individual strategies and cooperative networks for managing the ill-effects of work. Mill workers still switched employers or walked out. They still spat and self-medicated. After the 1948 introduction of the NHS, operatives incorporated state healthcare into their network, including Welfare Officers and NHS doctors. While outside the scope of this article, such initiatives began replacing rather than paralleling collective action. Nevertheless, a constant through the years of industrial growth and decline in both Lancashire and New England was the commonality of working-class experiences of workplace ill health and responses to it. Addressing the consequences of industrialization was a class issue, not a gendered one, with operatives left to address the working environment themselves. The human costs of industry were universal; so too were the methods of managing them.

Conclusion

Both social policy and historical arguments suggest that many western nations were headed towards a paternalistic welfare state in the twentieth century, seeking to aid industrial workers and their dependents, with America heading towards a pioneering maternalist welfare state.¹⁰² The patriarchal discourse of gender comprised campaigns to either 'protect' women or to remove them from the workplace.¹⁰³ This paper provides a parallel, multi-layered narrative about working-class experiences of health at work and the associated role of gender. It reveals how the social, political and economic contexts affected both the conception of work-related ill-health and responses to them. Gender only entered the working-class experience because women were responsible for the household health, which explains why medical advertising targeted women. Ultimately, however, workers were left to address working conditions as they saw fit. As McIvor and Johnston found with British coal miners facing dusty conditions, mill workers in both countries were pragmatic and realistic.¹⁰⁴ How operatives responded to conditions related to understandings of the causes of ill-health, local and individual circumstances. This article has shown how British and American operatives' daily management of unhealthy working conditions suggests a commonality of textile workers' experience of workplace health which incorporates working and living conditions. Here, occupational health overlapped with workplace health. These understandings were framed by the broader social and economic conditions.

This multi-layered synthesis of medical, business and labour history highlights the commonality of the industrial experience and how this overshadowed social and political perceptions of gender. While it supports Dembe's argument that medical knowledge is a contested terrain and occupational diseases are socially constructed, it also reveals how occupational health is entwined with broader workplace health and living conditions.¹⁰⁵ If we are to fully understand the intricate and changing relationship between health, work and gender, further studies are needed about the complex relationship between health in the living and working environment and working-class experiences of ill-health.

* The author would like to thank participants at the 'Women in Changing Labor Markets' Workshop at Lund University, 2015, for their comments on a previous version 'We were never told anything like that': Women Textile Operatives and Unhealthy Working Environments in America and Britain, c. 1870-1960', as well as the editors and three anonymous reviewers for their feedback.

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- ⁹⁴ LRO DDX 1123/6/2/130 *Blackburn and District Power-Loom Weavers', Winders' & Warpings' Association*, Letter from Jos Cross, David Shackleton and Fred Thomas of the Weavers' Association to Unknown, Nov. 30, 1910.
- ⁹⁵ Roberts, *Woman's Place*, pp. 46-47.
- ⁹⁶ J. Jackson (chair), *Home Office Report of the Departmental Committee on Artificial Humidity in Cotton Cloth Factories* (London: HMSO, 1928).
- ⁹⁷ Eg. *CFT*, June 29, 1928 and February 15, 1929.
- ⁹⁸ Weston and Adams, *Performance*.

⁹⁹ Mclvor, *History of Work*, p. 141 and *Factory Inspectors Report 1937*, p. 24.

¹⁰⁰ *The Manchester Guardian*, Aug. 11, 1932.

¹⁰¹ Alan Fowler and Lesley Fowler, *The History of the Nelson Weavers' Association* (Nelson: 1984), pp. 73-76.

¹⁰² Eg. T. Skocpol, *Social Policy in the United States: Future Possibilities in Historical Perspectives* (Princeton, 1995); S. Koven, 'Borderlands: Women, Voluntary Action, and Child Welfare in Britain, 1840 to 1914', in Koven and Michel, *Mothers*, pp. 94-135; Lewis, *Politics of Motherhood*; Dwork, *War is Good for Babies*; Koven and Michel, 'Womanly Duties'.

¹⁰³ Eg. Harrison, *Not only the 'Dangerous Trades'*.

¹⁰⁴ Johnston and Mclvor, *Miners' Lung*, esp. p. 310.

¹⁰⁵ Allard Dembe, *Occupation and Disease: How Social Factors Affect the Conception of Work-Related Disorders* (New Haven, CT, 1996), pp. 3-21.