Old Age, Gender and Physical Activity: The Biomedicalization of Aging

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A Contemporary Paradox

The biomedicalization of aging, forged over a century ago by socially constructing old age as a diseased, dependent and inactive “stage of life” has strongly influenced the way many people think about the physical and sporting possibilities of aging men and women. Such a view has fostered age-grading systems and perpetuated the tendency to view aging negatively and as a medical “problem” requiring medical assistance, despite increasing contemporary evidence of the importance of social and behavioral factors in explaining health and aging. ¹ Perceptions of old people as helpless, sick and dependent upon medical intervention “may actually teach older people to become dependent and sick, encouraging them to act the part while simultaneously affirming the power of the medical model to define what is real and important.”² The belief is perpetuated that the problems of aging are biological and physiological rather than social and behavioral and hence can only be fixed by medical technology, if at all.

Furthermore, many physicians remain unclear about which changes found in elderly patients are pathological, which represent normal aging and what to advise in either case. The elderly are often insufficiently impressed with the “use it or lose it” argument in their dealings with medical personnel. Some doctors, for example, have been found to considerably underestimate the

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The Biomedicalization of Aging

The average life-expectancy of seventy-five year old women, leading them to dismiss the utility of behavioral changes that would reduce morbidity. Though sources of resistance to the biomedical construction of aging are increasingly apparent, a distinction continues to be made between providing the elderly with "just enough" assistance for modest maintenance but not "too much" for free and enjoyable living. These restrictive norms of a culture biased toward youth have operated to decrease the range of choice of the elderly as much, if not more than physiological and economic limitations. Though Laslett talks of an emerging "Third Age" of personal fulfillment begun after leaving the labor force, old people are still often viewed as "running out of program," living out their older years inactively and devoid of purpose. This condition creates, for some, a vulnerability to and dependence upon external sources of labelling, many of which communicate a stereotyped, negative message of the elderly as in poor health, incompetent and useless.

Although there are distinct indicators of increased interest and participation in healthful physical activity and sport, fewer than twenty per cent of Americans over the age of sixty-five are as physically active as they could be for optimal functioning. Older women, particularly, are under-represented among today's active elderly. While health limitations clearly have a direct influence on their physical activity patterns, perceived barriers to health and strongly held beliefs about the potential risks of vigorous exercise during old age seem to remain salient among many elderly women. Indeed, it is a paradox that one of the main reasons given by elderly women for not being more physically active is their


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declining health and the perception that they are “too old,” while at the same
time scientific research increasingly demonstrates that one of the certain
benefits of physical activity is health improvement. 10

It is a further paradox that, while women have proven more durable than men
from a physiological standpoint, they have done so in a culture which, until
recently, has encouraged them to take on the characteristics of aging too
readily. 11 Despite their superiority in living longer than men (even in pre-
industrial western society female life expectancy was eight months longer than
that of males), 12 women have, especially since the late nineteenth century, often
been considered old and frail earlier than men, pressed to retire sooner than
men, and generally viewed as less useful and less capable of dealing with the
vicissitudes of aging. 13

There is evidence that women continue to internalize such beliefs as they age.
The substantial improvements in the health status of elderly women since the
turn of the century have not necessarily been accompanied by a similar level of
improvement in subjective feelings about health and well-being. Older women
are reporting higher rather than lower rates of disability, symptoms and general
dissatisfaction with their health. 14 Furthermore, they consistently rate their
health more poorly than do men, and they hold stronger beliefs than men in the
merits of restricted physical activity. 15 As the gap between objective health
status and subjective well-being (which is an important motivation to exercise)
remains wide, medical sociologists seek to explain why elderly women con-
tinue to adopt a “sick role” so readily regardless of their actual state of health. 16

Society’s current preoccupation with physical fitness provides a partial
explanation, for paying constantly increasing attention to one’s body and its
health and fitness can negate real gains in health by leading people to assess
their health more negatively. “Bodily awareness, self-consciousness and intro-

10. See, for example, Louis Harris and Associates (eds.), The Perrier Study: Fitness in America (New York:
Great Waters of France Inc., 1979); Joan L. Duda and M. K. Tappe, “Personal Investment in Exercise Among
Adults: The Examination of Age and Gender-Related Differences in Motivational Orientation,” in Ostrow, Aging
and Motor Behavior, 239-255.
44-57.
13. Stearns, “Old Women,” 48, notes that “with a few limited exceptions, no serious improvement in the
articulated view of old women can be noted from 1800-1950 despite their rapidly-increasing numbers.” T.
and P. Liddiard (eds.), Aging Population: A Reader and Resource Book (New York: Holmes and Neier, 1979),
72-80; R. Mowsesian, Rusted Realities: Work and Aging in America (Far Hills, New Jersey: New Horizon Press,
1986).
14. Lois M. Verbrugge, “The Twain Meet: Empirical Explanations of Sex Differences in Health and
15. Walter R. Gove and Michael Hughes, “Possible Courses of the Apparent Sex Differences in Physical
Health: An Empirical Investigation,” American Sociological Review 44 (1979): 126-46; David Mechanic,
16. Verbrugge, “The Twain Meet”; see, for example, David Mechanic, Medical Sociology, 2nd ed. (New
York, Free Press, 1982); Sol Levine, “The Changing Terrains in Medical Sociology: Emergent Concern With
B.S. Bolaria and H.D. Dickinson (eds.), The Sociology of Health Care in Canada (Toronto: Harcourt Brace,
spection are associated with a tendency to amplify somatic symptoms inducing worry about health where before there was none. 17 A more complex explanation locates a deepening or a hardening of negative attitudes toward the physical capabilities of the elderly, especially aging women, in the last decades of the nineteenth and early years of the twentieth century. During these years, American middle-class society more readily conceived of aging as a distinct period of life characterized by decline, weakness, and obsolescence, rather than accepting it as a natural process of continuous development and maturity. The professions, particularly the medical profession, played a key role in articulating the unique and generally uninviting conditions of a “stage of old age.” They assisted in promoting societal recognition and a large measure of popular acceptance for the view that old age was a disease, a perilous condition, requiring cautious age-appropriate and gender-appropriate behavior and close medical supervision.

This paper examines the impact of developing medical conceptions of the body in the nineteenth century upon the formation of negative stereotypes of aging and explores why social limits defining the ways in which old people could be independent and physically active were imposed more readily upon aging women than aging men. In particular, it focuses upon the role that shifting medical paradigms of the workings and treatment of the body played in shaping our cultural image of old men’s and women’s physical capabilities.

The Role of the Medical Model of Aging in Shaping Negative Attitudes Toward Old Age

It is impossible to discuss old age in the present without describing its past. And in these descriptions there is a body of beliefs, often implicit, which comprises a coherent idea of the modern history of old age. 18

The special consequences of the aging process have only recently become the focus of sustained study by historians. 19 Those attempting to explain the evolution of negative attitudes toward the elderly, while disagreeing upon a precise time line, generally agree that the prestige of the aged has rarely been high in western society and that an increasingly negative image of the elderly has emerged during the last two centuries. 20 Fischer, for example, has claimed

19. History’s tendency, says Simone de Beauvoir, has been to exclude both older people and women, on the assumption that history (or at least what matters in history) is made largely by young or middle-aged men. Old Age (London: Hormandsworth, 1970). This is particularly so in the case of old women, for most historians of the social aging process have focused upon the experiences of old men. The experiences of aging women have not been examined systematically by either historians of aging or feminist historians. Older women are virtually non-existent in written history says Dale Spender, Women of Ideas-And What Men Have Done to Them From Aphra Behn to Adrienne Rich (London: Routledge and Kegan Paul, 1982); Majorie C. Feinson, “Where are Women in the History of Aging,” Social Science History 9 (1985): 429-452; J. Roebuck, “The Invisible Woman is a Little Old Lady: The Need for Change in Assumptions and Paradigms,” Paper presented at the 37th Annual Meeting of the Gerontological Society of America (San Antonio, TX, 1984).
20. Haber suggests that those historians who have discerned a radical and sudden change in American social perceptions toward the elderly at selected “crucial” periods, may well have overlooked long existing negative
that even if it could be argued that there was a golden age for old people in days gone by, towards the end of the eighteenth century a revolutionary change in age relations was already beginning to occur.

To be sure, assumptions emanating from Renaissance humanism and the Enlightenment had cast a positive view upon aging as a process of development toward maturity, wisdom and superiority supported by appropriate attention to the use of the Galenic-Arabic “six things non-natural.” The doctrine of the non-naturals (air for breathing, food and drink, exercise, sleep, evacuation and control of the passions) had provided a coherent view for eighteenth century discussions of health and hygiene based upon the view that man lived in harmony with the natural world. Medicine might assist in curing disease and dealing with the contra-naturals, but the individual was to take charge of the non-naturals, to put off the infirmities of old age and prolong life where possible by following a reasoned course of action. For the elderly, viewed from nature’s perspective as essentially “cold” and “dry,” a regimen was needed to emphasize the “warm” and the “moist,” a “springlike regimen, vivifying but not excessive.” The sexes too were seen to differ in their needs. Men were “robust and healthy,” women “feeble and delicate,” and each required regimens defined by their different social roles. The pursuit of well-being was thus an individual matter as was age, gender, and of course class-specific since few could afford the luxury of a healthy and organized life. Nor was the physician expected to supervise personal regimens, for at best he might ignore or underestimate the


The notion that the individual was responsible only to himself in ensuring a long and healthy life, however, was increasingly challenged as the eighteenth century drew to a close. The period of the French and American revolutions, notes Fischer, was a time of social revolution in attitudes toward the role of the individual and the state in which hopes for state action on behalf of public welfare replaced the emphasis on individual responsibility. This assisted in undermining the traditional system and authority of age relations and provoked an increasing hostility toward old age. Although an apparent semblance of age equality was introduced, beneath the surface “a new sort of inequality was being born, a new hierarchy of generations in which youth acquired the moral advantage that age had lost.” By the 1820s, suggests Fischer, an increased antipathy toward the aged and their needs and abilities was becoming apparent.

Changing perceptions about the aging process were fostered particularly by the dissemination of new scientific understandings about the human body. The positive connotation given to the possibilities of healthy old age by eminent American physicians such as Benjamin Rush in 1797 in his Medical Inquiries and Observations was challenged by new scientific research in the first half of the nineteenth century, especially the clinical studies of a group of pathologists at the Paris School of Medicine, who were investigating the body in an entirely new way.

Influenced by the philosophy of Descartes, who saw the world as a machine composed of inert bodies, moved by physical necessity and indifferent to the existence of thinking beings, positivistic mechanical science began to emphasize the importance of empirical observation and the physical causation of observed phenomena.
Nature was perceived in mechanistic terms, which led in biology to the idea that a living organism could be regarded as a machine which might be taken apart and reassembled if its structure and function were fully understood. In medicine, this same concept led further to the belief that an understanding of disease processes and of the body’s response to them would make it possible to intervene therapeutically, mainly by physical (surgery), chemical or electrical methods.  

For early nineteenth century medical researchers, the idea of placing an emphasis on underlying causation allowed and directed the search for specific diseases and encouraged objective empirical exploration of the physical body. In particular, “studies in anatomy and physiology served to demonstrate the power of empirical investigation and mechanical explanation, often contradicting established wisdom about the body that dated back to Aristotle and Galen.” Medical clinicians began to see a body which had a new anatomy, and to liken this body to a machine which could be controlled by the application of emerging, objective scientific knowledge. Both the reduction inherent in the machine model and the dualism it generated led inexorably to narrow analyses of disease causality.

The disease theory provided both a common basis of understanding for doctors, and a basis for bringing science to bear on the problems of medicine. A mechanistic, empirical view of the human body provided an appropriate foundation for the emerging paradigm of the specific etiology of disease. By the late nineteenth century, the germ theory of disease had gained credibility as a result of research done by bacteriologists such as Koch and Pasteur, leading medical scientists to assume that the specific cause of disease could invariably be located in the body’s cellular and biomedical systems.

There were two serious weaknesses in this unifactorial model of disease, however. One was the view that each disease had only one cause; the second was a dependence on the idea that all changes in function were referable to changes in structure (i.e., when something was wrong a disease could be identified). Such conceptions worked directly against the “physiological” view of disease as a generalized phenomenon put forward by Galen, Hippocrates and Aristotle; a view which saw the origins of disease in an imbalance of the natural forces within and outside the person. Although the concept of a unique cause of

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disease eventually proved inadequate to explain those factors within and outside of the person which affected his or her condition, it nevertheless persisted by focussing medical attention upon the repair of the parts of the body machinery rather than upon the whole person in his or her environment. The search for altered structure to locate disease similarly proved to be inadequate (though tenacious) in view of the many cases where disease seemed to be present without an alteration in structure.

Strong foundations of the disease theory of medicine and its implications for changing conceptions of old age were thus being developed during the nineteenth century by clinicians focussing upon structural abnormalities of the body. Through autopsies performed on the elderly, medical researchers revealed specific disease entities of old age, which suggested to them that senescence was much more than just a last gasp of energy before the vital force was spent. “Merely by growing old, the elderly appeared to have developed the external symptoms and internal lesions that were the signs of specific, debilitating illnesses.” 36 This view of “senile pathology” was bound to challenge more benign assumptions of aging, for if disease was a pathological condition of the elderly, then old people, even in apparent good health, were doomed to decreasing productivity and certain deterioration. 37 Furthermore, the potential efficacy of known therapeutic measures was clearly called into question.

Though well informed by the French experts about the distinctive pathologies of senescence, many physicians simultaneously retained a strong belief in ancient vitalist theories which described old age as a time of depleted vital energy about which very little could be done if it had been poorly husbanded and already spent:

Although pathological studies could be interpreted as replacing vital energy with mechanical or chemical processes, most English and American medical writers seemed to find no conflict between the clinical-pathological views and the age-old metaphoric model of aging. In their texts, the two theories were neatly combined: The tissue or cell degenerated while the organism systematically wasted away. 38 Loss of energy could thus explain pathological changes as well, hence the notion of vital energy, based upon Newtonian principles which saw the body as a discrete energy field, remained an essential aspect of an American view of aging increasingly focussed upon pathology. 39 Once force had been expended in one function, it was no longer available to any other. If some doctors questioned why the active seemed to live longer than the very inactive, despite having “spent” more energy, such an inconsistency caused few establishment physicians to abandon the notion that physical and mental activity used up the fixed

amount of energy apportioned for the life-span. The body, drained of energy wasted away as it aged even as the body deteriorated and degenerated from pathological changes. Drained of energy, the senses dimmed, motor skills weakened, and debilitation and disease inevitably followed. Indeed, lack of energy in the aged rendered them special prey to numerous fatal diseases. Dr. J. M. French wrote of the exhaustion of the sum of human energy in late age. “The old man’s bank is already overdrawn,” he said, “and he is living from hand to mouth.”

Once perceived as an object, the medicalized body was understood to require outside medical management, subject to the authority of an objective observer who could “read” the story of pathological causality into the aging individual’s experience. “Advanced old age, which had earlier been regarded as a manifestation of survival of the fittest was, by the late nineteenth century, denigrated as a condition of dependency and inexorable deterioration.” While advocates of prolongevity and promoters of the use of the non-naturals in enhancing the quality of life and extending the life span continued to be popular at many levels of society, a growing number of doctors focussed upon ways of dealing with the “disease” of old age and its ramifications in both men and women. The notion of unavoidable and irreversible senility in the worn-out body machine became well established in the medical literature and many of the medical community no longer seemed inclined to differentiate between normal old age and pathological infirmity.

The Social Construction of Old Age

The mechanical model used by physicians to view the aging body was particularly appropriate to a rapidly industrializing society. The notions of specialization and standardization that were advanced by industrialization derived their roots and legitimacy from the machine model of humanity and society where individuals were regarded as interchangeable parts of a whole within the machine of the factory (or society) which would wear out from prolonged use.

Achenbaum claims that the forces of modernization reinforced negative views of old age which had already been set in motion by social and intellectual forces earlier in the century. The decline in the status of the elderly grew steadily worse as a result of social Darwinism and accelerated industrialization. The years between 1865 and 1914, he suggests, became a further significant transitional period during which a deeper consciousness of old age and its problems

42. Gruman, ‘Cultural Origins.”
emerged and gerontophobia became progressively more intense. While social Darwinism gave rise to descriptions of society as continually “progressing” with time and age, this assumption was not extended to aging individuals. Positivist social thought, prevalent in Victorian Britain, Bismarckian Germany and America after about 1876, generated a model of society where the young, due to the march of progress, were considered superior to their elders. Since evolutionary progress, to the new scientific professionals and experts of efficiency was seen to be directly related to higher productivity, this was bound to work against those who were considered to be no longer at the peak of their productive powers. Adult maturity and healthful vigor were increasingly conceived of in terms of productive efficiency. The aging individual, lacking the ability to produce, was no longer of use to the evolution of the species and was increasingly viewed as programmed for death.

The demographic, social and economic transformation of the nineteenth century accelerated an alteration in the position of the old and helped to further shape the culture’s perception of the last stage of life. Public concern for the phenomenon of old age stimulated a growing body of new professionals, who were bent upon defining and dealing scientifically with emerging social progress, to categorize old age as a discrete social problem directly related to the dislocation caused by a modernizing society. “The socio-economic problem of the old man or woman as we know it,” wrote Rubinow, “is specifically a problem of modern society, a result of the rapid industrialization within the last century.”

While urbanization and industrialization combined to erode some of the traditional support systems of the elderly and to exacerbate their loss of independence, changing occupational structures further penalized aging workers who became steadily unemployed as manufacturing and mechanical jobs requiring special skills became more important. A person in old age, said Quetelet “was far less likely to be productive, creative or agile.” Increasingly, it seemed, the old were perceived as weak and incapable of learning new skills while the fast pace of industrial work was thought to wear people out more quickly. “Since there was little scientific verification of such theories . . . one

had to encounter only occasional cases of debility among older workers to reinforce the notion that they could not keep up.” 50 The older a worker was, the sicker he would get. Thus, an individual’s productive power was perceived to rise and decline according to age rather than ability. It became standard practice by the 1890s for some industries to demote or shut out older workers. 51 “Out of the factory and off the judicial bench,” the old were to disengage. 52

Dr. William Osler confirmed this negative assessment of the old as unproductive and devoid of energy in a much quoted farewell address to the Johns Hopkins University in 1905. “The effective, moving, vitalizing work of the world [was] done,” he said, “between the ages of twenty-five and forty years . . . the anabolic or constructive period in which there is always a balance in the mental bank and the credit is still good.” While men above forty were comparatively useless, once they were over sixty, they were absolutely useless and “it would be of great benefit to society if all men stopped work at that age.” 53

In a world increasingly dedicated to the doctrine of youthful masculinity and the strenuous life, the outlook for the elderly male was indeed tenuous. The similes of social mortalism pronounced by Theodore Roosevelt—“rust, feebleness, flabbiness and decadence,” all pointed up the perceived growing menace of age and decline. Roosevelt, for example, condemned those elderly men who were “mere lumberers of the earth,” and no longer “fit to break through the routine and to show . . . extraordinary energy . . . initiative . . . and willingness to accept responsibility.” 54 There was nothing, said Dr. Stockton, “to replace the effort of a man under forty.” 55

The Special Circumstances of Aging Women

Attitudes toward the aging female body were profoundly influenced in the nineteenth century by the machine paradigm of the body and the idea that an old and less efficient apparatus was of little use to society. While William Osler viewed all men over sixty as old and absolutely useless to society, the medical literature tended to characterize women as old and useless at an even earlier stage, the time when she could no longer bear children. In an era that extolled the virtues of the machine, “woman, as reproductive vehicle, came increasingly under scrutiny as the forces of production and

reproduction were drawn into ideological alignment." Men were perceived to be old when they could no longer do their work; women were presumed to be old when “the noblest aim of their existence,” childbearing and rearing was over.

Since menopause marked the end of reproduction, which was woman’s chief work, attitudes toward that event reflected a woman’s status in society and equated her completed work with a used-up body and a finished life. After menopause,

The body itself does not long delay entering into decrepitude, and soon we see the woman- once so favoured by nature when she was charged with the duty of reproducing the species-degraded to the level of a being who has no further duty to perform in the world.

Women who survived beyond forty were persuaded that menopause marked the beginning of a period of depression, of heightened disease incidence and of early death. The arrival of menopause, described by a number of popular medical text-books as a catastrophic experience, demonstrated that her body had run its useful course and begun its final decline. Heralding an unpleasant train of symptoms and inconveniences to the system, it was a discrete event-an end to womanhood. Thus, for many middle-class women, the onset of menopause was understood to be the gateway to old age even though they themselves, and a number of doctors, could not help but observe that some women could live through it, live longer than men and indeed survive in better health than their elderly male counterparts.

No one disputed the fact that the average woman was beginning to survive the average man, underlining, of course, the contradiction between the biological fitness of women and their social treatment as weak or inferior. (Life expec-
tancy for middle-class white American women at the end of the nineteenth century for example, was 51.08 years, while men could expect to live for 48.23 years). The shorter life-expectancy of the male was believed by some physicians to be due to the strain of family responsibilities and anxieties of the business world which wore out the body machine. The risks of maternity, suggested Dr. Napheys “do not equal these peculiar perils of manhood.” More importantly, however, the reductionist underpinnings of the machine model of the aging body lent support to the medical notion that regardless of their current health status or expected life-span, once females had lost their main function at menopause, they entered senescence and decline and their normal physiological condition became pathological.

Prescriptions for Exercise in Old Age: Aging, Gender and Physical Activity

Once the experts agreed that old age was a distinct and debilitating stage of existence, institutions and programs were increasingly designed to separate the old from the work, wealth and play of the younger generation. As the authority of medical pronouncements and industrial efficiency experts spread, it was no longer seen to be natural for older people to participate in physically demanding pursuits.

Not surprisingly, the more formal establishment medical literature providing advice about appropriate types of physical activity for old men and women reflected fatalistic medical connotations of aging as an irreversible state of debilitating illness and senility. “Gruesome and depressing as this medical advice was ,” commented G. Stanley Hall, “it had nevertheless a certain grim fascination to know what a cohort of disorders encamp about and prey upon the aged, any group of which is liable to assail and perhaps take the citadel of life by storm.”

Turn of the century medical literature confirmed that in many respects, the traditional humoral pathology of prolongevity hygiene proponents such as Italian Renaissance nobleman Luigi Cornaro was being superseded by the development of pathological anatomy and bacteriology and the revelation of complex forces causing disease on a microscopic level. Influenced by new disease concepts and the new methods of modern medicine the medical establishment insisted that it could no longer be maintained “that a man could have no better doctor than himself and no better medicine than the temperate life.” The emerging view of old age as a distinct and diseased life-stage thus required, not so much personal hygienic sagacity as age-appropriate, medically approved patterns of behavior.

Doctors such as J. W. Bell advised their colleagues to pay increased attention to senile pathology. In a speech to the 50th Annual Meeting of the American Medical Association in 1899, he encouraged fellow doctors to show more responsibility in advising and treating the problems of the aged in all aspects of their lives, including advice on physical activity. Indeed, exercise prescriptions formed an important part of the lifestyle management advice given to those in advancing years. A man can take any reasonable form of exercise between the ages of eighteen and thirty without injury to his health, said Dr. Wainwright in the Medical Record, but it goes without saying that the aged “should undertake no violent exercise whatever. . . . If they are allowed any outdoor sport at all they should take gentle exercise involving only slow steady movements.” Only participation in those outdoor sports and activities which were possible without over-exertion was considered advisable to postpone senile decay and “the evil day of decrepitude.”

Establishment physicians recommending exercise for hygienic purposes tended to accept that most of the debilities of aging could not be turned aside, but that some types of impairment might be slowed through appropriate activity, especially if it had been systematic from the early years. It is generally accepted, said Dr. Taylor, that “old people are unfit for activities and must do little or nothing but exist,” though he conceded “that the healthier and happier people are those who are reasonably active.” Carefully designed exercise prescriptions were clearly necessary. Any postponement of the degenerative effects of age “have much to do with the forms and qualities of the exercises. Free exercises in the open air, proportional to the capacities of the individual, are of the greatest importance and should be regulated with the same care . . . as any other medical measures.” It was possible, therefore, that regular exercise with appropriate limits for aging men might delay the onset of degeneration, slowing the decline before the wheels of the machine finally stopped.

Where women were concerned, establishment doctors were convinced that the perceived disorders of menopausal and aging women rendered them in special need of medical attention and protection at an earlier age than men. “All intelligent physicians,” claimed Dr. Napheys, knew that the change of life was particularly dangerous to women, and hence the years following that event required constant monitoring and systematic treatment. Although old women might be in perfect health, old age alone signified disability. Activities that had once been easily performed were now viewed as the potential cause of serious infirmities. Aging women were perceived to be invalids in need of care, lacking the necessary vital energy to participate in onerous daily activities and requiring supervision in all lifestyle habits. An old woman’s blood, for example, was

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perceived to be thinner than a man’s at birth and to have been weakened consistently with each birth and at every menstrual period.\footnote{72} It was also suggested that her shorter stature than the man’s propelled her more rapidly along life’s path to old age (less energy to spend on more reproductive demands), though allowed her to live somewhat longer (smaller frame required less of the energy left).\footnote{73} In the event that a well-regulated regimen might render her body less susceptible to senile illness, recommendations were made for women to avoid all severe mental or bodily effort or exhaustion. Over-exertion could easily lead to cardiac arrest, and a host of other life-threatening conditions.\footnote{74}

A careful therapeutic regimen was recommended for post-menopausal women in which a combination of rest and gentle exercise was designed to equalize the circulation of the blood and activate the natural body tendencies to prolong health and equilibrium as far as possible.\footnote{75} Although this was a similar medical regimen to that advocated for aging men, the difference lay in the application of conservative medical regimens at an earlier age for females than for males, socializing middle-class women, whilst still in their forties, to take on the characteristics of aging by disengaging from active pursuits and anxiously conserving their body machine.

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The mechanical model of the body and the “classical disease theory” thus provided the foundation and legitimization for the social construction of old age as a distinct life stage for men and women requiring similar mild dosages of physical activity and the circumscription of vigorous participation in life’s affairs. Modernization and the drive to increase industrial efficiency had encouraged the application of a systems approach to managing society with its requirements for standardization and the application of the concept of macro-efficiency. This approach required the system to be managed according to standardized concepts and classifications rather than on the basis of individual characteristics or idiosyncratic features of man, woman and/or machine.

Scientific professionals and efficiency experts focussed upon the dominant functions of systems and groups, classifying people into appropriate categories with assigned tasks, and subjecting the life-course to increasing surveillance, control and normalization. This lead to a much more extensive institutionalization of the life-course, which became socially structured into orderly sequences of psycho-social growth and development.\footnote{76} The elderly were firmly coded into a socially constructed stage of “old age” at the age when standardized informa-
tion suggested their functional utility was over. Men were classified as old when statistics or impressions of the “average” suggested they could no longer perform effectively in the work force and hence should be retired. (The retirement age for men would be pegged at sixty-five, in spite of the fact that many men worked long and successfully beyond that age). By acknowledging the loss of the female’s reproductive system as the end of her productive efficiency, women were propelled into a socially constructed stage of old age at a substantially earlier age than men. The role transition to becoming old could begin at forty-five or even earlier, even though it was clear at the individual level that many women could be and were vigorous and effective workers for years after menopause. Since the female might well live longer and was perceived to begin old age earlier than man, her stage of old age could be substantially longer than the male stage of old age. Yet, however long the stage, and however wide the differences in physical abilities, the prescription of rules concerning behavior in old age for women was almost identical to the advice provided to the much older group of “old men.” Old people as a “class” were to slow down, to rest and, in Gubrium’s terms, put on the mask of aging to confirm the acknowledged and standardized association between physical aging and decline. Women, however, were to put on the mask on sooner and more firmly than men.

One must agree, however, with Haber that neither prescriptive ideal nor social reality could have completely dictated how the elderly were perceived and treated. Old people varied in their individual experience of work and recreation, health status, familial and economic situation, geographic setting and ethnic background. In both the medical and popular literature one could find descriptions of people who obviously had conceptions of age other than their chronological one, and whose physical behavior did not conform to the standardized norm for “old age.” There were remarkable (though not frequent) examples of longevity feats, septuagenarian pedestrians and cyclists, aged swimmers and gymnasts, and mountain climbing seniors. Old people were not always content to be onlookers, and bicycling and golf were viewed as potentially appropriate for elderly citizens, despite the fact that caution was


78. Retirement policies, for example at the progressive firm of Cadbury’s in England, set the retirement age in 1900 at ten years earlier for women than men. This was necessary, claimed the Company, because women “could not carry on so long.” J. Roebuck and J. Slaughter, “Ladies and Pensioners: Stereotypes and Public Policy Affecting Old Women in England, 1880-1940,” Journal of Social History 13 (1979): 105-114.


80. Haber, Beyond Sixty-Five, 174.

81. See, for example, Richard Cole Newton, “Age and Exercise,” Journal of the American Medical Association 53 (1909): 730-31; G. Stanley Hall, Senescence, 100-138, for a number of historical examples; Humphry, Old Age.
continually applied to “old people with their brittle vessels and degenerate muscles” who should avoid sudden strain, and elderly females who “might exaggerate and overdo the amount of exercise good for them.”82 Golf especially held out promise as an “old man’s game” that “could be taken by anyone who can walk two miles in one hour.”83

While the Doctors did not subscribe wholeheartedly to the negative view of a run-down machine, avoiding the effort of life in an attempt to prolong it, the medical profession nevertheless had an important and lasting influence upon society’s view of the pathology of old age and the restrictions implied by this conception. The biomedicalization of aging, and the notion that women age and decline earlier than men inevitably influenced future views of sport and exercise for the elderly.