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The Time of the Change

The Medicalisation of Menopause and Reproductive Ageing

At a time when assisted reproductive technologies (ARTs) such as artificial insemination (AI) and *in vitro* fertilisation (IVF) have become commonplace, women's interest in preserving their bodily tissue in an attempt to maintain fertility in the future is surprisingly contentious. In the previous chapter I suggested that the controversy about OC followed, at least in part, from the renegotiation of ideas and practices of reproductive ageing and timing reproduction that emerge with the possibility of freezing one's eggs. OC provides the occasion for both resisting and insisting on reproductive age norms, while introducing novel disciplinary and commercial opportunities to capitalise on broader negative attitudes towards ageing. Yet for all their novelty, OC practices reference and redefine ideas on the relation between normative attitudes towards bodily time—or ageing—and the medicalisation of the female reproductive cycle that far predate the technology's recent success. In this chapter, I will consider the linking of reproductivity and ageing in one important moment in gynaecological history, in which the end of the female reproductive cycle and midlife transitions became an interrelated concern in the medicalisation of menopause.⁵⁰

I focus on the earliest entrance of menopause in British gynaecology, marked by the first English book-length publication on menopause by E.J. Tilt in 1857 and its subsequent editions up until 1882. As one of the instigators of menopause's medicalisation, Tilt is a pivotal figure in the history of gynaecology whose studies make explicit the legitimising discourses that position menopause as a recognisable pathology in need of medical management and as “a subject of legitimate knowledge” in gynaecological research (Foucault 1973, 137). In offering a medical explanation for menopause and its symptoms, his studies also actively engage a variety of existing conceptualisations of the menopausal body and reproductive ageing prior to the development of a more unified—if not monolithically so—specialist consensus. In *The Change of Life in Health and Disease* (1857), Tilt appealed to concurring models of the menopausal body that situated “the change” in the “bad” blood, the womb, the ovaries, and its extractions.

Critical feminist perspectives have pointed out how gender inequalities may be perpetuated through medical constructions of the female body and its reproductive

⁵⁰ An earlier version of this chapter appeared in the *International Journal of Feminist Approaches to Bioethics*. See Van de Wiel (2014c).

capacities. Shildrick and Price, for example, argue that these constructions “are founded in linking the feminine to a body that is curiously and uniquely unreliable” and therefore “demands attention and regulation” (1999, 3). They point to a double movement in which, on the one hand, sexual difference affects the degree to which bodies are medicalised and, on the other, gender stereotypes are reiterated and naturalised in the treatment and conceptualisation of these bodies. I will argue that the dimension of age normativity may similarly be written into medical constructs of the menopausal body and that Tilt’s work makes this explicit.

Foucault’s concept of the medical gaze as developed in *The Birth of the Clinic* (1973) is a tool for understanding the complexity of menopause’s medicalisation. A Foucaultian reading avoids simple oppositions between oppressive medicine men and victimised patients, but considers the knowledge practices and the discursive power distributed through them. For Foucault, power is not localised “in anybody’s hands,” but rather individuals are “the elements of its articulation” and “always in the position of simultaneously undergoing and exercising this power” (1980, 98). Discursive power is thus actualised in the knowledge constructions of bodily truth—and the mechanisms that produce them—that are circulated in medical language and practices employed by medics and patients alike (Radtke and Stam 1994, 4).

While the Victorian gynaecological tradition is clearly sexist by our standards, the point in this chapter is not to identify a historical culprit for continued inequality, but to examine the mechanisms underlying the interaction between medical knowledge production of the body and a broader gender politics of ageing. My reading of Foucault’s *The Birth of the Clinic* gives an account of the specific epistemological shifts in medicine that enabled an understanding of menopause as both a medical concern and a marker of gendered life course progression.

In Foucault’s discussion of the medical gaze I identify four dimensions that become articulated through the observation and treatment of the body in the medicalisation of menopause in Tilt’s work. The first three dimensions of Foucault’s medical gaze correspond to my interest in normalised constructions of anatomy (spatial), its relation to ageing (temporal) and the normative frameworks through which they become meaningful (social). Combined, they highlight the medical gaze’s fourth dimension: the promotion of (self-)surveillance by anticipating physical futurity.

Through my reading of Foucault’s medical gaze as structurally interconnecting anatomy, age, and social norms in processes of medicalisation, I will argue that almost all of Tilt’s gynaecological writing on menopause has in it a claim about ageing. I will examine plethoric and utero-ovarian constructions of menopause in Tilt’s treatises and analyse their relevance for imagining ageing by distinguishing three mechanisms: the coupling of the medicalisation of reproductive ageing with the inscription of social

norms onto the body's temporal schemes, the conceptualisation of the body in time through visual cultures of medicine organised by the medical gaze and the anticipation of futurity in the body as a disciplinary strategy. This analysis thus historicises the intertwining of gender and age norms in Western cultural conceptions of menopause, some of which continue to hold cultural currency today, as will become clear in the following chapters' discussion of OC.

Digital Parts

The digital age is a phenomenon we associate with computers, data banks, and mobile phones developed over the last thirty years, but some 150 years prior, the first English physician to author medical tracts devoted entirely to menopause voiced his concern about a different "digital" age. In the preface to *The Change of Life in Health and Disease* (1870), Edward John Tilt writes about the use of the speculum to observe the womb:

Although a digital examination be invaluable to ascertain the consistency, the size and the shape of the womb, it is often perfectly useless and unreliable for the diagnosis of ulceration [...]. Indeed, it cannot be too often repeated to those who treat the diseases of women, that if the ocular examination of diseases of the womb were to fall into disuse, all further progress of uterine pathology would be arrested; nay more, it would soon retrograde to what it was before Récamier took it up. (ix)

As a pioneer in the study of menopause within the relatively new specialty of gynaecology, Tilt employs various justificatory narratives to validate his observations and treatment of the female change of life. Educated at the Parisian hospitals on which Foucault would base his analysis of the anatomo-clinical turn, Tilt positions the French disciplinary development of gynaecology and its early study of "*la menespausie*" at the centre of his argument.⁵¹ Rather than only advocating the use of a diagnostic tool, he positions the speculum as an instrument of progression in the absence of which medical time would "retrograde." In fact, he attributes the very development of a medical specialty focusing on women's reproductive bodies to the speculum's introduction:

⁵¹ Tilt started his medical studies at St George's in London, but before finishing his degree he moved to Paris to obtain his M.D. and gain work experience at Parisian hospitals as Récamier's student. Tilt was also influenced by Gardanne, one of Récamier's Parisian followers, who coined the term "menopause" in his *Avis aux Femmes Entrant Dans l'Age Critique* (1816). When Tilt returned to England halfway through the century, his interests reflected the French gynaecological tradition, which was more visually-oriented and had developed a focus on menstrual health and menopause, as evidenced by over thirty doctoral theses on the female change of life defended at the University of Paris in the 1802–30 period (Wilbush 1980, 264). In *The Change of Life*, Tilt references the work of Gardanne and Récamier as main influences for the development of the gynaecological speciality in menopause.

“Gynaecology, or the accurate study of diseases of women is the youngest branch of medical literature, for it began in 1816, with Joseph Récamier (1774–1852) and the better means of diagnosis that he introduced” (Tilt 1882, vii). By writing his discipline’s history as predicated on medical technology, Tilt ascribes formative importance to the introduction of the speculum’s ocular, or visual, perspective in observing and interpreting the female body.⁵²

Tilt’s attention for the speculum as an instrument that brings the interior body into the physician’s view can be read as an extension of the new “medical gaze” Foucault makes into his object in *The Birth of the Clinic* (1973). Foucault positions the gaze in relation to an epistemic shift in Western medicine from a pre-nineteenth-century theoretical and disease-focused “classificatory” model to an “anatomy-clinical” medicine focused on observing the diseased and dissecting the deceased body (1973, 2). He identifies a shift in the way in which disease was perceived in relation to the body, a change in the “spatialisation and verbalisation of the pathological,” away from an earlier classification of diseases as separate phenomena and towards an approach that specifically focuses on the body as the “space of origin and of distribution of human disease” in the anatomy-clinical turn (Foucault 1973, xii, 1). By means of the medical gaze, the pathological becomes recognisable through the visible and conceptual mapping of the body according to norms of health, clinical observation practices and the vantage point of the autopsy.

What makes this anatomy-clinical turn an epistemic one is its effect on practices of knowledge production of the body and related conceptualisations of health and disease. The medical gaze comes to bear not only on means of diagnosis, but

on the type of objects to be known, on the grid that makes it appear, isolates it, and carves up the elements relevant to a possible epistemic knowledge (savoir), on the position that the subject must occupy in order to map them, on the instrumental mediations that enables it to grasp them [...] and on the forms of conceptualisation that it must practice and that qualify it as a subject of legitimate knowledge. (Foucault 1973, 137)

This epistemic work of the medical gaze can be read in the medicalisation of menopause in the decades following the development that Foucault describes. Not simply describing the female body, medical tracts discursively construct menopause and its corporeal

⁵² Positioned in an English “war against the speculum,” Tilt became an advocate for the use of the instrument and criticised those who avoided it out of considerations of prudence. For a treatise on the “war on the speculum,” see *The Speculum: Its Moral Tendencies*, by a Fellow of the Royal College of Surgeons (1857), or Moscucci (1993) for a more recent historical analysis.

manifestation as a subject of legitimate knowledge that can be mapped and understood by the expert gaze of the gynaecologist. In Tilt's *The Change of Life*, I read several contesting conceptualisations of this body, each isolating different body parts as explanatory locus of the menopause and each implicating specific, valued ideas about ageing. In doing so, I distinguish four dimensions of Foucault's medical gaze that operate simultaneously in these processes of knowledge production: spatiality, temporality, social normativity, and futurity.

First, the spatial dimension of the medical gaze entails new ways of seeing the space of the body in relation to notions of normality and pathology (Foucault 1973, 164–65). The transition that Tilt attributes to the speculum is not only a technologically motivated change that makes previously hidden inflammations visible to the physician's perception. It also indicates an instrumental mediation of new knowledge practices through which the examined body is observed in relation to a "generalised state of health" (Lupton 2003, 91):

Up to the end of the eighteenth century medicine related much more to health than to normality; it did not begin by analysing a "regular" functioning of the organism and go on to seek where it had deviated, what it was disturbed by, and how it could be brought back into normal working order [...]. Nineteenth-century medicine [...] formed its concepts and prescribed its interventions in relation to a standard of functioning and organic structure, and physiological knowledge [...]. (Foucault 1973, 35)

The medical gaze's spatial dimension thus refers to the co-constitutive viewing of the patient's body in accordance with a normalised "anatomical atlas," through which the healthy state and the laws of pathology are spatialised (Foucault 1973, 3). Tilt's presentation of the speculum makes this work of the medical gaze explicit by stating that Récamier's group of gynaecologists used the instrument "to bring the sexual organs of women within the range of the general laws of pathology" (Tilt 1882, vii). The establishment of gynaecology as a field of inquiry as part of this turn provided the discursive framework within which menopause emerged as a medical concern, as an effect of the distinctions drawn between "the change of life in health and disease" as Tilt's title has it (1857). As "the new medical perception finally attributed to itself the task of mapping the figures of localisation," the female midlife body was a site of contestation in which Tilt's 19th-century gynaecology assigned the "seat" of menopause to the "bad" blood, the womb, the ovaries, and its extractions (Foucault 1973, 140).

In order to understand the significance of localising menopause as pathology in specific body parts, I highlight the second, temporal dimension of the medical gaze. The

relevance of time is primarily a result of the anatomico-clinical “technique of the corpse” in which the dead were dissected to reveal what remained enveloped in darkness in the living (Sheridan 1980, 39–41; Foucault 1973, 141). In this context, Foucault speaks of the depth of the medical gaze, both as it traverses into the body, revealing interior surfaces, and as it resignifies death from the absolute end-point of life to a perspective from which the living and diseased body could be better understood. The speculum is a logical extension of the late-eighteenth-century anatomico-clinical autopsy, transporting this practice from the dead corpse to the depths of the living interior body to understand its particular pathological structure.

The centrality of the dead body as site of revelation for life’s workings reconceptualised ageing as a key phenomenon in medical thought. Not only were the dead inspected retrospectively, but, in the living, processes of ageing were understood as a degenerative progression towards death: “Degeneration lies at the very principle of life, the necessity of death that is indissociably bound up with life” (Foucault 1973, 158). This focus on degeneration increased medical interest in ageing throughout the life span.⁵³ As the anatomico-clinical study of “diseases of women” determined the normality and pathology of female reproductive organs, the nature of the medical gaze also added a temporal dimension to these observations, whether by viewing them in relation to specific ages or by noting the rhythmic nature of monthly or epochal transitions.⁵⁴

As the medical gaze standardises corporeal time-space, it also operates through a third, social dimension that relates knowledge production of the patient’s body to an understanding of social norms. Foucault remarks that “disease is caught in a double system of observation: there is a gaze that does not distinguish it from, but re-absorbs it into, all the other social ills to be eliminated; and a gaze that isolates it, with a view to circumscribing its natural truth” (1973, 43). The integration of social ills into observed pathology gives the medical gaze a social dimension that interprets the body by associating disease and health with particular lifestyle choices. As will become clear in the case of menopause’s medicalisation, the social dimension of the medical gaze

⁵³ Situated in the epistemic anatomico-clinical shift at the Parisian hospitals that Foucault describes in *The Birth of the Clinic* (1973), the medical gaze was formative for the development of geriatrics as a medical specialty concerned with ageing as physiological decline. Knowledge production in geriatrics was organised around the observation of the elderly in Parisian hospitals (Katz 1996, 46; Ackerknecht 1967, 50, 174). Gynaecology employed a different type of medical gaze, focused on the living body’s interior surfaces through the gaze of the speculum. Although the studies of both ageing—particularly increasing longevity—and human reproduction have long traditions in Western medicine, only in the context of new 19th-century specialisations like geriatrics and gynaecology did their combination generate the coining of menopause as a distinct pathology to which medics could devote their careers.

⁵⁴ Most Victorian writers locate the expected age of menopause somewhere in the forties. Leith Napier is most specific in establishing an average age of last menstruation of forty-seven and eight months (1897, 85). Other writers position “the period of this great change” somewhere in between 40 and 50 years (Barnes 1873, 263; Churchill 1864, 218; T. J. Graham 1861, 94; McMurtrie 1871, 218). Tilt references exceptional cases of early and late menopause, but also uses 45 years as the average age (1870, 49).

associates pathology with social deviance, while normative behaviour is considered to favour healing. Medical discourse and its particular conceptualisation of bodies and their pathologies thus become an important source for diagnosing existing cultural ideals.

The significance of the medical gaze's interpretative work follows from Foucault's observation that "it was no longer the gaze of any observer, but that of a doctor supported and justified by an institution, that of a doctor endowed with the power of decision and intervention" (1973, 89). Not only are medical discourses "a powerful influence—some would say the most powerful influence—on constructions of the female body, and on what it is to be a woman," but, through diagnoses and treatments, interpretations of the body become inscribed into its materiality (Shildrick and Price 1999, 145).

The final dimension of the medical gaze, its futurity, follows from the combined social and spatio-temporal nature of observing the patient's body. By invoking uncertain future states of health and disease, present medical observation and treatment can gain disciplinary force. Foucault hints at this process when he draws a parallel between anatomo-clinical medicine and the church: "to the army of priests watching over the salvation of souls would correspond that of the doctors who concern themselves with the health of bodies" (1973, 32–3). In Tilt's work the salvation of gynaecology was not located in the afterlife, but in future menopausal and postmenopausal health.

An alternative to digital inspection, Tilt's advocacy of the new "ocular examination" in gynaecology symbolises a medical gaze that points beyond practices of increased corporeal visibility to novel ways of seeing that are indicative of a new organisation of normality and pathology in the body (Tilt 1870, ix; Foucault 1973, 164–65). Indebted to its origins in dissection, the medical gaze's work has a temporal dimension that overlays the corporeal spatiality of the "anatomical atlas" through which it reads into the body a network of mappings derived from its projected future in autopsy (Foucault 1973, 3). However, in Tilt's text the medical gaze does not produce a uniform mapping of the menopausal pathology in the female body, but rather simultaneously employs various anatomical atlases through which the change of life could be explained. Focusing specifically on Tilt's blood theory and organic approach to menopause, in the next section I will discuss the contesting localisations of menopause in different body parts and the ideas about ageing that are expressed through them.

Balancing Blood: Plethoric Menopause

Tilt's plethoric menopause holds a tension between an older humoral understanding of health as a balanced flow of fluids in, out, and through the body, and a later approach that Foucault describes with the anatomo-clinical turn, in which the body is "composed of discreet organs with specific functions and secretions, rather than as a continuous

system of flows” (Freidenfelds 2009, 25). In its plethoric conceptualisation, menopause is understood as a temporary condition in which the absence of menstruation causes congestions of surplus blood, resulting in symptoms like hot flushes and digestive problems. Whereas in earlier constructions of the sexed body “menstrual bleeding could occur in a multitude of ways and was not necessarily restricted to non-pregnant, non-lactating women, but could also be experienced by men, by expectant mothers and through various alternative routes,” by the time of Tilt’s writing, menstruation, and its cessation in menopause, was understood as a specific secretion of the uterus and later came to be understood as linked to ovulation and female fertility (McClive 2005, 79, 86). Rather than a holistic economy of fluids, Tilt’s menopausal plethora was localised in specific reproductive body parts and, consequently, clearly gendered.⁵⁵

The menopausal plethora was not an isolated gynaecological problem, but a physical expression of the transition from one life course to the next. As the term “change of life” suggests, Tilt positions menopause as a pivotal point in relation to a broader understanding of the life span as divided into various epochs. Especially in women, adult ageing was not only understood as the decline tending towards the vantage point of death that Foucault highlights, but also entailed age-specific transition periods in which the body reconstituted itself to a new stage of life:

Instead of flowing on in smooth tranquility from the cradle to the grave, the stream of life is marked by rapids, which have been called critical, metamorphic, or developmental epochs. (Tilt 1882, 3)

Tilt’s language, its association of health with flow and tranquillity, hints at the plethoric understanding of menopause, in which problems were taken to arise from internal imbalance and turmoil. The postmenopausal woman would eventually regain a new balance, but in the menopausal epoch plethora could be induced if her body would “suffer the blood to stagnate in congested tissues” (Tilt 1857, 80).

The positioning of changes in the reproductive body as organising principle for women’s life course transitions hints at the way in which the passage of time was gendered in the 19th century. At a point in history when official time was standardised in England (1880) and technological developments such as the railway system called for strict scheduling, women were associated with timelessness as inhabitants of a

⁵⁵ This shift from the plethoric to the organic model of menopause is paralleled with a historical transition in the conceptualisation of sex. In *Making Sex*, Thomas Laqueur describes the latter as a transition from what he calls a “one-sex model,” in which women and men were conceptualised as hierarchical variations of the same physical principle, to a “two-sex model,” which introduced a conceptualisation of female and male sexes as characterised by a “physiology of incommensurability” (Laqueur 1990, 4–6).

romanticised domestic space (Heath 2009, 15). Maternal love and domestic bliss were idealised as belonging to women's time. In opposition to the regulation of time encroaching on people's lives through routinised processes of industrialisation, "the emerging discourse of domesticity, especially, inculcated and validated a set of feelings—love, security, harmony [...] motherly instincts—in part by figuring them as timeless" (Freeman 2010, 5). The clock of women's time materialised in their reproductive organs, which positioned them within set life courses and in relation to the available roles of "potential mothers, actual mothers or retired mothers" (Jalland and Hooper qtd. in Heath 2009, 15).

In the absence of a similar periodical significance ascribed to the male reproductive function, the progression through life courses itself became differentiated along gender lines. According to Tilt, men did not experience as frequent periodical crises, nor did their sexual organs change with equal influence on the rest of their constitution. Changes in women's generative organs, however, entailed both a reconfiguration of general health and social expectations of life course management:

Puberty is common to both [sexes], but the impulse then given to the constitution of man by the sexual apparatus is, in general, fully effective and all-sufficient to ensure its permanent activity until extreme old age; whereas in woman, this crisis is very liable to be delayed or perverted, and even when puberty has been effectually established, the health of woman is dependent on those oscillations of vital power which render menstruation healthy or morbid. Matrimony, pregnancy, parturition, lactation, are like critical periods, curing some complaints, giving greater activity to others. (Tilt 1882, 3–4)

Thus establishing male normalcy as opposed to female pathology, men's effective development was not in need of medical intervention, whereas women were expected to be in health crises at various transitions in life. These transitions were, remarkably, not only of a physiological nature, but also included social events such as matrimony. Whether matrimony was used as a euphemism for sexual activity and potential conception or was itself considered to be a biological transition, its inclusion in this list of "critical periods" illustrates how the socio-cultural life courses were understood to be quite literally discernible in, and caused by, the female body. The construction of women's bodily ageing therefore functions as an instance of what Freeman calls chrononormativity: "a mode of implantation, a technique by which institutional forces come to seem like somatic facts. Schedules, calendars, time zones, and even wristwatches inculcate [...] 'hidden rhythms'[:] forms of temporal experience that seem natural to those whom they privilege" (2010, 3). Tilt's epochal transitions are examples

of such hidden rhythms, which, once they began to depart from what were considered to be their natural interval, caused medicalised conflicts.

The temporality of the menopausal transition itself was similarly conceptualised as having a rhythmical character. Within the plethoric model, Tilt and his patients anticipated a continued monthly intensification of symptoms during which the previously released menstrual blood congested the body. Menopause was thus characterised by a recurring state of anti-menses rather than the absence of menstruation altogether. Menstrual symptoms associated with the abdominal area (uterine cramps and digestive problems like diarrhea and constipation) had their parallel digestive discomforts in the monthly state of plethoric anti-menses. Discussing them at greater length and before the now quintessential menopausal symptom of hot flushes, Tilt reports lumbo-abdominal pains and hypogastric symptoms in over half of his patients (1857, 161). In keeping with the plethoric logic, lumbo-abdominal pains are the most frequently occurring “compensating actions” that recur on a monthly basis, as menstruation had before (Tilt 1857, 54).

A testimony to the temporal standardisation of the medical gaze, which normalises the continued cycle, Tilt observed a variety of monthly symptoms in the majority of his (post-) menopausal patients (1851b, 49). This is no surprise to him as

for thirty-two years, it had been habitual for woman to lose about 3oz. blood every month, so it would have been indeed singular if there did not exist some well-continued compensating discharges acting as waste gates to protect the system, until health could be permanently re-established by striking new balances in the allotment of blood to the various parts. (Tilt 1857, 54)

In order to compensate for this plethoric superfluity in the menopausal woman, the body was purged in other ways. Hot flushes, nowadays a sign of hormonal changes, were then considered proof of a purging body. While bleedings were falling out of grace and were increasingly deemed ineffective in other areas of medicine, Tilt and his colleagues continued to recommend bloodletting to compensate for the absent menstruation (Ulvik 1999, 2487–89). However, under the influence of the anatomo-clinical turn, the plethoric approach became more focused on specific organs, as exemplified by Tilt’s reasoning for localised bleeding: “by diminishing the quantity of blood, we slacken the energy with which it flows to some particular organ, or its momentum, and thereby diminish the liability to congestion” (1857, 84–85).⁵⁶

⁵⁶ Tilt’s colleague Van Oven accordingly advised applying leeches to the cervix should symptoms occur at monthly intervals (Van Oven 1853, 6, 13, 16, 31–3, 38, 103–4).

Although understood as compensatory purgative for the plethoric state, hot flushes could also occur after the change, in which case they expressed a social norm in keeping with a renewed imperative to postmenopausal prudence: “The recurrence of flushes so late in life is not to be wondered at, for woman has been made a blushing creature, and who has not seen women of 60 or 70 blush at the thought of a possible offence to modesty?” (Tilt 1857, 57–58). Modesty was to be reflected in her clothing: “at the cessation of menstruation the vicarious functions of the skin are so important as to require its being covered as much as possible” (Tilt 1851b, 104–105). Assuming it common knowledge, Tilt wondered whether it was “necessary to mention that [menopausal] symptoms will be increased, by the frequenting of Balls, Routs, Operas &c., where, in addition to the numerous stimuli encountered, hot and impure air must be breathed?” (1851b, 103–104). In their advice, doctors like Tilt forbade activities that were generally thought unbecoming of (post-)menopausal women, whilst upholding a nurturing, calm asexual ideal.

The significance of lodging age-specific ideals in constructions of the menopausal body is that these ideals were not simply seen as cultural preferences, but thought to be unquestionably ingrained in women’s nature—to the extent that engagement in over-exciting activities not befitting her sex and age would give her a more difficult menopausal transition. These ideals were not only motivated by the logic of the plethora, but were also replicated in the utero-ovarian approach to menopause.

Uterus and Ovary: The Effects of Atrophy

In the blood theory of menopause, the localising tendency of the anatomico-clinical turn was manifested by the resignification of menstrual blood as uterine and quintessentially female, while the treatment of plethora following its cessation changed from general bloodletting to bleeding in the genital area. Yet Tilt’s work also positions the uterus, and later the ovaries, as the defining core of women’s nature. Accordingly, he understands menopause through the observation of changes in these organs: “The uterus has been regarded as the fundamental portion of the female generative system, a distinction which in reality belongs to the ovaries” (Tilt 1851a, xxiii). This localised understanding is characteristic of the anatomico-clinical turn, in which “the seat is the point from which the pathological organisation radiates. Not the final cause, but the original site” (Foucault 1973, 140).

In Tilt’s discussion of atrophy in the utero-ovarian seat of menopause, the gendered anatomical standard of normalised decline was temporally bound to a physical and social life course. Tilt described menopause as atrophy of the ovaries, resulting in organs “resembling a peach-stone,” sometimes “not larger than a horse-bean,” and determining “corresponding changes in the fallopian tubes, which contract and are

sometimes obliterated; it also causes the womb to become atrophied[,] [...] the vagina often becoming narrower and shorter” (1857, 11). The “spatialisation and verbalisation” of Tilt’s medical gaze created a gendered anatomical standard of normalised decline to characterise midlife (Foucault 1973, xii). For Tilt, changes in standardised reproductive organs’ sizes were prescriptive markers through which age-specific social norms were affirmed, either by a reference to a parallel epochal transition in puberty or by naturalising a change into the asexual and charitable postmenopausal life course.

Tilt positioned observations of the internal physiology of menopause as the mirror image of early sexual maturation: “Puberty and the c. of life are caused by anatomical changes, the one by ovarian *evolution*, the other by ovarian *involution*” (Tilt 1857, 11; emphasis in text). The parallel Tilt drew between the epochs of puberty and menopause was not limited to observable physiology, but had implications for his judgment of women’s agency:

The disturbance of regular ovarian action, during the first part of the change of life, sometimes tells unfavourably on woman considered as a *moral* agent. Her mode of dealing with the every-day occurrences of life may betray a want of principle, contrasting in a striking manner with her previous rectitude of conduct, and a return to that untruthfulness which may have characterised puberty. (Tilt 1882, 116; emphasis in text)

Echoing Foucault’s assertion that social ills were integrated with physical pathology in the anatomo-clinical turn, Tilt proceeds to list cases of women being ill-tempered, angry, leaving their families, becoming tyrannical if they do stay at home, turning introspective, stealing, murdering their children, and becoming suicidal (1882, 116). It is striking that these are predominantly relational problems, which betrays an understanding of women’s moral agency primarily in relation to her family. For Tilt the primary failure of a menopausal woman is a failure to care. This failure, too, was understood in relation to a parallel phase of puberty, one that normally preceded the time of maternal caring. Women’s temporary return to this state at the end of the reproductive cycle suggests a reading of menopause as not only a physical, but also a moral involution.

As the realisation of the reproductive ideal became thwarted once women passed childbearing age, menopause signified a transition into a new gender-specific normative life course. Tilt celebrates a postmenopausal ideal of an asexual woman whose nurturance of husband and family expanded to broader society.⁵⁷ He prescribes how

⁵⁷ For “the connection between medico-scientific theories and prescribed social limitations on women” (Levine-Clark 2004, 22), see Ehrenreich and English (1978), Showalter (1987) and Poovey (1988).

women's maternal nature could be properly maintained later in life: "Time dulls the eye, robs the cheek of its bloom, delves furrows in the forehead, but cannot quell the seraphic fire burning in the heart of women, prompting them to deeds of charity, and to heal the deep wounds which afflict society" (Tilt 1857, 128).⁵⁸ In Tilt's work, this shift towards a non-reproductive postmenopausal life course, in which the woman's primary role moves from caring from the family to caring for society, is primarily predicated on the physiologically-motivated departure from sexual and reproductive functionality.

Menopausal atrophy was considered to be a sign from nature that marriage and sex ("connexion") were no longer appropriate:

In the latter part of this period these organs have a tendency to become atrophied. Can there be a clearer indication that until after the menopause, their hitherto appropriate stimulus interferes with a natural process? Hence it is unreasonable to marry during this unsettled period [...]. Even in those who have been long married, connexion at the change of life is a cause of uterine disorders [...]. I deem it imprudent for women to marry at this epoch without having obtained the sanction of a medical adviser. (Tilt 1870, 111-112)

The affirmation of the cultural taboo of menopausal non-reproductive sex is read into women's anatomy as physical changes become interpreted in a way that reinforces dominant ideas on sexual activity at this age. Tilt's explicit statement that women need their doctor's permission to marry—with the intention of consummating the union—exemplifies the medical time-table as a disciplinary tool for the control of activity that Foucault identifies in *Discipline and Punish* (1977, 149). In this early rendition of "the medical clock as a tool of medical power," Tilt prescribes morals as medicine, based on temporal standards of reproductive transitions rather than chronological time (Bordo 1999, 72). Through its situatedness in the medical field, Tilt's reading of menopausal atrophy establishes not only the naturalness, but also the healthfulness of dominant age and gender norms. In the next section I suggest that the association between health and age-normativity, established in the process of medicalisation, was strengthened by the anticipation of future states of health and disease.

⁵⁸ This sentiment was mirrored in popular writing on the appearance of women: adventuress Lola Montez wrote in *The Art of Beauty* that colouring ought not to be used by "ladies who have passed the age of life when roses are natural to the cheek. A rouged old woman is a horrible sight—a distortion of nature's harmony" (1858, 49). Journalist Eliza Lynn Linton, furthermore, criticised women in a series of articles in the *Saturday Review* (1868) for "acting and dressing inappropriately and for not attempting to find an interest outside herself" (qtd. in Perkin 1993, 147). These criticisms also suggest that "many middle-aged women seem not to have been willing to stay put in the asexual, self-effacing, all-nurturing role that society had mandated for them" (Perkin 1993, 147).

Anticipating (Post-)Menopausal Futures

In Foucaultian logic, the endeavour of gynaecology is propelled by its orientation towards death, the direction of which necessitates a negotiation of age, or time in the body. The vantage point of the dead body on the autopsy table becomes a constitutive force “endowed with that great power of elucidation that dominates and reveals both the space of the organism and the time of the disease” (Foucault 1973, 144). I have mentioned above the understanding of degeneration as progress towards death and linked it to medical interest in ageing. As the anatomo-clinical gaze has as its project to “constitute a projective pathological anatomy,” the time of degeneration or disease is not limited to its manifestation in symptoms, but also comprises their *potential* future manifestation as integral to the spatial organisation of the organism (Foucault 1973, 162). Here I explore how the medical gaze’s socio-cultural work of linking physiological developments to cultural life courses functions through the anticipation of futurity and thereby implants menopausal vigilance and the need for its medical management in life phases before and after “the change.”

As the renaming of midlife from what had previously been known as “prime of life” to “decline of life” suggests, 19th-century concerns about age are characterised by an apprehension of the earliest signs of ageing and a growing consciousness of possible perils in later life courses (Heath 2009, 22). This concern with midlife ageing may be positioned in relation to the 19th-century rise of the middle class, which co-emerged with an increase in longevity. The middle class adopted practices of the gentry, including attempting to ensure continued health into old age by visiting medical professionals, “whose power, wealth and influence began to steadily improve with this popularity” (Kellehear 1984, 716). The anticipation of old age in midlife, which became understood as the decline of life, is in keeping with this development and provides the context for Tilt’s introduction of the medical management of menopause.

Tilt’s reading of menopause as a “critical” phase layers the cessation of menstruation with both this midlife anxiety and the awareness of futurity in the body.⁵⁹ The medical gaze works to “project upon the living body a whole network of anatomo-pathological mappings: to draw the dotted outline of the future autopsy” (Foucault 1973, 162). This implies that the medical gaze views the patient’s body not only in its present manifestation, but in relation to its prospective bodily futurity in death: “Death, which, in the anatomical gaze, spoke retroactively the truth of disease, makes possible its real

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form by anticipation” (Foucault 1973, 158). Beyond a mere forecast, this makes futurity an integral part of the understanding of the body, the significance of which becomes intensified during critical transition periods like midlife and menopause.

Tilt and his contemporaries regard menopause as a problematic period that “begins at cessation and concludes with the permanent restoration of health” (Tilt 1882, 1).⁶⁰ Whereas Foucault’s medical gaze positions death as future vantage point, in Tilt’s text menopause becomes the turning point for a future retrospective positioned, prior to death, in renewed life. I return to Tilt’s above-mentioned quote:

The stream of life is marked by rapids, which have been called critical, metamorphic, or developmental epochs, and during which an unusual predominance is acquired by one or by several of the organs which together form the human frame. (1882, 3)

Rather than death proper, the epochal view of women’s lives identifies several future reconstitutive transitions—little deaths in the less joyful sense of the word—towards which the present manifestation of the body tends. Symptomatic of a metonymic view of women as defined by their reproductive organs, the progression of the female life span is interpreted primarily in relation to changes in these body parts, which have “unusual predominance” as the original seat of “the diseases of epochs justly deemed critical” (Laqueur 1990, 22; Tilt 1882, xi). In these body parts, the medical gaze locates death not only in the grave (or on the autopsy table), but at the end of reproductive life.

In keeping with this epochal approach to the lifespan, menopause both “describe[s] the closing scenes of the life of woman,” and entails

a series of beautifully adjusted critical movements, the object of which is to endow a healthy woman with a greater degree of strength than she had previously enjoyed [...]. The immense importance of this change on the subsequent lifetime of women cannot be too highly rated. (Tilt 1882, xi, 4)

Not only do its trials improve women’s health, but menopause “may even promise them a length of life and a strength of constitution superior in general to that of the opposite

⁶⁰ As discussed above, Tilt and his contemporaries understood menopause as the mirror phase of puberty; the onset of menstruation was fraught with the same dangers as its cessation. The sense of urgency associated with menarche and puberty similarly followed from the influence this transition was thought to have on future life courses: William Potter writes in *The New York Medical Journal* that “during them she lays the foundation for future weal or woe” (Potter qtd. in Vertinsky 1994, 49). As pubertal medical management sought to promote development into a reproductively efficient woman, so adult life required a morally informed healthy lifestyle to avoid a difficult menopause and, in turn, the change of life needed to be medically managed to ensure longevity and health in later life.

sex similarly advanced in years,” thus explaining women’s greater longevity (Tilt 1851a, 106). With future health and longevity dependent on it, menopause became laden with considerable significance, which led to its moralisation and further medicalisation. By conveying the message that any disruptions during this period might have long-term effects that could only be prevented by careful medical management, Tilt’s medical tracts seek to establish menopause as a significant new gynaecological specialty.

Tilt and his contemporaries argued both that good behaviour—in keeping with established gender roles—in early life prevented a difficult change of life and that the proper management of the menopause was key to future health beyond the transition. Writers of the 19th-century purity movement were in the habit of explaining the severity of menopausal discomforts by “indiscretions” committed in younger years (Foxcroft 2009, 186).⁶¹ Within this logic, disease becomes social punishment, nature’s moral justice. Similarly, the promised reward of longevity and future health for following the physician’s morally charged advice transforms menopause into a tool for promoting social norms in life courses preceding the change.

Tilt’s contemporary Barnes advised women to be vigilant throughout the menopausal period:

during the whole of this period, the woman should carefully watch her own condition—bearing in mind, that various organic diseases are then most likely to commence, that the latent seeds of hereditary evil are the most likely to become developed, and altogether, that she is passing along a way beset with dangers; but that prudence and watchfulness will assuredly guide her safely through the road. (1873, 119)

Although it was accepted knowledge that men suffered more from “decay” in their climacteric period, women were considered to be the ones on the path of danger; they would have to watch their behaviour and bodies to survive the transition. The tone used for men’s ageing in the same text is significantly less prescriptive and fearful. Men are encouraged to think about their own health, discuss it with their doctors and inform them of the family history of diseases. In the face of increased likelihood of “decay,” men do not have to remain weary or guard their everyday behaviour; rather, Barnes advises “an individual to examine somewhat into his own condition,” asking questions such as “have I hereditary tendency to disease?” (1873, 111). The neutral “individual” positions

⁶¹ One example is the American surgeon John Kellogg, who, in his *Ladies Guide in Health and Disease: Girlhood, Maidenhood, Wifehood, Motherhood* (1883), argued that disregard for “nature’s laws” could result in a menopausal experience that was a “veritable Pandora’s box of ills, and [that women] may well look forward to it with apprehension and fore-boding” (qtd. in Foxcroft 2009, 187).

the male patient as universal norm, while the shift in perspective to the first person and the posing of a question rather than the certainty of a road “beset with dangers” position men as less liable to disease and less in need of a physician’s council at this time.

Thus, the combination of the disparity between the perceived dangers of male and female ageing and the lasting influence of menopause on future health resulted in a gendered double standard of ageing in 19th-century British medicine. Given the importance and danger ascribed to menopause, there was much more at stake for women. After instilling a sense of peril and responsibility in his patients, Tilt argues that

a physician has no right, by his opinion to put to sleep the anxieties of his patient [...]. [Whenever] a female, at this period, which is universally admitted to be a critical and dangerous time for her, comes to complain of symptoms referable to some morbid condition of the reproductive tissues, it is clearly our duty to give a considerate attention to her case and not to dismiss her. (1857, 8)

Here the tension between offering medical help and affirming the need for treatment becomes apparent. The concurrent processes of normalisation and pathologisation that Foucault identified in *The Birth of the Clinic* are played out when menopause is described as a natural and necessary transition, while an impetus for expert management is created through the normalisation of the perils associated with it. Victorian gynaecologists not only provided cures, but also constructed the interpretative framework within which the need for treatment is generated and symptoms become recognisable. Tilt and those in his footsteps thus prescribed a chrononormative organisation of life courses in which the critical nature of the menopausal transition, and the medical advice associated with it, affect women both before and after the change. Life courses did not only exist in discreet sequence, but became defined in relation to one another through the anticipation of bodily futurity.

In keeping with the earlier parallel drawn between medicine and religion, Foucault suggests that “salvation in the next life has been commuted to a salvation in this life (health, wellbeing, security, etc.)” (qtd. in Dreyfus and Rabinow 1982, 213–5). Future health was the salvation offered by gynaecology as Tilt’s critical presentation of menopause affirmed the need for the young medical specialty and its involvement in “the change.” In the same move, however, it located the responsibility for future health in women’s own everyday behaviour. The age-appropriate normative work in Tilt’s understanding of menopause provides an exemplary example of the move from the medicalisation of a life event to the adoption of a moral code to fit it. The mechanism at work in the case of menopause and the Victorian ideals of True Womanhood was an

early rendition of medical risk management and functioned as a moral tool to influence the behaviour of younger generations in anticipation of their later years.

Tilt's medicalisation of menopause thus entailed the establishment of the physicality of reproductive ageing as organising principle for social life course management and norms of age-appropriate behaviour. His writing reflects an attitude to menopause as a transition from one life course to the next; health is expressed through an easy transition and appropriate settlement into a new, non-reproductive role. Reading the body in anticipation of the next epochal life transition, the medical gaze employs bodily futurity as a disciplinary tool to both create the need for medical management and encourage the patient's self-surveillance throughout the life span.

Conclusion

In this chapter, I have read Tilt's medicalisation of menopause in early gynaecology as a discursive operation in which understandings of female reproductive physiology and socio-cultural ideas of ageing become articulated through one another. His construction of menopause as a foreseeable yet potentially dangerous stage of ageing was predicated on an epochal organisation of the female life course organised by changes in women's bodies, including a plethoric state following the cessation of menses and a decreasing size of the reproductive organs. Once grouped together and conceptualised as signs of menopause, the concurrent normalisation and pathologisation of physical changes in women's reproductive bodies naturalised norms of maternity, modesty and sexuality associated with female midlife. The emphasis on menopause's dangers affirmed the need for expert management and self-scrutiny according to these norms both at the time of the change and during its anticipation.

By distilling a set of three mechanisms following from this interlinking of ideas of ageing and reproductive anatomy, my discussion of Tilt's medicalisation of menopause and Foucault's medical gaze provides points of reference for the following chapters' analyses of the contemporary gender politics of ageing in relation to egg freezing and the processes of biomedicalisation associated with each step of the OC procedure. The first mechanism historicises the way in which understandings of life course progression become predicated on age-related changes in women's reproductive bodies. On the one hand, the gender-specific history of naturalising age-appropriate ideas points to a process in which particular age normativities—whether of timing childbearing, appearance, partner choices or sexual expression—become lodged in constructions of the reproductive body and thereby thought to be ingrained in women's nature. On the other hand, Tilt's particular interpretation of physical reproductive changes as organising principle for critical epochal transitions in the life span not only suggests that the notion of ageing as crisis is inherent in the early medicalisation of female reproductive ageing,

but it also indicates a broader practice of identifying particular ages as moments of transition that require attention and, potentially, medical intervention. The normative force of the tight knot constructed between the biological “truths” of the female reproductive function and life course progression may be observed in the controversies associated with contemporary transgressions of its temporal logic, including late and postmenopausal motherhood, cross-generational egg donation and manipulation of reproductive ageing with IVF or egg freezing.

The second mechanism follows from Foucault’s medical gaze and pertains to the work of visual cultures of medicine in the conceptualisation of the body in time. Although Tilt presented the speculum as the instigator of gynaecological development that brought the previously invisible interior reproductive body into view, Foucault’s understanding of the importance of the medical gaze follows not directly from a technologically-mediated increased visibility of the body, but from the idea that “the relation between the visible and invisible—which is necessary to all concrete knowledge—changed its structure, revealing through gaze and language what had previously been below and beyond their domain” (1973, viii). The medical gaze thus concerns not only bodily revelation, but new ways of imagining the body in relation to what becomes medically observable. In this study of OC, the visual and linguistic mediation of the tension between the visible and the invisible frequently recurs in the complex relation between the inner and the outer body after egg extraction, in the differences of scale between the observable and cellular body, and in the mediation of the (in-)discernible temporalities of bodily, embryonic and cellular ageing.

Thirdly, in Tilt’s construction of menopause as an expectable yet dangerous transition in the female life span, the anticipation of bodily futurity had the disciplinary effect of promoting normative values to safeguard future health. The reference to bodily futures in promoting the need for medical management and self-surveillance both preceding and following the time of the change is indicative of the political work implicit in these conceptualisations of menopause. On the one hand, they normalise the understanding of gendered ageing processes as medical concern and, on the other, they have implications for the individual agency that can be exerted over ageing. In discourses of OC, the anticipation of future (in)fertility and (non)reproduction plays a key role in conceptualising reproductive embodiment and imagining age-related life course transitions. As an intervention aimed at future reproduction, OC itself may be characterised as an anticipatory intervention. In the next chapter, I explore the function and effects of anticipation in discourses of OC in detail through a reading of Marieke Schellart’s documentary *Eggs for Later*.