Four

The Restitution Narrative

Illness in the Imaginary

The restitution narrative is the first of three types of narrative that I will propose. A narrative type is the most general storyline that can be recognized underlying the plot and tensions of particular stories. People tell their own unique stories, but they compose these stories by adapting and combining narrative types that cultures make available.

By a narrative type, I mean what a teller of folktales means when referring, for example, to a naming story. In the naming story, the protagonist has to guess the *true* name of the antagonist. The guessing counts because the antagonist threatens the protagonist; the antagonist's power can only be undone by speaking his true name. The protagonist may do the guessing himself if he is a trickster. Other protagonists need a helper, such as the mouse in the best-known naming story, the Grimm Brothers' "Rumpelstiltskin." Learning the value of the helper, whom the protagonist may initially reject, is a frequent subplot. Around the basic plot of the naming story all sorts of variations occur, just as naming can occur as a subplot in another story, but the narrative type remains identifiably within these variations.

My description of the naming story is not a random example of a narrative type. Although few would say it in these words, the teller of an illness story seeks to learn the true name of the

disease, and perhaps her own true name as well. Nietzsche understood this, choosing to name his pain "dog."[1]

Why propose "types" of illness narratives and suggest that individual stories somehow "fit" one type or another? The risk is creating yet another "general unifying view" that subsumes the particularity of individual experience. The advantage is to encourage closer attention to the stories ill persons tell; ultimately, to aid listening to the ill. Listening is difficult because illness stories mix and weave different narrative threads. The rationale for proposing some general types of narratives is to sort out those threads.

My suggestion of three underlying narratives of illness does not deprecate the originality of the story any individual ill person tells, because no actual telling conforms exclusively to any of the three narratives. Actual tellings combine all three, each perpetually interrupting the other two. I limit myself to three basic narratives because if these types are to be used as *listening devices*, more than three seems less than helpful. Certainly, other types of narratives can and should be proposed.[2]

I consider each narrative type in four sections, beginning with its plot. Second, I describe the elective affinity that the narrative type has to the action problems of embodiment (control, body-relatedness, other-relatedness, and desire). Third is how the narrative works as a self-story. Finally I discuss the power of each narrative type and its limitations.

In any illness, *all* three narrative types are told, alternatively and repeatedly. At one moment in an illness, one type may guide the story; as the illness progresses, the story becomes told through other narratives. The particularity of any experiential moment can thus be described by the narrative type that predominates at that moment. The three narratives are like patterns in a kaleidoscope: for a moment the different colors are given one specific form, then the tube shifts and another form emerges. The retelling of illness stories, particularly the writing of oral stories, isolates the story of the moment from the narrative flux that marks lived storytelling. At the bedside, the kaleidoscope turns much more quickly than in print.

Each narrative reflects strong cultural and personal preferences. The strength of these preferences presents a further barrier to listening to the ill: both institutions and individual listeners steer ill people toward certain narratives, and other narratives are simply not heard. But barriers provide possibilities for insight. Reflection on one's own narrative preferences and discomforts is a moral problem, since in both listening to others and telling our own stories, we become who we are.

The Restitution Plot

The restitution narrative dominates the stories of most people I talk to, particularly those who are recently ill and least often the chronically ill. Anyone who is sick wants to be healthy again. Moreover, contemporary culture treats health as the normal condition that people ought to have restored. Thus the ill person's own desire for restitution is compounded by the expectation that other people want to hear restitution stories.

The plot of the restitution has the basic storyline: "Yesterday I was healthy, today I'm sick, but tomorrow I'll be healthy again." This storyline is filled out with talk of tests and their interpretation, treatments and their possible outcomes, the competence of physicians, and alternative treatments. These events are real, but also they are metaphors in Schafer's sense of enacting the storyline of restoring health (see chapter 3). Metaphoric phrases like "as good as new" are the core of the restitution narrative. Such phrases are reflexive reminders of what the story is about: health.

Restitution stories can be told prospectively, retrospectively, and institutionally. I heard a prospective restitution story when

I met a man who, I had been told, was about to undergo surgery for cancer. I told him I was sorry to hear he was ill. He looked at me as if he was not sure what I was talking about and then, changing his expression to sudden recognition of what I referred to, immediately assured me it was "nothing." When we later spoke at length about his surgery, he told a story of how he would be able to assimilate various outcomes into his life without undo change. His prospective restitution story gave him the courage to face surgery. Later, following what turned out to be a long surgery and serious diagnosis, he might have needed a different story at a time when he lacked the energy to put one together.

I heard a retrospective restitution story one evening at a cancer support group. The group begins with a ritual that many groups use some variation of. Each person says his or her name, what kind of cancer he had, and when. Sometimes a bit of personal news is added. Most people close by saying, in a rising voice, "I'm fine!" Most regular group members are in remission from cancer, but this evening a woman attended who was currently in treatment. While she was describing the cancer she had, she broke into tears. The group response was for the person sitting next to her, the next speaker, to interrupt with her own introduction. She did this very briefly, moving to a particular emphasis on "I'm fine!" No one commented on the interruption or returned to acknowledge the distress of the person in treatment. Thus the group expressed its preference for restitution stories and its discomfort at hearing illness told in other narratives.

The restitution narrative not only reflects a "natural" desire to get well and stay well. People learn this narrative from institutional stories that model how illness is to be told. A major northeastern American hospital distributed an oversize tabloid newspaper supplement describing its cancer center. The brochure is sixteen pages long, printed on better than newsprint

paper, and features obviously professional photography. Most of the content comprises the stories of three cancer patients. All three are told as restitution stories: "Within two weeks, Joan was back to work full-time," "Harry now has a new immune system that gives him every reason to believe it's a whole new ball game," and "Today, Mary has resumed her active, productive life—even adding a new pastime."

The brochure certainly fulfills a public education function, providing sidebar glossaries that clearly explain types of cancer and different treatments. But no patient is shown *in* treatment or affected by treatment. Photographs show patients pursuing their various "pastimes" of gardening, sports, and other hobbies. One radiotherapy machine is shown but not in use; the professional staff are posed sitting on it, as if having a conference. The patients' stories tell what their treatments were, but the emphasis is on life after treatment: returning to "I'm fine!"

Prospective patients reading this brochure are being educated not just about different cancers and their treatments. The brochure provides models of the stories patients ought to tell about their own illnesses. Institutional medicine is asserting its preferred narrative. This assertion goes beyond hospitals to the strategies that more powerful interest groups use to shape the culture of illness.

The most pervasive or, depending on one's values, the most insidious model of the restitution story is the television commercial for non-prescription drugs, frequently cold remedies. The plot unfolds in three movements. First, the ill person is shown in physical misery and, often though not always, in social default. Some activity with spouse or children is going to have to be canceled or work missed. The second movement introduces the remedy. As in the naming story, a helper may be involved in bringing the remedy, and also as in the naming story, a subplot may involve the sufferer's initial rejection of the remedy and thus of the helper. Eventually the remedy is taken,

and the third movement shows physical comfort restored and social duties resumed. The success of the remedy validates the helper, and a hint of renewed romance may close the story.

To live in contemporary culture is to see such commercials without even noticing them; magazines can condense the plot to a single image, knowing that the reader/viewer will fill in the rest from memory. These advertisements set in place the narratives of the stories that real people tell about real illnesses. Commercials, like the hospital brochure described above, not only condition expectations for how sickness progresses; they also provide a model for how stories about sickness are told.

Here as elsewhere popular culture is most powerful when it reinforces habits of thought acquired elsewhere. The restitution plot is ancient: Job, after all his suffering, has his wealth and family restored, and whether or not that restoration was a later interpolation into the text, its place in the canonical version of the story shows the power of the restitution storyline. Television literally commercializes the Job story: the good person is suddenly struck down, but suffering is bourgeois (for example, a missed party or sports event), the remedy can be purchased, and the only learning involved is where to find relief next time.

Behind the hospital brochure and the commercial lies the modernist expectation that for every suffering there is a remedy. The consequences of this master narrative are complex. When the restitution ending is tacked onto Job, the nature of suffering changes from mystery to puzzle, to use a distinction from William May, who borrows from Gabriel Marcel.[3] A *mystery* can only be faced up to; a *puzzle* admits solution. The restitution ending of Job leaves the reader with the impression that somehow Job got it right, first in dialogue with his three friends and then in the whirlwind. The restitution is his prize for solving the puzzle, even if exactly how he solves it is not quite clear. Without the restitution, his suffering would remain a mystery, and a troubling one. The mystery cannot be solved, and while a person can seek to measure up to what a mystery presents, one cannot "get it right" because there is no "right" way to get it. This absence of solution makes mysteries a scandal to modernity.

Modernity seeks to turn mysteries into puzzles, which is both its heroism and its limit. Sociology, as one aspect of the modernist imagination, describes illness in its own restitution story, which is Talcott Parsons's theory of the "sick role," first presented in the early 1950s but elaborated throughout Parsons's career until his death in the late 1970s.[4] By a role, Parsons meant action that involves complementary expectations for behavior. Thus the "sick role" describes behavior the sick person expects from others and what they expect from him. These expectations are *institutionalized* in such matters as sick leave from work and medical care; they are validated by social *norms;* they are *functional* for society as a whole; and they are *internalized,* meaning that individuals regard their expectations around sickness as normal and natural.

Parsons makes three assumptions about the social meaning of illness. First, illness is not to be regarded as the sick person's fault. In an age that understands contagion and infection, becoming ill is not an indicator of moral failure but only the result some excessive stress, which Parsons perceived as both social and physiological. Second, the sick person is exempt from normal responsibilities, both at work and at home. Sick people can expect this exemption, and others have a reciprocal obligation to offer it. Third, because exemption from normal responsibilities requires social control lest its privilege be abused, the sick person is obligated to place himself under the authority of a recognized professional. Compliance to "doctor's orders" is fundamental to the social control aspect of the sick role; exemption is balanced by obligation.

Few social science students of medicine accept the sick role

as a definitive description, but its narrative remains sufficiently compelling so that it can never be dismissed. I am not concerned here with the theory's empirical adequacy—for example, *are* most people excused from normal obligations when ill?—but rather with its force as a master narrative of restitution stories.

The sick role is a modernist narrative of social control. People become sick, in Parsons's view, when their normal obligations become overpowering or conflict with each other. Sickness is functional for society as an escape valve for excess social pressures. The problem of sickness from this functionalist perspective is how to give people sufficient time to recover without producing dropouts. Exemption must be granted, but it must also be regulated. The physician is explicitly a social control agent. For Parsons, one of the most important aspects of the physician's performance is refusing to "collude" with the patient; medical sympathy is to be limited by the overriding message that the sick person's task is to get well and return to normal obligations of work and family. The physician is there not to pander but to prod, gently but firmly.

Perhaps the central implicit assumption of the sick role, and what I believe provides its narrative force, is that people *do get well*, and many other people who do not get well want to continue to believe they will get well. To those whom I call members of the remission society, the sick role as Parsons describes it has little relevance. These people accept some level of illness as the permanent background and intermittent foreground of their lives. For Parsons, particularly the middle-aged Parsons who formulated the theory, any journey into the kingdom of illness is a limited one, from which return is both expected and possible.[5] The idea that the changing physical capabilities caused by sickness require ongoing renegotiation of social obligations and personal identity is not part of Parsons's theory.

Precisely because getting well is the only outcome Parsons

considers as acceptable, his theory of the sick role both reflects the assumptions of modernist medicine and inscribes the validity of these assumptions in a broader narrative of what society requires to function successfully. Whether or not the sick role describes the *experience* of being ill, and most agree it does not, it remains a powerful narrative of what medicine *expects from* the ill person and what other social institutions expect from medicine. At the core of those expectations is the assumption of restitution: returning the sick person to the status quo ante.

Behind the restitution narratives of popular culture and sociology is medicine. So much has been written about medicine's single-minded telos of cure that I will finesse quotation from some definitive clinical source and tell a mundane story. A physician friend told me, with distress, about his patient who is dying of cancer. The physician's distress is not from her dying; everyone dies, and many die too young. He hates watching his patient fall into a world of hospital specialists who refuse to accept that she is dying and continue to perform invasive tests that cannot lead to any viable treatment. Of course, it is his judgment that the treatment is futile, and the specialists might see the case differently.[6] But here was the same story, told so many times, being told again. Obsessed with cure, medicine cannot place the woman's story in any other narrative. Massive resources are expended, and, more important from the perspective of my physician friend, his patient is not being helped to find her way toward her own version of a good death. Medicine's hope of restitution crowds out any other stories.[7]

The restitution story, whether told by television commercials, sociology, or medicine, is the culturally preferred narrative. Nothing less is at stake in the viability of this narrative than the modernist project that Zygmunt Bauman calls "deconstructing mortality."[8] Modernity, Bauman argues, exorcises

the fear of mortality by breaking down threats, among which illness is paradigmatic, into smaller and smaller units. To use May's distinction, the big mystery becomes a series of little puzzles. Medicine, with its division into specialties and subspecialties, is designed to effect this deconstruction.[9]

When my mother-in-law, Laura Foote, was dying from cancer, we all knew she was dying. At least one reason why our family never talked about her dying was that until two days before she died we remained fixed on the incremental remedies that medicine continued to offer. However clear her deterioration, there was always another treatment option. As long as small puzzles could be solved, fixing this or medicating that, the big issue of mortality was evaded. Each specialist carried out his task with some success, and the patient died.

In its place, this deconstruction into small tasks can be therapeutic. When I was entering the hospital for my own recent biopsy, I found it mildly relieving to be subsumed in movements from one preoperative test to another; completing each form was a small victory, and I appreciated the distraction from my larger fear. But eventually the reality and responsibility of mortality, and its mystery, have to be faced. Doing so requires a story outside the restitution narrative.

The Restorable Body

Although belief that the sufferings of illness will be relieved is always the preferred narrative for any body, some bodies show a greater affinity for restitution narratives than others. These bodies can be described using the dimensions of control, body-relatedness, other-relatedness, and desire. Because bodies do not stay put on these dimensions, affinity for the restitution narrative is a *stage in the embodiment process* of illness that every body passes through. When some variation of restitution is in the foreground of the person's story, it will be interrupted

by other narratives, just as restitution interrupts these other narratives when they occupy the foreground.

On the control dimension, the teller of the restitution story wants the body's former *predictability* back again. This predictability is not simply the mechanical functioning that comes with a symptom-free life. What needs to be staved off is the deeper contingency represented by illness itself: the contingency of mortality. Any sickness is an intimation of mortality, and telling sickness as a restitution story forestalls that intimation.

But contingency is not so easily dispelled. The restitution is brought about by an agency outside the body: medicine operating through either surgery or drugs. The body's own contingency is remedied, but only by dependence on an agency that is other to the body. For the teller of restitution stories to consider the paradox—that this dependence institutes its own contingency—would spoil the restitution: in the television commercial the availability of the drug is unquestionable.

The body of the restitution story is fundamentally *monadic* in its relation to other bodies. The disease model of medicine reinforces this conception of each patient "having" a disease, and this disease model articulates well with modernist emphases on the individual as an autonomous entity. The same conception of the individual that makes it sensible to speak of "having" a disease can speak of "having" rights, "getting" an education, or, as will be discussed in the last chapters, "having" empathy. Diseases, rights, education, and empathy are seen as properties of specific persons, not as expressions of persons' relationships to others. Talk about "having" the disease turns the monadic body in upon itself.

The body that turns in upon itself is split from the self that looks forward to this body's restitution. The temporarily broken-down body becomes "it" to be cured. Thus the self is *dissociated* from the body. Both the TV commercial narrative

and the sick-role narrative suggest the presence of a person inside the body who is affected by that body yet remains detached from it. The body is a kind of car driven around by the person inside; "it" breaks down and has to be repaired. The restitution story seems to say, "I'm fine but my body is sick, and it will be fixed soon." This story is a practice that supports and is supported by the modernist deconstruction of mortality: mortality is made a condition of the body, the body is broken down into discrete parts, any part can be fixed, and thus mortality is forestalled. Sickness as an intimation that my whole being is mortal is ruled out of consideration.

Finally, the body in restitution stories may be "it," but it wants to be cured; desire remains *productive.* What will cure the body is a commodity, whether that takes the form of a drug or a service, and however it is paid for. The TV commercial is a powerful master narrative not only as it instills the notion that for every ailment there is a remedy, but also because it shows the remedy as a packaged item to be purchased. Restitution is not only possible, it is *commodified.*

Commodification is a crucial aspect of the deconstruction of mortality: as long as I can buy this to fix that, I sustain an illusion of permanence. So long as there is more to buy, whatever needs fixing will be fixed, and I will continue to be. Lest this last mini-plot line seem exaggerated in its simplification, look in any newspaper for what Nicholas Regush, a medical investigative journalist, calls the "gee whiz" stories that pharmaceutical companies regularly send him for publication.[10] Whatever is wrong with the body, these stories describe the imminent development of a high-tech remedy that will cure it.

My sympathy for Regush's cynicism derives from having to sit through medical lectures that could only be called wildly enthusiastic as they proclaimed impending cures for cancer. If I have cancer again, I might seek these physicians and technologies, but another effect of the technologies—besides curing

some people—is to imply that mortality itself is an avoidable contingency. Amid talk of the advances in genetic screening and manipulation, of drugs that can be delivered to the specific tumor site, and of new diagnostic imaging machines that detect pathology even earlier, amid all this restitution talk, the single certain fact of death has little place. The "gee whiz" news releases and medical self-congratulations are not wrong, but they betray a conspicuous lack of narrative balance: other stories are happening as well, and the restitution story crowds them out.

The body that predisposes choice of the restitution narrative, and the body that this narrative chooses, thus falls somewhere between the *disciplined body* and the *mirroring body.* The restitution story usually demands adherence to some regimen, and this medical (or alternative) compliance demands a disciplined body. But this body is also mirroring because of its emphasis on consumption. The restitution story is about remaking the body in an image derived either from its own history before illness or from elsewhere.

The mirroring body lives principally in what Lacan calls the realm of the Imaginary, where the self comprises images from elsewhere, layered upon each other to become that self. The reliance on images is obvious in the TV commercial: the "bad body" of sickness is juxtaposed with the "good body" of health, achieved after the remedy. The images presented for identification are clear. Identification is equally a central function of the physician in Parsons's sick role. The physician not only cures by his medicine, he also models health in his personal presence. The core of this "health" for Parsons is not the physician's own embodiment but his role performance. The physician is fulfilling the normal work obligations that the sick person has given up as he assumes the sick role. The image offered for the patient's identification is that of functioning worker.

The language of this last paragraph is filled with terms often used pejoratively: consumption as a mode of activity, identification with images, the primacy of work obligations. Against these pejorative connotations, I reiterate that the Imaginary as a mode of being is essential; self-identification in images only becomes neurotic when the individual lives *exclusively* in the Imaginary. Mirroring and disciplined bodies are perfectly appropriate modes of being; the problem, as with any mode of being, is becoming fixated in one of these bodies. The restitution story may be the first story I tell myself whenever I am ill, but I try to remind myself that other stories also have to be told.

Restitution as Self-Story

In the restitution story, the implicit genesis of illness is an unlucky breakdown in a body that is conceived on mechanistic lines. To be fixable, the body has to be a kind of machine. A Nobel prize-winning physician was interviewed in my morning paper. He suggested that for the reporter to understand his work, he should think of the body as a television set, and an elaborate analogy followed.[11] Restitution requires fixing, and fixing requires such a mechanistic view. The mechanistic view normalizes the illness: televisions break and require fixing, and so do bodies. The question of origin is subsumed in the puzzle of how to get the set working again.

This disinterest in genesis is typical of modernist thinking. Ernst Bloch wrote that modernists "do not seek legitimation in the original founding act, but in a future still to arrive."[12] The TV commercial does not consider how the person got sick in the first place; founding acts are effaced. Parsons does consider the forms of strain precipitating the sick role, but he does not discuss any need to change the conditions that gave rise to those strains. That the person in the sick role will return to the

same conditions is not a consideration. As long as there is an infinite future of getting fixed, changing originating conditions seems irrelevant.

The absence of concern with genesis in restitution stories is clearest when other stories provide a contrast. The same morning newspaper that quoted the Nobel-winning cancer specialist also carried a feature on women suffering various ailments that they suspect result from leakage from silicon breast implants.[13] For these women, the "founding act" of having the initial implant is crucial: what they were told about the implants, what their surgeons knew, what the manufacturer knew, and why they had the surgery ("My self-esteem was low") are all reviewed in detail. But these, sadly, are not restitution stories; the women anticipate being sick for the rest of their lives and even passing that sickness on to their children.[14] When restitution is judged impossible, the founding act becomes crucial; when restitution is possible, the "future still to arrive" is preferred.

This preference for the future also affects how the interruption of illness is interpreted. Both the TV commercial and the sick role focus on sickness as interruption, but this interruption is finite and remediable. Restitution means that if there are any future interruptions, the sick person now knows the remedy that can fix them. The restitution narrative is a response to an interruption, but the narrative itself is above interruption. By contrast, the silicon breast implant story begins with a woman worrying whether her child's skin rash might be another result of silicon she believes he absorbed during breast feeding. Her worry is presented as an interjection that interrupts the questions the interviewer has been asking, just as the rash interrupts the woman's train of thought, just as the silicon-induced illnesses present a future of interminable interruptions. Her story is not a response to an interruption, but a narrative that is perpetually being interrupted.

The purpose that restitution narratives aim toward is twofold. For the individual teller, the ending is a return to just before the beginning: "good as new" or status quo ante. For the culture that prefers restitution stories, this narrative affirms that breakdowns can be fixed. The remedy, now secure in the family medicine cabinet, becomes a kind of talisman against future sickness. One explanation for why Parsons does not consider the implication of returning the formerly sick person to the same conditions where he first became sick is that if sickness does return, the remedy can always be taken out of the cabinet, and the person can always go back to the doctor. In the extended logic of restitution, future sickness *already will have been cured.*

Just as the restitution narrative projects a future that will not be disrupted by illness, it also protects memory from disruption. In the restitution narrative, memory is not disrupted because the present illness is an aberration, a blip in the otherwise normal passage of time. The "normal" trajectory remains intact. After I had cancer I saw a colleague who had been on leave during my illness. He was most solicitous about what had happened to me, and finally mentioned that he himself had had cancer once, but it hadn't amounted to much. As we talked it developed he actually had the same cancer I had, a testicular tumor, but while his was found early and operated on immediately, I suffered from misdiagnosis and extensive secondary tumors.

Our diagnostic differences were equally narrative differences. His story had turned into a restitution narrative before he had time to tell it any other way. His memory of cancer was something remembered outside of memory, insofar as memory involves placing experiences into patterns, albeit changing patterns. He remembered cancer, but cancer was scarcely part of any pattern of recollection. For the teller of the restitution story, sickness is not memorable, though restitution may be,

especially if it is exceptional. Restitution makes a good story after the fact only if it was unexpected.

My colleague's cancer experience was over in a couple of weeks. For that incident to have crystallized any significant issues of responsibility would have been unusual, though this also happens. A woman who has made a vocation of her volunteer work for our local cancer society explains her commitment, in emotional terms, by describing a cancer scare she had. She was investigated for a condition that turned out not to be cancer and, so far as I know, has not caused her health problems since. But she was intimate with a family whose lives were determined over many years by the cancer and eventual death of the mother. That intimacy gave her cancer scare a narrative context, and thus a force, that the actual cancer of my colleague never acquired. Her experience left her with a heavy sense of responsibility; she joined Schweitzer's community of those who bear the mark of pain. Even though the medical facts of her case fit a restitution model, her narrative is not one of restitution.

The issue of responsibility suggests one of the crucial differences between types of narrative: the difference concerning what sort of agency the narrative affords the ill person. In the restitution narrative, the responsibility is limited to taking one's medicine and getting well, wellness being defined in contrast to illness. Other narratives understand the experience of illness in a way that makes returning to the same life that was lived before illness impossible as a moral choice. Schweitzer expressed this when he wrote that whoever "has learned what pain and anxiety really are must help to ensure that those out there who are in physical need obtain the same help that once came to him."[15]

Schweitzer is positing a restoration to health, but not within a restitution narrative. Life for the person Schweitzer describes has changed fundamentally, even though illness is

cured. Responsibility is based on an ongoing sense of solidarity with the ill, this solidarity transcending the present health or illness of one's own body.

Is the restitution narrative capable of generating self-stories? No, in the sense that restitution stories bear witness not to the struggles of the self but to the expertise of others: their competence and their caring that effect the cure. In this witness restitution stories reveal themselves to be told *by* a self but not *about* that self. The self of the mirroring body is realized in identifications with images of others; the witness of the restitution story can only be to the validity of those images.

But this "no" must be qualified by recognizing that not every illness story has to be a self-story; even among the seriously ill, many people do not have their sense of coherence disrupted. Little is perceived as having been taken away, so what is there to reclaim? Consciousness has remained sovereign over its experience. The restitution narrative has its proper sphere: images of health can model behavior that many people can adopt and adapt. The problem arises when the ill person does not find restitution, or when someone who can only tell restitution stories encounters another whose health will not be restored.

The Power and Limitations of Restitution

Restitution stories are compelling because they often are true: many people do exit the kingdom of illness, sooner than later, good as new. The cultural power of these stories is that their telling reflects one of the best impulses in modernity: the heroism of applied science as self-overcoming. Robert Zussman, summarizing his study of medical work in intensive care units, coins the phrase "the banality of heroism." "If [medical house-staff] are heroic," Zussman writes, "they are heroic in

the routine course of doing their jobs, preparing for the future, and getting through the day."[16]

Ill people who tell restitution stories practice their own banality of heroism. They live out illness as a matter of doing their jobs as patients, preparing for the future after illness, and getting through their own days. The restitution story, precisely because it treats sickness as banal, displays a heroism in the face of bodily breakdown. But this heroism of the ill person is invariably tied to the more active heroism of the healer.

The respective heroisms of physicians and patients are complementary but asymmetrical. Each heroism is required by the other, but physicians practice an active heroism, while patients accept a passive heroism. This asymmetry is not a problem—it may be the only sensible arrangement—but the ill person who adopts this narrative as his own self-story thereby accepts a place in a moral order that subordinates him as an individual.

This subordination is implied in Zussman's observation that physicians' sense of responsibility is not to patients so much as it is to other physicians. He goes on to refer to house-staff valuing medicine as "an encapsulated intellectual challenge." Zussman is well aware that not all patients will appreciate the physicians' values of collegial responsibility or encapsulation, but these values are nevertheless "of primary importance to the profession of medicine."[17]

Zussman's insightful depiction of medical heroism can be placed in a larger perspective by Bauman's distinction between the modernist "hero" and the postmodern "moral person."[18] The hero believes in a cause that is "nobler, loftier, more worthy than their own self-preservation." What Zussman describes as "the profession of medicine" assumes the stature of such a cause; he makes it clear that the comfort and often the safety of both patients and physicians are worth risking. "The profession of medicine" could easily join Bauman's list of mod-

ernist causes that are "the continuation or promotion or triumph of an idea: that of a nation, of a race, of a class, or a 'way of life', of God, sometimes of 'man as such'" (209).

Across the postmodern divide and in contrast to the hero, Bauman's "moral person" takes as his cause "the life or well-being or dignity of another human being" (209). The moral person would risk neither himself nor anyone in his care for such an idea as "the profession of medicine." If an idea does not respect the value and dignity of any immediate person, if it demands the person be sacrificed, then it is not an idea worth respecting. But that is a postmodern attitude.[19]

Restitution stories inscribe a modernist narrative both in illness experience and in medical treatment. The first limitation of restitution stories is the obvious but often neglected limitation of the modernist deconstruction of mortality: when it doesn't work any longer, there is no other story to fall back on. Restitution stories no longer work when the person is dying or when impairment will remain chronic. When restitution does not happen, other stories have to be prepared or the narrative wreckage will be real.

Sherwin Nuland, writing as a senior physician who has attended many deaths, evokes the "final sharing" that can snatch "an enduring comfort and even some dignity from the anguished fact of death."[20] Nuland castigates his medical colleagues whose adherence to an ideal of cure robs dying persons and their families of this sharing. What he calls "the seduction of The Riddle" (249) is what I call being captured by the exclusivity of the restitution narrative. This narrative leaves no place for stories that will disencumber the dying person of what Nuland describes as "the baggage we shall all take to the grave": "unresolved, breached relationships not healed, potential unfulfilled, promises not kept, and years that will never be lived" (261). Even the very old, Nuland observes, do not always escape having this unfinished business.

Nuland asserts a stronger version of responsibility than any other medical commentator. "The dying themselves," he writes, "bear a responsibility not to be entrapped by a misguided attempt to spare those whose lives are intertwined with theirs" (243). The restitution narrative can be just such a trap.

Another limitation, perhaps opposite to the above, is that restitution is increasingly a commodity that some can purchase and others cannot. Imagine the person watching the TV commercial who has the same ailment but no money to buy the remedy. High-tech medicine offers more and more restitutions that fewer and fewer people will be able to afford.[21] Thus the restitution story as a *generalized* narrative of illness can be predicted to become increasingly restricted in its availability.

But even if medical progress will be limited in whom it benefits, this progress is real and remains the ultimate power of the restitution narrative. The ultimate limitation of restitution is mortality: the confrontation with mortality cannot be part of the story. Sometimes what cannot be told is dramatic, as when my physician friend cannot wrest his patient from specialists and discuss her imminent death with her. Other times nothing prohibits talking about death, but something just as strong inhibits this talk.

Zygmunt Bauman, responding to arguments presented by Norbert Elias, describes why the restitution narrative is inadequate to make mortality available to experience. "Perhaps it is not just the delicacy of manner that deprives us of speech [when we encounter the dying]," Bauman writes, "but also the simple fact that, indeed, we have nothing to say to a person who has no further use for the *language of survival;* a person who is about to leave the world of busy pretense that that language conjures up and sustains."[22]

Professional medicine, on the sociological accounts of Parsons, Zussman, and other students of its practices, and on the practitioner accounts of physicians like Nuland, institutional-

izes having nothing to say beyond the language of survival. Its studied self-restriction to that language is the core of its banality of heroism. This core shows widening cracks in postmodern times. Many physicians seem less interested in being heros, in Bauman's modernist sense, and more interested in being moral persons. Nuland's self-reflections, and their enormous popular reception, are one indication of this shift; David Hilfiker, in his life as well as his writing, is another.[23]

My interest, however, is less in forecasting medical change and more in what happens to ill people. What happens when those who have always spoken their own experience in the language of survival find that language has nothing left to say about themselves, once the viability of restitution has run out? What body-self is left, when the end of survival is imminent? The tragedy is not death, but having the self-story end before the life is over. It is a tragedy if having nothing else to say means that these people have no further use for themselves; if in Audre Lorde's phrase they have lost any language in which they can remain available to themselves. Living can certainly be more than the "life of busy pretense," and stories are available that conjure up these other possibilities. But before describing stories that affirm life beyond restitution, the stories that deny any possibility of restitution must be heard.

Five *The Chaos Narrative*

Mute Illness

Chaos as Non-Plot

Chaos is the opposite of restitution: its plot imagines life never getting better. Stories are chaotic in their absence of narrative order. Events are told as the storyteller experiences life: without sequence or discernable causality. The lack of any coherent sequence is an initial reason why chaos stories are hard to hear; the teller is not understood as telling a "proper" story. But more significantly, the teller of the chaos story is not heard to be living a "proper" life, since in life as in story, one event is expected to lead to another. Chaos negates that expectation.

Chaos stories are as anxiety provoking as restitution stories are preferred. Telling chaos stories represents the triumph of all that modernity seeks to surpass. In these stories the modernist bulwark of remedy, progress, and professionalism cracks to reveal vulnerability, futility, and impotence. If the restitution narrative promises possibilities of outdistancing or outwitting suffering, the chaos narrative tells how easily any of us could be sucked under. Restitution stories reassure the listener that however bad things look, a happy ending is possible—Job with his new family and cattle, basking in God's graciousness. Chaos stories are Job taking his wife's advice, cursing God and dying.

Chaos stories are also hard to hear because they are too