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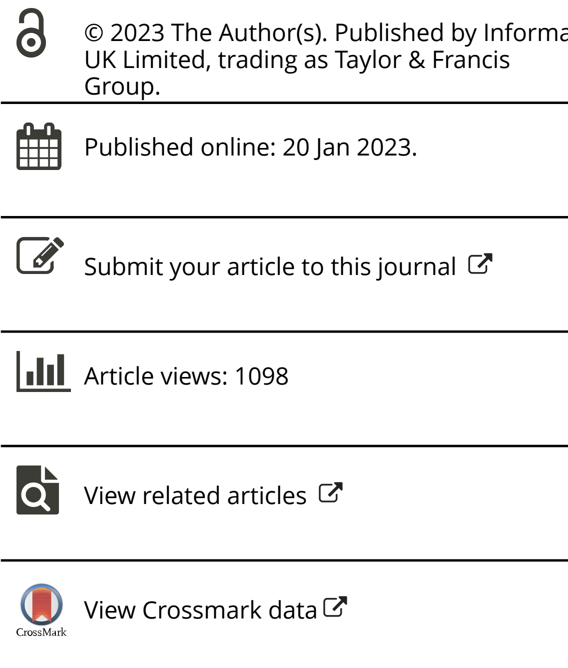

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'I Hated Adult Hospitals, and Adult Medicine and Adult Patients': Chris Adrian's 'A Better Angel' and American Medicine's Anxious Relationship to Ageing

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ABSTRACT

American author-physician Chris Adrian's short story 'A Better Angel' (2006) explores US healthcare's problematic relationship to ageing and death and how this is shaped by its 'cultural infatuation with youth'. The story follows the immature and feckless Dr Carl as he becomes a reluctant companion to his dying father. Paediatrician Carl is a junkie who has cheated his way through medical school, despite the constant presence of a hypercritical guardian angel. Though he is a doctor, Carl abhors the adult world and its association with ageing, frailty, and vulnerability, declaring he hates 'adult hospitals, and adult medicine and adult patients'. Terrified of the 'emotional contagion' that inter-dependent relationships demand, medicine ironically becomes the perfect haven for a man who despises responsibility and obligation. I argue that the depiction of childhood, parent–child relationships and the elderly in Adrian's story makes visible how youth and ageing are one of the binaries upon which the discourse of American medicine depends. An 'Impaired Physician', Carl deploys the compartmentalised culture of modern medicine to maintain a barrier between himself and what he considers to be the ugly side of human existence that entails dependence, decline and the inevitability of death, reflecting Alan Bleakley's claim that 'modern medicine is like a spoiled child who becomes unable to develop adult caring and warm relationships or emotionally satisfying collaboration'.

KEYWORDS

Age; ageing; youth; adult; death; America; medicine; physician; Chris adrian

Introduction

Entangling the medical with the fantastical, physician-author Chris Adrian's short story 'A Better Angel' (2006) blurs boundaries, challenges linear narratives and explores the permeable nature of the binary categories upon which modern medicine relies, such as youth versus age and life versus death. Adrian's story, first published in *The New Yorker* in 2006 and later included in a collection of the same title, demonstrates how contemporary biomedicine is framed by 'the polarisations of modernity (subject/object, active/passive, knower/known, mind/body, doctor/patient)' (Hooker 2015, 542). It also shows how the fraught tensions between such oppositions make them vulnerable to collapse. Alan Bleakley asserts that polarisations such as 'normal versus pathological, health versus illness, and cure versus care' are essential to maintaining the authority of the physician, as '[a]lthough

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medicine is riddled with uncertainty, it characteristically controls this by reducing its subject matter to oppositional categories' (Bleakley 2013, 67). For Bleakley this 'logic' within medical culture, and particularly in the education of doctors, results in a biomedicine that deploys a 'key strategy . . . of oppositionalism' where 'the rational is opposed to the irrational and the former is dominant over the latter' (Bleakley 2013, 63). The physician protagonist of 'A Better Angel' attempts to exploit the binaries between the well and sick and the young and old as a refuge from the complexities and challenges of adult relationships, as he retreats into a perpetual adolescence to avoid the demands of the adult world. The tension between the definitive authority of medical science and the chaotic uncertainty of human experience, and the ways in which the figure of the doctor is expected to overcome and master the distinction between such binary categories, is central to 'A Better Angel'. Indeed, the story itself entangles, and refuses to privilege, the 'realistic' portrayal of the practice of 'rational' medicine as it also relates 'irrational' and fantastical events.

'A Better Angel' depicts the crumbling world of the 'impaired physician' (Adrian 2012, 112) Carl a man who is burdened by the extraordinary presence of a hypercritical guardian angel who catalogues his 'every failing' (122). The story follows Carl's desperate attempts to control his life and avoid anguish when he is compelled to become the unwilling carer for his dying father, and he does this via the sort of 'strategy of oppositionalism' identified by Bleakley. Carl's father is a man he can hardly look at, let alone 'save', even though the angel says Carl has miraculous healing powers to 'touch him and make him well' (128). In his struggle to supress distressing childhood memories, and to distance himself physically and emotionally from the dying father he is meant to save, Carl tries to exploit the ways in which the discourse of medicine separates the doctor from the patient, the healthy from the sick, and how it sets youth and ageing, and life and death in opposition to each other.

The story expresses Carl's hatred of the ageing bodies of his patients and his terror at seeing his own dying father 'at the extremes of abandonment and grief' (Adrian 2012, 118). And, as the story portrays the protagonist's attempts to suppress his own personal trauma, it also depicts an American culture that tries to deny the instability and permeability of the binary oppositions between the well and the sick, and the young and the old. As Rosemary A. Stevens states '[h]ealthcare is so embedded in American culture and politics that to write about it is to write about our country writ large: What we value. How we think. How we govern' (Stevens et al. 2006, 4). Adrian's surreal and disturbing story draws upon how 'the increasing secularisation of western societies' and their 'dependence on rationality' have led to a 'turn to biomedicine and science as the ultimate weapons against illness, disease and premature death' and how this has 'generated discourses and practices which tend to deny the fragility and mortality of the human body' (Lupton 1994, 1). The story portrays Carl as a corrupt physician whose position as a doctor enables him to reject the ageing and frail adult patients that repel not only him but wider American culture.

America's Age Anxiety

America is famously viewed as having a 'cultural infatuation with youth' (Berkowitz 2017, 23) but as Lawrence R. Samuel argues, 'the nation's past fifty years have in many ways been heavily defined by the idea of aging, with key moments ranging from politics

(the passage of Medicare) to science (the genetic revolution) to medicine (the rise of "antiaging" medicine) to education (the creation of gerontology as a field of study)' (2017, 9). Since the end of the twentieth century, the ageing baby boomer generation has meant 'the number of persons aged 65 and older in the United States has risen at an unprecedented rate' and '[t]he proportion of the total U.S. population over age 65' has continued to 'increase dramatically' (Carr, Pemmarazu, and Rice 1996, 5). In 2019, the U.S. Census Bureau forecast that by '2030, when all boomers will be older than 65, older Americans will make up 21% of the population up from 15% today' meaning that 'the graying of America will be inescapable: Older adults are projected to outnumber kids for the first time in U.S. history' (Vespa 2018).

However, the 'graying' of the American population has not brought with it a wider acceptance or celebration of ageing. Instead, ageing in America has come to be defined by an '"[a]larmist demography"' (Gullette 2011, 10) where it is viewed 'as a monstrous entity set upon destroying welfare states and generational futures' (Katz 2014, 19). The sense of impending peril can be seen in the concerned language of the statisticians – the ageing of America is 'dramatic', 'unprecedented' and 'inescapable'. Canadian critic Andrea Charise notes that in Western culture older citizens are frequently described in '[t]erms like the "silver (or grey) tsunami", "age wave", "grey hoard", "avalanche", or "flood" . . . not only by popular media but in professional registers as well' (Charise 2012, 3). In America, this 'liquid cataclysm' (Charise 2012, 3) of the 'aged' is seen as a national disaster-in-waiting, and 'political discourse in the United States is saturated with social and economic ageism, including widespread hand-wringing about the insupportable economic "burden" the older generation increasingly imposes on younger workers' (Port 2021, 1). The widely held belief that growing older is a catastrophic event reflects how ageing in America has come to be understood. Decline ideology alienates the young from the old, setting them in opposition to each other. This negative ideology of age persists despite the ways in which 'aging goes to the essence of humanity; it is one of our very few common or even universal experiences . . . as each of us gets older every day regardless of our race, gender, or other socially defined division' (Samuel 2017, 9).

The negative stereotypes and fear that surround older age mean that 'the prevailing discourse of aging in present-day Western culture [is] one of inevitable and irreversible decline' (Andrew 2012, 47) - an anathema to America's narrative of progress. As a consequence, in a U.S. culture that reveres youth, biomedicine has become the authority with which to understand, and perhaps even resolve, the challenges posed by the ageing bodies of America. Peter Conrad defines 'medicalization' as 'a process by which nonmedical problems become defined and treated as medical problems, usually in terms of illness and disorders' (Conrad 2007, 4). Critics have noted how this process of medicalisation has become applied to older age in America to the point where it is difficult to view ageing outside of the clinical gaze. Patricia Andrew asserts that 'the medical profession has taken upon itself the task of eradicating illness and prolonging life – indeed, its primary objective is seen as preventing death' (Andrew 2012, 56). And John Vincent describes how America has embraced the idea that medical science will somehow overcome old age and, as such, physicians are seen as 'the warriors against old age in white coats' (Vincent 2003, 140). As Vincent further explains, '[o]ur belief in the progressive nature of science is such that we are confident that these warriors will ultimately triumph in the final battle with death' (Vincent 2003, 140). This search for

a solution to the 'problem' of older age (and possibly even death) means that 'the biomedical model has dominated the understanding of aging in Western culture' resulting in a 'medical model [which] focuses its attention on the pathology of aging, considering sickness to be the "natural" consequence of biological decline' (Andrew 2012, 56). Vincent argues that '[t]he dominance of Western scientific medicine has transformed old age from a natural event to a disease … The medicalisation of old age has become so powerful during the modern period that it may be seen as a form of cultural domination, [and] as a process structuring people's perceptions of old age' (Vincent 2003, 138–143). The 'increasing "medicalization" of old age in Western societies' (Wyman et al. 2018, 202), and particularly in American culture, has led to '[t]he equation of old age with illness [which] has encouraged society to think about old age as a pathological, abnormal, and an undesirable state, which in turn shapes the attitudes of members of society toward the elderly and of the elderly toward themselves (EAlford et al. 2001, 46).

> 'A Better Angel' presents a disrupted narrative about decline and lost potential that exposes the limited ways in which ageing in America can be understood and in particular how 'the aging body has become a site of social and cultural devaluation in the contemporary West' (Howson 2004, 154). Adrian's short story reflects the dominance of a 'decline ideology' in America's understanding of age via a protagonist who sees 'aged' bodies as 'abnormal', and 'undesirable'. The story demonstrates how medicine has come to shape what it means to grow old in US society through its 'discourse of decline'. Such a discourse limits an understanding of the human life course as anything more nuanced and multifaceted than allowed for by the binary of 'desirable' youth versus 'catastrophic' older age. By doing so, Adrian's story evokes Segal's call for Western society to stop finding ways to repress the complexity of older age and to 'acknowledge the inevitability of grief, pain, and conflict in human affairs, [and to see] them as part of what it means to lead a full life, even what we might call a "good" life'
>
> (2014, 33).

'A Better Angel' and the Narrative of Decline

In Adrian's story 'grief, pain and conflict' are everything that the protagonist seeks to avoid. Medicine's oppositionalism appeals to a protagonist who fears the ambiguity and uncertainty that ageing, and adulthood necessitate. In his own life, and as he witnesses his father's deterioration, Dr Carl feels all too strongly such a discourse of decline and in response rejects the 'responsibilities, commitments and autonomy of adulthood' (Blatterer 2007, 1). As Gullette argues, because of the ideology of decline 'age anxiety' (Gullette 2004, 21) has begun ever earlier in America and is 'backing down the life course' (2004, 33). For Gullette, 'Americans are becoming obsessed with age, not because of increasing longevity, but because of premature decline. Age is becoming an overriding constructor of difference and an alarmingly ubiquitous focus of subjectivity throughout the life course' (2004, 35). Gullette describes a 'hardening of age divisions' (Gullette 2004, 3) in America via 'mechanisms that construct an obsession with age', such as '[d]ecadism, generationalism, and named age cohorts' (2004, 3). These mechanisms place the young in opposition to the old, but simultaneously also structure the process of ageing as one of the continual and inevitable decline as 'the only change to be expected in adult life is deterioration' (Walsh 1983, 4). This means that 'the life-course opposition of progress

and decline constrains narrative options in our culture' (Gullette 2004, 19). Within 'A Better Angel' the binary thinking of medicine allows Carl to compartmentalise and distance himself from the adult world – to harden the division between himself and the aged – but it also leaves him unable to find an alternative discourse with which to process the complexities of human existence that confront him when he returns to his dying father.

American culture, like Carl, struggles to find a narrative that expresses how it should feel about the process of the ageing and the inevitability of death it would rather evade. Critics have noted that '[t]he United States is a death-denying society' (Evans and Kamienny Montvilo 2021) and '[m]any Americans desire a society without death and keep their distance from people and places routinely associated with death' (Gold, Binstock, and George 2011, 242). Medical science seems to offer a resolution to America's dilemma with mortality by both striving against death and by containing and categorising the older bodies that have come to be aligned with death. But while medicine might want to pay 'little credence to the biological certainty of death' (Kaufman and Schulz 2006) older people are 'Memento Mori, reminders of death in a culture that is steadfastly turned to the here and now' (Hess and Hess 1980, 5) and whose existence questions the mastery and control of a medical science in which contemporary culture has placed so much faith. If ageing in America has become a 'disease', we might see it in the same way in which Charles Rosenberg has described sickness – as the 'final and ultimately inaccessible citadel of human idiosyncrasy' (2009) - that which challenges rational thought and medicine's insistent search for definitive answers. 'A Better Angel' reflects the anxieties surrounding ageing and death in contemporary America as it depicts a doctor who retreats from the adult world as he tries to 'manage indeterminacy' (Mantovani 2016, 219).

The struggle to find a way to maintain the opposition between 'young and old' and 'adult and child' (and its inevitable collapse under such strain) is central to 'A Better Angel' where Carl's dysfunctional upbringing means he has grown up fearing the 'emotional contagion' (Hooker 2015, 547) that adult relationships demand. It is narrated in a present time by the now adult Carl, but the narrative also moves between recollections of his unsettlingly cynical practice of medicine and a troubled early life. We follow as the quasi-prodigal son Carl leaves San Francisco to return to Florida to become a reluctant companion for his dying disciplinarian father. He is pressurised into coming back to his family home by his sisters and his guardian angel, despite Carl being his father's 'least favourite child, and the last person he wanted taking care of him when he got very ill' (Adrian 2012, 111).

The youngest of four siblings, and the only boy, Carl is evidently a child of privilege. He grows up on his father's Florida plantation farmed by immigrant labour and 'where he could walk all afternoon without leaving his orange groves' (110) and Carl attends a school where '[t]here were no poor children' (126) - a depiction of a cosseted childhood in a family whose abundant wealth prospered on exploitation. But despite all his advantages, Carl does not thrive in this privileged environment, and he recalls a lonely childhood, where he invented friends to play with 'since I really had none of my own' (110) and his sisters 'hated to have me underfoot' (110). It becomes apparent that his siblings' hatred went further than simply the drawing of 'false maps' to send Carl on the pointless 'quests' around the plantation that he remembers. Towards the end of the story

his delirious father reveals that '[y]our sister tried to drown you when you were two' (130) and, equally disturbingly, that when Carl was a baby his mother had tried to smother him '[j]ust a little, with a blanket . . . she was depressed, and that's what you do when you're depressed' (131). Throughout the story, as we learn more about Carl's past, it becomes evident that, in his experience, adults in caring roles are not necessarily loving or compassionate, and his experience of childhood contradicts how in 'contemporary western cultures [childhood] is typically viewed as a time of innocence and joy and is seen as being distinct from adulthood' (Howson 2004, 141).

This idea of lost childhood innocence is reiterated when, as an adult doctor working in ER, Carl recalls coming across the 'worked-over corpse' of a woman who was his drug dealer and 'sort of girlfriend' as he 'went into the trauma room to fetch a warm blanket for a cold baby' (118). Unnervingly, he relates that '[s]he was beaten to death by a boyfriend more passionate but less gentle than me' (118). Any sense of Carl's act of caring and compassion in bringing a blanket for the baby is disrupted by his emotionally distant thoughts towards the dead woman, which disconcertingly conflate violence with love. The very moment that Carl displays nurturing qualities is undermined by his attitude to his dead lover. Carl is a paediatrician, a specialism in which women are over-represented and one that has become stereotypically associated with 'maternal and nurturing attitudes' (Davis and Allison 2013, 22). But Carl's troubling attitude towards the murdered woman more closely aligns him with 'the pervasiveness of misogyny throughout clinical and academic medicine' (Kaye 2021, 2267) than the 'feminine tolerance of ambiguity' (Bleakley 2013, 67) and 'tender□minded' (Bleakley 2013, 59) medicine that Bleakley hopes will counter the 'current dominant patriarchy' (Bleakley 2013, 59) of modern medical practice.

And the blanket Carl brings to the baby recalls the blanket that his mother tried to smother him with, and also echoes his thoughts about the 'smother pillows' of 'the women in charge of the palliative care programs' (127). The image of smothering is repeated yet again as he relates that he believes his guardian angel would be happy if he smothered any child patient who she prophesises will be a future criminal with 'the great pillow of righteous prevention when they are 6 months old' (113). Such inversions and contrasts between care and cruelty, and innocence and condemnation are repeated in the narrative – even in the very closeness of the word 'smother' to 'mother' - and they disturb the nurturing qualities of adults whether male or female. Carl and his domineering father are the only male characters in the story, but the female characters who surround Carl – from his death-loving angel to his fratricidal sisters – do not necessarily present stereotypically 'feminine' values of nurture or care. The convergence of the comforting image of a warmed baby with the distressing figure of the battered corpse also demonstrates how Carl is constantly drawn near to the complexity of the adult world and the human frailty he hopes he can insulate himself against. Such evasions become increasingly impossible to sustain as Carl is confronted with the fragile nature of supposedly oppositional categories like adult and child.

Carl's often detached recollections of disturbing experiences make it become starkly apparent that the appearance of a guardian angel to a six-year-old Carl has not improved his troubled life as we might expect. Patricia Andrew comments that in the narrative of childhood 'children are seen as moving through the life course in progressive stages of physical, psychological and social development that prepare them for the adult world'

(Andrew 2012, 47). But the Angel who promises Carl a remarkable future instead stifles his potential, and the weight of the future disrupts his ability to progress and evolve. Rather than saving Carl and becoming a source of divine inspiration, the angel's presence is decidedly ambivalent, and her first interaction with Carl is to half-heartedly (and unsuccessfully) warn him of an impending wasp attack with the smugly judgemental words 'I wouldn't do that if I was you' (Adrian 2012, 110). The event lands the allergic Carl in hospital and introduces him to the joys of opiates and, also, uncovers his innate talent for deception and duplicity as '[e]ven back then I was a quick and subtle thinker when I was stoned' (111). When Carl asks why the angel didn't warn him about the nest of yellow jackets that sting him, she simply replies, 'I'm not that kind of angel' (111). This is an angel who will 'scowl impotently' (114), 'berate' (116) and shake her head in disapproval but will not intervene in the increasingly chaotic events of his life.

The angel is herself is a figure who disturbs the 'essentialist binary opposition[s]' of modernity where 'mind is contrasted with body, spirit with soul, active with passive ... rational with irrational, reason with emotion ... adult with child, male with female, immortal with mortal' (Lupton 1994, 87). She is a shapeshifter who can be both 'majestic' and 'hideous', 'beautiful' and 'ugly' and simultaneously masculine and feminine - '[her] hand that was soft and white on one side and hairy and rough on the other' (Adrian 2012, 131). Though disembodied and invisible to all but Carl, the figure of the angel, like the story itself, combines the spiritual and the bodily, the rational and the irrational. She represents both 'innocent' youth and 'decrepit' age. Sometimes she appears sweetly as a girl in a yellow dress 'with a furry kitten face on the front' (110). But she also torments the age adverse Carl by manifesting in her 'haggery' (118) as a bag lady, 'dressed to shock, with a plastic shopping bag on her head, in a filthy housedress, and a dead cat wrapped around either foot ... the cats going squish and squash as she stepped' (113–114). This obviously isn't a stereotypical 'guardian angel' who might offer the protection but is one instead drawn to mortality, and who is 'pleased by death' and excited by sniffing people 'and predicting the hour of their demise' (116).

As well as unsettling the kind of polarities that modern medicine relies upon with her love of death and ambiguous appearance, the angel's presence also disrupts the progress of Carl's life and hampers his ability to reach maturity. Carl's life encapsulates how the dominance of the life-course as a narrative of decline means that ageing 'can be a buried terror even for those still young (even ideally young: male, single, highly educated and child free')' (Gullette 2004, 19). Carl's terror for the future and suppression of the past means that subsequently he is unable to contemplate or accept obligations to anything other than his own pleasures and addictions. Rather than concede to the angel's monumental prophecy that the 'true sweep of history' (120) is toward him, Carl prefers to spend his life shirking his fate and rejecting the world of accountability and inevitable suffering that the ambiguous angel represents, and he does this – in a way that confounds and disturbs the reader's assumptions – via his role as a paediatric physician.

The 'Blunt Binary of Young and Old'

'A Better Angel' is an expression of an 'American age ideology' (Gullette 2004, 21) that relies upon a stark binary thinking that sets youth and age in opposition. Such an ideology leaves a lack of alternative discourse with which to comprehend the human

life course. As Andrew asserts, the two extremes of youthful advancement and aged deterioration result in a 'progress-versus-decline binary that has effectively covered most of the available narrative possibilities, thereby limiting the emergence of alternative discourses for understanding or explaining age' (Andrew 2012, 47). Woodward further explains that 'one of the intractable problems of the discourse of age itself [is that] it pivots on the blunt binary of young and old, as if there were only two states of age. It is surely clear, however, that the meanings of our experience over the long lives that we may live cannot be expressed by the rhetoric of young and old' (Woodward and Woodward 1999, xviii). Carl tries to deflect uncertainty via the 'blunt' binary oppositions that American culture and American medicine upholds because they shield him from the ambiguity of the ageing adult body that represents a world of interdependence and responsibility. But, because of his evasion, Carl's narrative becomes limited by the polarities of progress-versus-decline. For Carl, deterioration is the only path that lies before him.

The angel is meant to inspire Carl to achieve great things, but instead her presence sets a course whereby Carl's life is spent evading her relentless criticism and demands. Consequently, the angel fails to oversee Carl's intended 'grand destiny' (Adrian 2012, 127), one which was meant to see him become a US president who would prevent 'national and individual catastrophe' (128) and 'save the whole world' (129). Patricia Andrew asserts that '[t]he decline narrative must be understood with respect to its counter-part, the progress narrative, which depicts aging in terms of growth and progress, occurring before the onset of decline' (Andrew 2012, 47). Carl's story was meant to be a narrative of unlimited potential and exceptional progress – the embodiment of the 'continuing upward advancement' (Andrew 2012, 47) of the American Dream. But instead, his is a narrative of decline and corruption from its beginning and one where instead of becoming 'a great man' (131), Carl ironically chooses to become a doctor. Medicine, a 'heroic' profession that one would assume to be based on social and personal responsibility, wanting to save lives and to make people 'better', has become for Carl the perfect hiding place from obligation and confrontation – and one that also allows him to feed his addiction to prescription drugs that numb his traumatic memories and blot out the angel's demands for him to 'finally stop fucking up' (131). Carl's desire to run from ambiguity and interdependence means that he views medicine as the perfect profession for him, despite his complete lack of diligence or integrity. There he can place youth – and the sort of 'love' of recreational drugs that is identified with youth culture – in opposition to 'hated' sickness defiantly declaring that 'I love babies and I love ketamine, and that's really why I became a paediatrician, not because I hate illness' (121).

Carl narrates how he uses his cunning, and presumably his financial privilege, to pay other people to take his exams and to cheat his way through medical school and then exploits his clinical status to 'pass' as a responsible adult (and gain access to prescription medicine).

Throughout the story, Carl manages to use the 'perceived power of the physician' (Caruso Brown and Garden 2017, 501) to hide from his responsibilities and from being held accountable, trying to dodge emotional burdens while also trying to evade the sorts of relentless demands that are associated with practicing medicine. He relates how '[s]ome nights as a resident I would withdraw into [a bathroom] and leave the intern to flounder and drown', ignoring their 'frantic pages', while 'taking little hits of whatever

I was really into that month' (117). Carl refuses to take on professional or adult responsibility and tells the reader that he 'would waste, and still waste, half my life in thrall to [lust] . . . to the exclusion of work and food and sleep, but never of drugs' (127).

The disparity between Carl's respectable professional persona and his depraved private life presents him as a Jekyll-and-Hyde-like figure, wrestling with a conscience that is personified in the form of his guardian angel. Disturbed physician Carl's fantastical struggle between good and evil is an extreme and exaggerated one, even if the '[u]se of narcotics and other drugs has historically been closely linked with physicians because of their close proximity to mind-altering drugs, narcotics, and drugs that elevated the mood' (Millikan 1999, 361). A junkie and a 'fake', Carl is, on the surface at least, the inverse image of the only other doctor we directly see in the story, his father's oncologist Dr Klar. Initially, she appears as Carl's absolute opposite and Carl readily casts her as an annoyingly capable adult whose very existence makes him feel reprimanded like a guilty child. Dr Klar stands for 'order and discipline' and 'success', and as such Carl cannot stand her presence - '[h]er immaculate white coat seemed the least perfect thing about her, but just being in sight of it I felt accused of slovenliness and failure' (Adrian 2012, 124). *Klar* in German means clear and transparent – the opposite of deceitful and 'dark' Carl. Dr Klar's name is a near of anagram of Carl, underlining the implication that for Carl she is his inverse image – efficient, competent, confident, open, and adult – a 'good' doctor, to his 'bad' one, upholding all the values that he shirks. When the angel first sees Dr Klar, she tells Carl that '[h]ere is the grandma of your better nature' (124), a moment that would seem to place Carl in the position of a feckless youth in relation to an older and wiser Dr Klar, as well as recalling the phrase from which the story takes its title. For Carl the opposition between himself and his father's oncologist reinforces the binary between youth and age. Dr Klar stands as a mirror to Carl's faults, and as mature adult to the irresponsible and childishly selfish Carl. It is one of many moments in the story that suggest that Carl isn't just shirking adult responsibilities but has in fact failed to mature into an adult at all.

On one level, this might seem to be the central irony of the story – here is a childish man passing as a fully functioning adult paediatrician and as such the story deploys images of the reasoned and mature culture of medicine to emphasise Carl's juvenile flaws. Certainly, Carl could be categorised as the over-privileged child who refuses to grow up and as an individual suffering from 'prolonged adolescence' (Côté 2000, 2) doing his best to 'experience as much pleasure as possible and to avoid responsibilities indefinitely' (Côté 2000, 2). Carl's aversion to responsibility, his shallowness and his sulky, avoidant attitude, all depict him as a 'man-child' suffering from a classic case of delayed development, something reiterated in descriptions of his appearance and his interactions with others. When he returns to his family home, Carl finds himself back in 'the single bed I slept in when I was five' (127), suggesting he has not moved beyond childhood despite being there as his father's carer. Physically, Carl is 'short and dark' (Adrian 2012, 112) as opposed to the 'very tall' (128) female hospice nurses who insist on open communication about death, and we are told his 'much older' (110) sisters are 'tall and light' (112), all three of whom are pregnant, another symbol of their 'adult' status. He has inherited the 'nearly black eyes . . . I can hide anything in' (112) from his 'six-foot-four' father, but not his height – showing he has quite literally failed to grow up. Echoing his view of Dr Klar, Carl also regards his father as an inverse image of himself and describes

him as his 'responsible reflection' (117), reinforcing Carl's own sense of his failure to function as a mature individual and an image, which sets him in opposition to the adult world.

Carl's immaturity and his attempt to retreat from the adult world is also apparent in his adolescent attitude and word choice. His language echoes that of a cranky teenager as he describes killing off patients with his 'bad math' or when he recalls his 'egregious fuck-ups' in medical school (Adrian 2012, 116). His juvenile outlook is especially evident when he recounts the time he spent in adult medicine as part of his clinical training. The reader can be left in no doubt about his negative feelings about adults as Carl declares that,

> I hated adult hospitals, and adult medicine and adult patients. I could not wait to get away from them in medical school, their aching lower backs and chronic depression and get-me-out-of-work related injuries. I hated especially the little old ladies with their parchment faces and frail broken hearts, who'd die if you frowned at them *(115–6).*

Here, Carl's response to the infirm and incapacitated is one of the emphatic hatred rather than empathetic understanding. His forceful repetition of the word 'adult' and his emphasis on 'hate' leaves no doubt of his absolute contempt for these patients. Carl minimises and derides their ailments, classing them as fabrications and pathetic gripes - 'their aching lower backs' and 'get-me-out-of-work related injuries'. His cruellest dismissal and especial hatred are reserved for the 'little old ladies', whose very vulnerability – their 'parchment faces' and 'frail' hearts – makes them especially repugnant to him. Kathleen Woodward has described the kind of 'aggressive shaming' that has become normalised in Western attitudes towards older women (Woodward and Woodward 1999, xii). Carl's reviling of his elderly female patients expresses the sort of 'pedagogy of mortification' that Woodward argues teaches 'an older woman to recede into invisibility' (1999, xii). This 'invisibility' occurs via a 'practice of . . . disregard' (1999, xii) - a disregard that Woodward notes often categorises and stereotypes older women as '"little old ladies"' (1999, xii), an attitude that Carl's thoughts entirely encapsulate.

Carl's selection of older women as the target of his most intense hatred reflects how this is a group that is, in the words of Martha B. Holstein, both 'hyper-visible' and 'invisible', either 'not deserving of attention, or in need of help' (Holstein 2017/2018, 8). As Gullette further adds, in America 'more of the frail and poor old are women than men. The rhetoric of being burdensome is loaded mainly on [them]' (Gullette 2011, 30). The 'little old ladies' of adult medicine are for Carl the perfect emblem of everything he rejects as they exemplify the idea of dependence and need. Adrian's construction of Carl as a misogynist makes such an attitude to older women unsurprising, but what is most striking about Carl's anti-adult rant is that it is the emotional, not physical, pain of the patients that truly disgusts him. Carl's adolescent outlook is emphasised as he minimises and derides the emotional pain of the adult patients and places himself in opposition to them.

Fortunately for Carl, modern medicine's fundamental 'drive toward separation and classification' which splits 'the practice of medicine into multiple specialties' (Gaines et al. 2004) means he can avoid elderly and ageing adults by specialising in children's medicine and becoming a paediatrician. Paediatrics perfectly suit the adult-hating Carl in his bid to insulate himself from the parts of life he considers to be unacceptable. He happily declares that he chooses paediatric medicine not because of any desire to help 'half-

dead premmies' (116), but because there he can attempt to evade sickness altogether. Carl chooses 'praising the beauty of well children' (121) over dealing with the incapacitated. As in wider American culture, Carl values an exterior appearance of youthful health, and rejects its opposite – the old bodies which signify 'systemic and systematic decay, loss and obsolescence' (Tulle-Winton et al. 2000, 73) with their 'unwelcome and undesirable' 'look of age' (Hepworth 2000, 40). In paediatrics he can, apparently, indulge his love of attractive things like 'doughnuts or handsomeness' (Adrian 2012, 116), focusing on unchallenging exteriors and avoiding the broken-down bodies of adult medicine that cannot be cured, but demand compassion.

Carl's attitude to his adult patients perfectly encompasses the concept of 'ageism', a phrase that American physician and gerontologist Robert N. Butler coined in the late 1960s to describe the 'prejudice by one age group toward other age groups' (Butler 1969, 243). While Butler recognised that all age groups were susceptible to feeling the effects of ageism, he argued that it particularly impacted upon the elderly as it reflected 'a deep seated uneasiness on the part of the young . . . a personal revulsion to and distaste for growing old, disease, disability; and fear of powerlessness, "uselessness", and death' (Butler 1969, 243). In every aspect of what he feels about his mature patients, Carl's ageist outpouring echoes the 'distaste' Butler describes. He defines adult and aged patients as workshy, pathetic, and lacking resilience with 'get-me-out-of-work related injuries', and chronic conditions. Carl places himself in opposition to the elderly patients, othering them rather than offering empathy. His outlook demonstrates how '[a]geism allows those of us who are younger to see old people as "different". We subtly cease to identify with them as human beings, which enables us to feel more comfortable about our neglect and dislike of them' (Wyman et al. 2018, 193). To Carl the adult patients are 'poor old zombies' (Adrian 2012, 216) and Carl prefers the 'beautiful' and 'fat and happy' babies (114) he encounters in the fake consultations he uses as a cover for scoring drugs. His thoughts align him with the sort of 'visual ageism' that Howson asserts is often associated with 'popular images of aging and old people in the contemporary West' (2004, 149). Everything that Carl sees in his adult patients conforms to the negative stereotypes of the elderly that Howson lists - 'bodily disease and decay, physical incompetence . . . lack of activity, isolation and/or institutionalization [and] dependency, via physical deterioration' (2004, 149). And Carl's response to the ageing bodies is also the 'typical' one of 'disgust or revulsion' (Howson 2004, 50).

But while such a negative response might be 'typical' within in US society, it sits uneasily with 'the prevalent image of medicine in American culture . . . [as an] objective, scientific pursuit' (Shapiro et al. 2009, 193). Carl's loathing of his older adult patients contradicts '[t]he image of the technically skilful, rational, and emotionally detached' physician that Western culture 'favours' (Kerasidou and Ruth Horn 2016, 1). And his spiteful thoughts towards the frail and the depressed also means that Carl simultaneously fails to live up to the model of the empathetic doctor who achieves 'the ideal balance between emotional overinvolvement and detachment' (Kerasidou and Ruth Horn 2016, 3). Set alongside his chaotic life, clinical incompetency and the surreal presence of his angel, Carl's sullen resentment of older adult patients would seem to be yet another sign of his 'kidult' persona that sets him apart from the rational, capable, compassionate, and fully grown-up medics who surround him. But does his dismissal of older adults'

afflictions conflict with Carl's physician status, or does the discourse of biomedicine actually strengthen and justify his abomination of older age patients?

'Modern Medicine is Like a Spoiled Child'

It could be argued that physician Carl's childlike and inappropriate attitude develops solely because of his individual and surreal circumstances – his damaged childhood and determination to shrug off his divine 'higher purpose'. But is it also a depiction of the inevitable effect of the 'stubbornly hierarchical and patriarchal' (Bleakley 2019, 1423) nature of modern medicine? Bleakley asserts that 'modern medicine is like a spoiled child who becomes unable to develop adult caring and warm relationships or emotionally satisfying collaboration' (Bleakley 2019, 1424). It may seem that it is strange and contradictory for Bleakley to align medical culture with the infantile, brattish, and dysfunctional image of the spoiled child. Traditionally, modern medicine and its doctors are viewed – like the exemplary Dr Klar – as the functioning 'adults' in a society where 'doctor knows best' (Hughes et al. 2000, 18). The 'professional paternalism' (Hughes et al. 2000, 18) of medicine means that patients are 'expected to play the infant role and the [physician] to act the adult one' (Hughes et al. 2000, 18) and are seen as 'quasi-children seeking help from their medical quasiparents' (Häyry 1991, 1). But for Bleakley, 'the historically paternalistic grip of medicine' exists not only between doctor and patient but also within medical culture itself, due to its obsession with hierarchy, competition, and authority, and he likens the medical establishment to 'the saturnine father who eats his young' (Bleakley 2019, 1424). This, Bleakley argues, means that the 'traditionally patriarchal [and] individualistic' ethos of modern medicine, 'socializes its young into hierarchical structures or eats them whole' (Bleakley 2019, 1422). As a result, medicine suffers from 'empathy decline and emotional detachment and insulation, compounded by growth of cynicism' (Bleakley 2019, 1422) - the very things that describe the spurned son Carl and his sceptical world view that rejects and demeans the emotional complexity of adult existence.

The damage that emerges from the toxic medical culture that Bleakley describes – one that places the physician in the role of both pious parent and maladjusted child – is echoed in the depiction of Carl's chaotic and unstable life. As the story progresses, Carl becomes increasingly unable to maintain the distinctions that insulate him, as he finds he can neither safely regress to the role of spoiled child, nor convincingly act out the role of the adult doctor. The situation reaches crisis point as he reluctantly returns to his dying father – whom Carl remembers as being very much like the terrifying and sinister god who devours his own young - 'imperious, dour and black-eyed … a man who should have an angel of his own' (Adrian 2012, 117). But, visiting him in hospital for the first time, Carl is confronted instead with a scene that disorders the divide between adult and child, as he finds his father,

> … laid out diapered in a dirty bed, as bald and as toothless and somehow as grand as Aslan on his table. He looked up at me when I walked in and said, by way of greeting, 'You!' and managed to invest the word with equal measure disappointment, accusation and surprise. I dropped my book and candy box and ran out. *(117)*

In old age and sickness, his father has become like a baby, 'diapered', 'bald' and 'toothless'.

The association of Carl's father with an infant reflects the 'classic image of the life cycle, where senility returns the child to the helpless dependence' (Blatterer 2007, 1) and how '[p]redominant in the representations of aging and older people are notions of infantilization, whereby aging people are reduced to childlike status' (Howson 2004, 150). But this role reversal isn't stable, as Carl becomes the frightened child when faced with an accusatory father, who is simultaneously as powerless as a vulnerable infant, yet as 'grand' as the sacrificial Aslan. Confronted by his father's sick body, the only way in which Carl can maintain the 'objective distance' of the physician, is to literally run and hide in the bathroom (Macnaughton 2009, 1940).

The striking and evocative reference to the image of Aslan embodies Carl's conflicted response to his frail father. Like Carl's father, C.S. Lewis' lion is a figure of power and vulnerability as he lies on the stone table. But Carl's reference to a children's book might also be said to reflect his inability to find a narrative to describe the mortality that confronts him, signifying a retreat to childhood when faced with the grief and suffering of adult existence. As Carl flees to yet another bathroom to hide, he tells the angel that 'I don't know what to do about what's back there in that room' (117). His words dehumanise his father - '*what's* back there' - reflecting how by necessity 'medical students learn to objectify patients' (Bleakley 2013, 37) to maintain their distance from the sick. But Carl's outcry also alludes to the ways in which medicine is expected to 'do' something about death - 'I don't know what to *do* about what's back there'. Carl despairs that it would be '[b]etter to be a garbageman than a doctor, when your father gets sick … then sickness would just be sickness, something to be borne and not something I was supposed to defeat' (121).

If medicine is a system that 'has become the dominant cultural framework for understanding death, the process of dying, and how to act when death approaches' (Kaufman and Schulz 2006), then Carl's anxieties and sense of futility demonstrate how the rational and pragmatic discourse of medical science cannot encompass the ambiguities of the human mortality it cannot defeat.

In Adrian's story 'Medicine's own problems with death' are even manifested in the 'good' and compassionate physician Dr Klar's actions (Callahan 1996, 14). Her behaviour suggests that she is not so much an inverse image of Carl as physician, but rather one who emerges from the same fraught pressures as Carl. Dr Klar too is defined by the attempt to maintain a distinction between binary categories that structure medicine's discourse. It is revealed that despite her being 'immaculate' brightness, Dr Klar shares some of Carl's 'dark' attitude to death. Behind her patients' backs the apparently optimistic Dr Klar displays a pessimistic attitude that might be said to emerge from the difficulty modern medicine has in confronting mortality and the need for doctors to offer resolution and hope. Deborah T. Gold comments that there is a 'patently false belief', in the medical world that 'patient death is viewed as failure' (2011, 242). Yet a sense of failure surrounding the death of a patient endures because '[t]he primary social role of physicians and other healthcare providers is to cure illness and sustain life at all costs' (Gold, Binstock, and George 2011, 242). Beneath Dr Klar's positivity is a sense that once medicine can no longer 'resolve' sickness, it has little to do but withdraw defeated. Dr Klar's every 'bright' utterance to her patients might be a positive exclamation - '"It's Dr Klar!"' and

'"Everything is fine!"' (Adrian 2012, 125) - but for fellow physician Carl she has a different and more depressing narrative, privately saying '"*What's the use*"' and '"*If he's alive in a month it will be a miracle*"' (125). Carl describes Dr Klar as Janus-like, and a binary figure, 'one of those oncologists who speak life out of one side of their mouth and death out of the other. For my father she had only good news; for me only bad. I hated her' (125). While Carl is intimidated by Dr Karl's competency and efficiency, he ultimately sees her as being like himself and every other duplicitous and cynical doctor who wants to evade the reality of the sick body and turn their back on death.

Carl's perception of doctors as those who cannot speak honestly to a patient about death echoes the claim that, by necessity, medicine is 'a profession of cynics' (Inui 2003, 16). Physicians-in-training are taught to note 'the difference between what we say and what we do . . . [and] learn that medicine is a profession in which you say one thing and do another' (Inui 2003, 5). This means that as an institution, medicine struggles to have adult and honest interaction with its patients because of the need to maintain the belief in the physician's authority and infallibility. For Carl, the culture of medicine is one that asks, 'what's the use?' (Adrian 2012, 125) when faced with end-of-life care, and one where 'doctors hear you are a doctor and enlist you in their hopeless task' (121), but this doesn't matter to him as he 'never wanted to make anyone better anyway' (121). His opinion allows him to justify his own sense of futility and cynicism, and it vindicates his attitude towards his adult patients who are representatives of everything he despises and rejects – dependency, ambiguity, and emotional complexity.

'A Better Angel', Modern Medicine and the Myths of Old Age

Carl's cynical outlook emerges from a need to assert the boundaries between life and death, youth, and age that both he and modern medicine rely upon. The fictional Carl's attitude to his adult patients might be distressing and extreme, but research has found that it isn't as exceptional within healthcare as we might hope. So, while Carl's insistent loathing of older patients, particularly his 'especial' hatred for 'frail' elderly women, might seem to be typical of his 'emotional detachment' and a manifestation of his disenfranchised (and often misogynistic) worldview, '[r]esearch suggests that ageist attitudes have been prevalent even among physicians' and 'that the elderly have been given very low priority by physicians' (Evans and Kamienny Montvilo 2021). Christina Garrison-Diehn et al. have reported how '[i]n spite of the variability of the human aging experience, negative stereotypes and biased behavior related to aging are culturally commonplace, including in healthcare settings' (Garrison-Diehn et al. 2022, 4).

Anecdotal reports of doctors' and nurses' 'perceptions of old age' see elderly patients described 'variously and pejoratively as "gomers", "crocks", "hypochondriacs" or as being "crotchety"', language that aligns closely with Carl's disparaging attitude towards ailing older age adults (Fineman 1994, 263). Inevitably, this negative attitude is acted out in the care given to those of advanced age where '[p]hysicians tend to be less patient, less respectful, less involved, and less optimistic with older patients compared to younger patients' (Wyman et al. 2018, 196). Of course, the core assumptions about older adults – what Butler called the 'myths' of ageing and that have been defined as 'Disengagement, Unproductivity and Inflexibility' - are not only 'widely shared by both doctors and nurses' but also reflect 'stereotypical and core representations of old age in American

society' (Fineman 1994, 264). The 'Gerontophobia' that Carl displays is widespread among the young in America and has been viewed as emerging from an almost inevitable and shared 'human desire to dissociate one's self from reminders of one's own inevitable death, leading to attitudes and behaviors that reinforce separation from individuals or groups that arouse fear of death, such as older persons' (Wyman et al. 2018, 196).

However, despite the widespread nature of ageism, it has been argued that healthcare professionals are particularly susceptible to believing in the myths of ageing. This belief is said to arise in physicians and nurses because of the compulsion to distance themselves from an 'anxiety regarding severe illness or death' and as a form of self-protection because '[h]ealth care professionals often have prolonged exposure to the most infirm, ill, and senile older adults, which may bias their perspective and intensify their willingness to disassociate from the older population through ageist practices' (Wyman et al. 2018, 195). As Evans and Montvilo assert '[w]ithout doubt, the fear of death causes some people to shun the elderly and to view them as being "different from us"' (Evans and Kamienny Montvilo 2021). It has even been hypothesized that 'physicians enter medicine because of their own above-average fear of death and try to conquer this fear by entering a profession where dying and death are rather frequent' (Dickinson and Tournier 1994, 1397). Such a theory might seem to resolve the reader's questioning of why somebody who lacks compassion and sympathy as much as Carl does might want to be a doctor. In these terms his personal traumas, and the dark insights about human suffering the angel teaches him, have drawn him to a profession that wants to distance itself from, and ultimately defeat, death rather than confront it. Carl's choice of profession could be read as a manifestation of how 'the anathema of dying is not only a problem for laypeople, but also for health professionals' and Carl's behaviour as mimicking a wider institutional discomfort that leads to a widespread desire among clinicians 'to avoid the dying' (Markson and Hess 1980, 271).

Carl's attitude might be read as a reflection of a particular medical mindset that distances itself from ageing because of how it has come to be aligned with death as it is that which 'cannot be controlled, cannot be managed' (Bishop 2011, 7). But such a reading places the polarisation of youth and age, and life and death, on the level of the individual physician's psyche rather than in the wider cultural context of America's attitude to ageing and death. It ignores the powerful ways that medical and social discourse shape each other in the United States, and how a society's medical system 'reflects [its] basic values and ideologies, but in turn helps them to shape and maintain them' (Helman 2000, 60). Carl's depiction of adult medicine reflects the reality of a twenty-first century clinical practice where doctors must learn to 'cope' with elderly patients who have 'chronic illness for which there [is] typically . . . no cure' (Barr 2010, 1). Ironically for modern medicine, the life-extending technology that it promotes no longer necessarily implies rapid and miraculous progress, but rather ethical dilemmas concerning lives that are increasingly sustained beyond 'natural' limits, and patients who have become a problematic drain on 'constrained economic resources' (Barr 2010, 1). As Wyman, Shiovitz-Ezra & Jürgen Bengel note '[i]n the USA . . . those over 65 years make up less than 15% of the population but account for over 36% of total health care costs' (Wyman et al. 2018, 193). Such a discourse results in 'proposals to revoke pensions and to ration medical interventions for older adults to reserve resources for younger, more highly valued citizens and for "future generations".' (Port 2021, 4). But as Gullette argues,

the perception that the ageing baby boomers are an economic drain is a manifestation of America's cultural ageism where '[o]ften resources for caring for people over sixty-five are discussed as if they were intrinsically scarce, rather than the result of policy. So-called reformers save funds for cronyism and making war that might relieve distress. The ageism of the 1960s, when Dr Robert Butler cannily coined the term, was a weak precursor of the decline ideology of the twenty-first century' (Gullette 2011, 13).

In an American culture where '[p]owerful links are made between aging, sickness and death' (Andrew 2012, 56) biomedicine has become seen as the answer to the supposed economic and social challenge this greying population poses. Estes argues that 'Despite the reality that the greatest burden of disease in old age now stems from chronic rather than acute conditions, public policy regarding medical care for the elderly clings to a medical engineering model, which constructs health and illness based on a rational system of causes within the context of the body's cellular and biochemical systems' (2001, 47). This 'social construction of aging as a medical problem' (Alford et al. 2001, 46) has made the 'treatment' of ageing a significant (and profitable) domain for the medical industrial complex and it has readily 'assumed the task of preventing, hiding or halting the aging process via the biotechnological advancements' (Andrew 2012, 56). One of the effects of the biomedical model of ageing is that growing older has become a 'personal problem . . . a universal condition of decline resulting from our biology. There's nothing to do about it until science solves it' (Gullette 2011, 5). As Gullette further explains, '[t]he "problems" of older bodies are not seen as a collective responsibility and the turn to the medical to understand means that society fails to recognise that aging-into-the-middle-years, or aging-into-old-age, or even aging-past-youth, can be better or worse depending on social context' (Gullette 2011, 5). Rather than focusing on the ways in which social prejudices and economic policies mean that human beings are, in Gullette's phrase, 'aged by culture' (Gullette 2004, 12), medicine's dominance of the discourse of old age has both constructed and reinforced negative stereotypes because '[i]n general, the medical model focuses its attention on the pathology of aging, considering sickness to be the "natural" consequence of biological decline' (Andrew 2012, 56). This has resulted in a gerontological discourse that others and defines those in older age as 'invariably inactive [and] lonely . . . a victim of . . . biological decrements' (Tulle-Winton et al. 2000, 74–75).

The biomedical model of ageing means that instead of 'countervisions and alternative experiences' (Gullette 2011, 24) the narrative of older age is dominated by an ageist decline ideology and '[p]eople see ahead of them, in grim shadowy forms, the prospective life-course narrative that the dominant culture provides – an unliveable mind and unrecognizable body, mountainous expense'. (Gullette 2011, 24). Carl's disgust at the frail, depressed and aching bodies of ageing adults isn't just personal or a reflection of a certain sort of 'death averse' personality trait, but it also reflects a wider social belief in the 'facts' of ageing, which equate America's elderly with 'disengagement from paid work, dependence on welfare and the erosion of social and cultural status' (Tulle-Winton et al. 2000, 75). The very existence of the chronically ill - '[a]n estimated 80–85% of people over age 65 have at least one chronic illness, and nearly one-half of older people report that chronic illness limits their activity to some degree' (Jamshidi et al. 1992, 169) - counters the 'special faith' (Grob 2010, ix) that US culture places in its healthcare because of the hope that it can 'prevent disease, promote health, and extend longevity' (Grob 2010, ix).

Adult and ageing bodies suffer from conditions that undermine the 'prevailing metaphors of medical education' that have been described as 'linear (find the cause, create an effect), and hierarchical (doctor as expert)' (Shapiro et al. 2009, 195).

Conclusion

The aged bodies that Carl sees in adult medicine don't require technological or pharmaceutical intervention, but rather compassion for their mundane and all too human distresses. When Carl declares that he 'never wanted to make anyone better anyway' (Adrian 2012, 121) it might seem heartless and counter to the belief that physicians hold the power to make things 'better'. But America's rapidly ageing population challenges such narratives of progress and undermines the central authority of the physician to offer a definitive cure.

One of the contradictions of modern biomedicine is how its practitioners are, on the one hand, drawn into an intimacy with the human body, but on the other hand are distanced from it by the processes of diagnosis and treatment that reduce people to body parts, and which convert bodies into categories of disease.

But rather than successfully shielding him from ambiguity, Carl's medical career is destabilised by reversals, and he is constantly drawn back to the susceptibility of the human body and his obligations to it. By the end of the story, he is his parent's carer, feeding him morphine milkshakes like a baby bird and ignoring his delirious father's commands to 'go to his room' (Adrian 2012, 129). Finally, Carl's destiny is reduced to doing the 'smaller human thing' that the angel demands of him, holding his father's dying body - '[j]ust put your hand to him and he will be healed . . . [j]ust put out your hand to him, and you will undo all the pain you've caused me' (125). Carl cannot be the Messiah who calls a sick man 'out of his bed' (130) and his touch does not cure his father, nor is it a grand destiny or a miraculous medical intervention. Yet the moment of intimacy is a 'great relief' to Carl, and he knows 'it must be to [my father], too' (132). Carl's father's final moments are chaotic and 'wordless' but 'lovely' (131) and Carl believes he is finally having 'the conversation' advocated by palliative care 'where you sort everything out and say your goodbyes' (132). At the moment of his death, Carl's father's ailing body no longer terrifies him and his face becomes 'beautiful, still yellow and sunken, but now utterly lovely' (131). However, it is unclear if the 'beauty' that Carl sees in his father's face (and in his own and the angel's face) is truly transcendent or because of the effects of the 'too good' (131) Ativan he is swigging. There is no clear resolution to the story and no sense that this is a moment that will 'turn around' (122) Carl's life and which will see him come to terms with his past and take responsibility for his disordered existence.

Rather than offer resolution, the ending of the story depicts a moment of genuine intimacy and tenderness as Carl sits next to his father 'who must have died sometime very recently' and puts his 'hands on his chest, and my head on my hands, and stayed that way for a long time' (133). Kollmer comments that '[s]cience and technology teach physicians how to treat disease, not how to help patients live with chronic, debilitating illness, or how to die' (Horton 2019, 3) and Adrian's short story can be read as a response to this repressed predicament which sits at the heart of medicine. 'A Better Angel' reveals the ways in which medicine tries to evade the problematic ageing body through a reversion to binaries that privilege youth, denigrate the old and promote 'clinical distance' (Coulehan

and Williams 2003, 10). The story explores how medicine might instead try to 'grow up' and embrace the ambiguity of sickness and the inevitability of ageing, by accepting that the complexities of growing old are central to our experience of what it means to be human.

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