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## The Manual of Disaster: Creativity, Preparedness, and Writing the Emergency Room

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# THE MANUAL OF DISASTER: CREATIVITY, PREPAREDNESS, AND WRITING THE EMERGENCY ROOM

Andrea Charise and Stefan Krecsy

## Abstract

This essay offers a critical examination of creativity discourse at the intersection of two disciplinary fields: health and humanities. In contrast to creativity's longstanding associations with making, imitation, or invention, we examine the relatively recent emergence of what we call creativity's *preparatory capacity*, particularly within critical discussions of healthcare and illness narratives. Working with fictional representations of the emergency room in physician-writer Jay Baruch's short story collection *Fourteen Stories: Doctors, Patients, and Other Strangers* (2007), we identify how particular narrative techniques are revealed in a range of emergency scenarios—both within and beyond the fictional setting—and what such deployments of creativity might signal for the future of literary studies more broadly.

## Keywords

creativity, the creative turn, health humanities, medical humanities, emergency, illness narrative, memoir, short story, physician writing, Jay Baruch, Arthur Frank, Don DeLillo, crisis, literary studies

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# THE MANUAL OF DISASTER: CREATIVITY, PREPAREDNESS, AND WRITING THE EMERGENCY ROOM

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**W**e begin with an aviation emergency: a plane has lost all power and its cabin crew is attempting to convince panic-stricken passengers that they are seconds away from a crash *landing* rather than a crash, full-stop. Apparently, there is some relief to be found in this distinction:

The basic difference between a crash and a crash landing seemed to be that you could sensibly prepare for a crash landing, which is exactly what they were trying to do. The news spread through the plane, the term was repeated in row after row. “Crash landing, crash landing.” They saw how easy it was, by adding one word, to maintain a grip on the future, to extend it in consciousness if not in actual fact. They patted themselves for ballpoint pens, went fetal in their seats. (DeLillo 91)

Then, as abruptly as they cut out, the engines come to life again and the plane lands safely at the nearest airport. This account of “sensibly” preparing for an anticipated catastrophe appears in Don DeLillo’s novel *White Noise* (1985), a fictional exploration of disaster preparedness—and, more importantly, the ways language and storytelling inflect, even structure, this process. For where other methods of preparation fail—the “Manual of Disasters” that a stewardess consults as she is pinned to the bulkhead, or the “death simulator in Denver” (90) that the Captain experienced during his training—the creative rebranding of the crash as a landing succeeds: not in forestalling the crash, but rather in making both the crisis and the passengers governable. The creative deployment of a single word allows the passengers to “maintain a grip on the future” by connoting two strategic fantasies: that the disaster’s appalling sequelae might be contained, and, that a catastrophic event can be prepared for even when its causes are, in the critical moment, unknown.

*White Noise*’s satirical trove of miscellany—be it the inexplicable “Airborne Toxic Event” (124-5); the “simulated evacuations” of Advanced Disaster Management, whose corporate mantra promises that “the more we rehearse disaster, the safer we’ll be from the real thing” (195), or the experimental drug “Dylar,” which treats nothing less than the user’s “fear of death” (187)—constitutes the set dressing for the novel’s interchangeable practice environments: emergency preparedness, academia, and hospital

admissions. In the years since DeLillo published *White Noise*, a range of disciplines have increasingly asserted the value of “creativity” and a shared discourse of “creative” solutions to crisis. As we shall argue, the deployment of creativity as a means to pre-emptively anticipate, manage, and manipulate the future calls for more rigorous examination of this concept’s far-reaching applications and global appeal—both within and beyond the literary-textual scenario.

A notoriously protean entity, creativity at once resists clear delineation while proliferating definitions. Here we are not making a universal or essentialist claim regarding creativity (of the sort advanced by Richard Florida, who describes creativity “as biologically and intellectually innate a characteristic to *all* human beings as thought itself” [4]). Instead, alongside Ken Robinson, we read creativity as akin to “applied imagination,” the process of putting one’s imagination to work, wherein creative insights or innovation “occur on the way to something: to meeting the overall objective, or to solving the central problem” (1999, p. 31).<sup>1</sup> Here, we attend to a novel use of “applied imagination” that characterizes creativity as a transdisciplinary technique for preparing for (rather than preventing or remedying) emergency in complex, often crisis-prone, environments.

By elaborating on this aspect of what has been called the “creative turn” (Harris 2014), we are not attempting to comprehensively delineate the characteristics of creativity *as such*. Instead, we identify the emergence of a preparatory strain of creativity discourse. From business to education to industry and medicine, disciplines far removed from art and aesthetics now claim creativity as a foundational aptitude. Across these disciplines creativity has become increasingly mobilized in response to “solving the central problem[s]” of our time, particularly in perceived or anticipated moments of crisis, uncertainty, and complexity. Creativity is valuable, it seems, because it allows us not only *to prepare* (a very different outcome than the making, imitation, or invention that have constituted creativity’s conceptual history over the centuries) but also *to respond* to a climate of urgent and perpetual crisis. It is creativity, and specifically what we term its *preparatory capacity*, that remakes the terrible finitude of the crash into a crash landing.

In what follows we focus specifically on the emergence of creativity discourse at the intersection of two disciplinary fields: health and humanities. Health (or “medical”) humanities is an interdisciplinary field that encompasses the critical exploration of human health and illness through the methods and materials of the creative arts and humanities.<sup>2</sup> From the macro-level of health system organization to the micro-texture of patient experience, healthcare practices around the globe provide a scenario ripe for creative intervention as rising demand, spiking costs, and profound inequities in patient access and outcomes present near-universal challenges. At the same time, healthcare offers a conceptual framework, lexicon even, for a more critical, humanities-based examination of creativity’s deployment within scenes of health and medicine, fictional or otherwise. We also write as

researcher-practitioners with thick experience working at the intersection of these epistemological and disciplinary domains.<sup>3</sup> It is from this perspective that we assert the need to more rigorously theorize the work of creativity as a humanistic endeavour with relevance to health, and why the emergence of creativity discourse within health practice and its fictional representation is, in fact, an issue with profound relevance to humanities disciplines, literary studies especially.

To be clear: we are at once eager and distrustful readers of creativity. We do not dispute the pleasures of—or inherent value in—the summoning of novel ideas and associations *ex nihilo*, nor the transformative leavening of classical *techne* into the *excogitatio* that has comprised the necessary condition of artistry in western culture since the late Renaissance period. Instead, our objective is to trace a specific ideation of creativity and its associated textual patterns which, we argue, are shared across a variety of fields—but especially in the context of fictional writings that involve situations of medical emergency. To foreshadow our analysis, we see the particular narrative logic of *creativity as a form of preparedness* most clearly expressed in the formal tendencies of emergency narratives, whose distinctive literary-textual elements frequently involve *in media res*, interruption, and (what we call) curtaining.

To better understand how creativity is deployed as a means of preparing for an immanent emergency, we first assess the emergence of creativity's preparatory capacity within critical discussions of healthcare and illness narratives. For sociologist of health Arthur Frank, while the experience of illness tends to cause a narrative "wreckage"—in which the "present was not what the past was supposed to lead up to, and the future is scarcely thinkable" (55)—such wreckage can only be organized and made legible once more through creative, and specifically narrative interventions. We then turn to fictional representations of the emergency room in physician-writer Jay Baruch's short story collection *Fourteen Stories: Doctors, Patients, and Other Strangers* (2007), where creativity is explicitly invoked as an authorial and clinical tool for navigating scenes of medical emergency. Working within Baruch's stories, we identify how particular narrative techniques emerge in the creative pursuit and representation of healthcare practice. Yet the narrative structure of the emergency room often overlooks, or excludes from consideration, one crucial detail: explanation of cause. When considered at all, cause in the crisis scenario remains uncertain, unclear, and ultimately, unimportant. DeLillo's vignette stages this scene in miniature (where the airplane both loses and regains power for no apparent reason). Likewise, throughout Baruch's stories of the emergency room, crisis and its pendent, creativity, become the white noise of everyday experience—something which has "just been happening, more or less to everyone" (DeLillo 52).

Though our focus remains on one particular expression of creativity (namely, the narrative dimensions of creative responses to, and preparation for, a complex or uncertain future) we recognize that this is taking place

within a contemporary moment in which creativity has become, in the words of Thomas Osborne, a “kind of moral imperative” (508). As we will make clear, the creative turn has become a trajectory: one whose language and attendant values are deployed largely without much recognition of its novelty, or the way such discourse may be used to frame—and thus articulate available solutions to—complex, “wicked” problems. In this context, calls to creativity across a vast range of disciplines must be read, at least in part, as the sign of an expanding triage mentality: a practical, rapid-treatment application for managing resource scarcity (real or perceived), disparities in supply and demand, burnout, and multi-system failure. Part of our work, therefore, is to demonstrate the value of narrative competence and the work of literary scholarship: not only the theoretical and aesthetic insights gleaned, but its import, power even, for better understanding the practical and imaginative settings of healthcare and its practices. We conclude by considering how creativity’s fostering of a triage paradigm—in a range of emergency scenarios, within and beyond the fictional setting—has direct implications not only for literary studies, but for the future of the humanities more broadly.

## Creativity as Preparedness

**T**he history of creativity and its shifting significance in Western thought has been thoroughly outlined by theorists including (to name only a few) Tatarkiewicz (1980), Sternberg (1999), Boden (1994, 2010), and Csikszentmihalyi (2009), although this history reaches back at least as far as Plato’s discussion of artistic creation in *The Republic* (c. 380 BCE). In the early nineteenth-century, William Wordsworth identified the poet’s creativity as “a healthful state of association” necessarily linked to the senses, anticipating to great extent the mid-twentieth-century formulation of creativity as essential to self-actualization (Maslow 1959). Creativity has therefore encompassed diverse, even contradictory meanings over time, ranging from imitation, inspiration, recombination, to making. The question of how to define “creativity” and “today’s creativity discourse” still provokes discussion (Harris 11), notwithstanding the popularity of Robinson’s notion of “applied imagination,” in which creativity constitutes the “process of having original ideas that have value” (2006, n.p.).

Yet one truth is evident: we live in the midst of a new phase of creativity’s timeline. What we are calling creativity’s *preparatory capacity* is perhaps nowhere more evident or concisely expressed than in the United Kingdom’s National Advisory Committee on Creative and Cultural Education (NACCCE, spearheaded by Robinson)—and its report, notably entitled *All Our Futures: Creativity, Culture, and Education* (1999)—which makes the association of creativity and futurity explicit.<sup>4</sup> In a similar vein, Richard Florida has served as a panegyrist to preparatory creativity, with such works as

*The Rise of the Creative Class* (2002), *Cities and the Creative Class* (2004), and *The Flight of the Creative Class* (2007), presenting the “creative class” as the necessary precondition for a vibrant, future-oriented new economy. Nassim Nicholas Taleb’s *Incerto* series (including the 2007 *New York Times* bestseller *The Black Swan: The Impact of the Highly Improbable*) argues for the necessity of flexible, creative thinking in the face of growing global complexity. All these popular writers articulate, in their own way, what Anne Harris identifies in *The Creative Turn: Toward a New Aesthetic Imaginary* (2014), as a trend among “industry and education leaders [who] are claiming that creativity is the one skill or disposition that can take us into the prosperous future, so everyone needs it” (4).<sup>5</sup> Creativity, in other words, has become that one needful thing insofar as it promises to meet the anticipated contingencies and complexities of the future. As the future grows ever more uncertain, it would seem, so too does creativity become ever more needful.

A similar rationale can be traced in the contemporary health setting, where creativity has been taken up by a range of medical educators and health practitioners as a way of better preparing for the challenges of clinical practice. Of course, we recognize the work of medical and health professionals as thoroughly creative: from the imaginative energy of formulating diagnoses, to the centrality of standardized actor-patient simulations and simulated settings in clinical education (including the OSCE or “objective structured clinical examination”), problem-based learning, “crash call” or trauma scenario training, or even the development of “the empathetic imagination” often cited as the basis of patient-centered health practice and educational aims (Munt and Hargreaves, 290).<sup>6</sup> To date, however, physician Alan Bleakley’s *Medical Humanities and Medical Education: How the Medical Humanities Can Shape Better Doctors* (2015) offers the most comprehensive consideration of medicine’s explicit engagements with creativity. In an admirably anatomizing overview of creativity’s multiple typologies, Bleakley explores creativity as an instantiation of humanities-based curriculum within the context of medical education. In a discussion of “Creativity as originality and spontaneity,” for example, Bleakley bridges the creative impulses of literary fiction with the objectives of medical practice: “In brief, readers have to fill in gaps, invent and elaborate as well as be left, sometimes, puzzled and confused in the face of ‘serious’ fiction. The parallel in medical education . . . is the patient’s narrative – complex, half-formed, laced with unsettling details, riddled with the ‘unsaid’ and so forth – that the doctor must ‘read’” (120). His stated objective is to more clearly account for the types of “innovations in medical education” that can, in the presence of the humanities, “facilitate creative change” (109).

For Bleakley, creativity emerges as a cipher of humanities-based, often explicitly *literary*, skills. Creativity, to large extent, entails a certain degree of narrative competence that is thoroughly imbricated with the futures of clinical education and medicine itself. Notably, Bleakley cites “preparedness” as enabling “Creativity as serendipity” (130), wherein “[t]

he active process of creation . . . may be literally to dip into a text in a calm fashion and see what comes up, by chance. This is quite different from both frantic search and pedantic research” (131). Elsewhere, emergency physician and short story writer Jay Baruch articulates a similar position concerning the role of creativity in medical education: “Traditional skills and expertise are not enough to prepare future physicians for the complexity, instability, and uncertainty of clinical practice. Responding and making meaning from ill-defined or unusual problems calls for, even demands, creativity” (2017, 40). While we will return to Baruch’s fictional work later, for now it is enough to highlight the fact that Baruch and Bleakley articulate a notion of creativity that, we argue, is applicable far beyond clinical practice. In claiming creativity’s role in preparing physicians for future care work, Baruch provides a clear summation of, and corroboration for, what we mean by creativity’s newly *preparatory* capacity more broadly. That is, to face future environments riven with instability, complexity, and uncertainty—which give rise to complex and novel problems—it is necessary to deploy “creative” solutions, which are increasingly framed as the product of applied humanistic and literary, indeed narrative, training and skills. Whether the complex environment is as localized as the emergency room or as broad as states of emergency (declared and undeclared), a similar conception of creativity is evidently at work.

The remainder of this paper limits itself to the treatment of creativity as represented in the literature of the emergency room. We do so not only because this application of creativity in health humanities demands further treatment on its own merits, but also because it serves as a representative case study for creativity more broadly. In this context, creativity is invoked as an antidote to failures of care, particularly in the form of storytelling; it is creativity that helps us prepare for our potential, if not already realized, patienthood.

## Creativity and the Futures of Illness

Like other foundational health humanities texts—including Rita Charon’s *Narrative Medicine: Honouring the Story of Illness* (2006) and Arthur Kleinman’s *The Illness Narratives: Suffering, Healing, and the Human Condition* (1988)—Arthur Frank’s *The Wounded Storyteller: Body, Illness, and Ethics* (1995, 2013) presents the literary imagination as the creative force required to make sense of illness and its interruption of health or, at least, life-as-normal. *The Wounded Storyteller*, like Frank’s autobiographically-inflected theorizations of illness more generally, identifies common patterns of illness representation in the western context.<sup>7</sup> Furthermore, and crucially for our purposes here, *The Wounded Storyteller* achieves its goal by presenting creativity as the means of not only mapping or organizing patterns of illness experience, but specifically *preparing for the future*: transforming a vaguely imagined potential patienthood into a predictable future of illness through

the possibility of its narrative recounting.<sup>8</sup> The ability to readily identify patterns of illness storytelling is the goal of what Frank calls a “remission society.” The capacity to creatively forge one’s own relationship to sickness, and conceive of life lived in the midst of health and illness, is no less than the remission society’s necessary condition.

Significantly, Frank elaborates upon the representational nature of illness-related “narrative types,” identifying specific literary techniques, plot structures, and syntax characteristic to each kind of illness story. *The Wounded Storyteller* focuses on the textual anatomy of three predominant types: the *restitution narrative* (in which illness is positioned as a transitory interruption of health, typified by heroic “survivor” stories), the *chaos narrative* (in which illness is represented as utterly and irremediably overwhelming a sick individual’s personhood, for example, in the typical case of Alzheimer’s dementia), and the *quest narrative* (wherein the sick person is neither cured nor overwhelmed by illness, but finds ways to live with and alongside such a condition). In highlighting the distinct narrative elements of powerful patterns of health storytelling, Frank’s work provides a high-level, neo-formalist view of the creative literary representation of health experience.

The entanglement of creativity and futurity is most dramatically staged in the context of the chaos narrative. Signalled syntactically by an entropic “and then and then and then” structure (99), chaos narratives present an urgent and incessant representation of an overwhelming present, often undermining narrative coherence and, accordingly, conventions of credible storytelling. Frank makes this point clear: “The lack of genesis in chaos stories has its corresponding lack in any sense of the future” (108). Moreover, in their “incessant present tense . . . the repetition of ‘and then’ losses and assaults admits no future, only a perpetual present” (204). As in the DeLillo passage cited earlier, in the midst of an abruptly encountered emergency, the immediate threat of a crash critically interrupts the creative possibility of a tolerable future. The acute temporality of the chaos narrative becomes an especially attractive site of attention for literary representations for medical emergency.

By contrast, the narrative delineations of the restitution arc—*today I am sick, but tomorrow I will be well again*—proscribe a singular, inevitable, and ultimately secure grip on the future. “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. . . . In the extended logic of restitution, future sickness already will have been cured” (Frank 90). The restitution structure is therefore ill-equipped to provide its storyteller—and others who adopt or assume it—with outcomes other than cure, recovery, survival, and conquest. The narrative vulnerability signaled by such representational tactics is similarly critiqued by Frank’s broader plot-based view: “When restitution does not happen, other stories have to be prepared or the narrative wreckage will be real” (94). In the context of representing illness experience, the urgent need *to prepare for*

less-than-optimal outcomes is both the engine and outcome of creativity.

One of the reasons the restitution narrative remains so robust, Frank argues, is that it reflects “one of the best impulses of modernity: the heroism of applied science as self-overcoming” (92). With reference to sociologist Robert Zussman’s case studies of medical ethics and time-pressured decision-making, the emergency room becomes the setting for “the banality of heroism. If [medical house-staff] are heroic . . . they are heroic in the routine course of *doing their jobs, preparing for the future, and getting through the day*” (Zussman, cited in Frank 92-93; emphasis added). A comparable point is made by Susan Sontag in *Illness As Metaphor* (1978) and its follow-up companion text *AIDS and Its Metaphors* (1989). From fighting disease, to improving immune defences, to aggressive medical interventions, and ultimately winning (or losing) hard-fought battles with illness, military metaphors, like the narratives of cure they populate, engineer heroic endings, tragic or otherwise. The emergence of a genre of literary writing that focuses on the working lives of such medical figures is therefore an ideal opportunity to refine our understanding of the entanglements of creative representations of health and illness with contemporary creativity’s emphasis on preparedness and futurity. Medical professionals whose literary writing focuses on this nexus of issues provide the most reflexive inroad into these ideas, and so we pivot to the ways that creativity discourse is operationalized in literary treatments of the clinical setting and the emergency room.

## Creativity as Clinical Tool

**F**or the past two decades, storytelling has been championed as a central concern of medical practice. As well, an increasing number of physicians have creatively represented their practice in fictionalized narratives—witness geriatrician Louise Aronson’s *A History of the Present Illness* (2013) or internist Charles Bardes’ *Diary of Our Fatal Illness* (2017). Emergency physicians in particular have been drawn to representing their experiences in fiction: while Vincent Lam’s Giller Prize-winning *Bloodletting & Miraculous Cures* (2006) is perhaps the best-known example, in this essay we take as a case study the writing of Jay Baruch, an associate professor in Alpert Medical School’s Department of Emergency Medicine at Brown University. Baruch’s prolific critical and fictional writings make him one of the most careful and reflexive thinkers of creativity in contemporary medicine and health humanities today. As evinced in articles like “Creative Writing as a Medical Instrument” (2013) and “Doctors as Makers” (2017), as well as two short story collections (*Fourteen Stories: Doctors, Patients, and Other Strangers* [2007], *What’s Left Out* [2015]), Baruch recognizes—and indeed experiences on a day-to-day basis—how illness is structured by underlying narrative patterns. Dedicated to the dual roles of “writing and doctoring, creatively”—as the byline for his personal blog puts it—Baruch advocates for creativity as a necessary response to the

irreducible complexity of medical treatment.<sup>9</sup> Building upon Frank's insights into the role storytelling plays in the experience of patienthood, Baruch argues that since "uncertainty and ambiguity make up the ambient reality of medicine," creativity and narrative techniques are "valuable clinical skills" (2017, 40).

In the Afterword to *Fourteen Stories*, Baruch "confess[es] that the most important year of my medical education was the year I spent away from formal training to begin a commitment to writing creatively" (FS 138). This year in the service of literature provided the tools of "literature and writing ... elements like motivation, character, tone and point of view," which allowed the physician-author to hear and heed the stories of his patients. For Baruch, these stories represent the realities medical students will face practicing medicine in the emergency room, and prepare medical students for these very realities. Elsewhere in his critical writings Baruch reiterates this position. In an account that mirrors the claims of the broader "creative turn" across a number of fields, he contends that creativity—and literary techniques more specifically—can, and indeed should, be divorced from "humanistic goals [and] instead ... [be deployed] as valuable clinical skills" (2017, 40).

As literary critics and readers, we have no objection to such a creative repurposing of our traditional subjects, objects, and modes of analysis, or even the distinction Baruch makes between humanistic goals—however they may be defined—and clinical practice. However, given our familiarity with such *tools*—to use that instrumentalist word—we wonder whether applying old tools to new problems can provide novel solutions as well as unforeseen complications. As with any toolkit, those that are readily at hand tend to frame how problems are conceived and, correspondingly, to constrain or condition possible solutions. If, as Baruch suggests, the "tools of literature" (2017, 40) can be (re)deployed as clinical tools to lift the curtain on patients through their stories, it remains to be seen what, if anything, remains outside the bright lights of the emergency room.

Where Frank foregrounds how creativity is deployed by *patients* as a way to order their own experience and prepare for their own future of illness, Baruch calls for creativity as a way for the *clinician*—as much as the ill-person—to prepare for the complexity and uncertainty which marks the chaotic environment of the emergency room.<sup>10</sup> While storytelling and listening are part of any medical setting or experience, for Baruch these skills become particularly vital given that the "crux of ED [emergency department] practice involves listening to stories, sometimes as many as thirty new stories each shift" ("Afterword" FS 138).<sup>11</sup> Although Baruch is trained as an emergency physician, he states that he is "first and foremost a professional story listener" (41). Or, as he puts it, his success as an emergency physician is defined by his success in becoming a "prepared" rather than a "pressured" listener:

So how do you get to the heart of the patient's tale when you're a 'pressured listener' trying to understand a pressured storyteller

in a chaotic environment. In my twelve years of practice as an emergency physician, I've found myself leaning more on the tools of my other life in literature and writing. By implementing literary elements like motivation, character, tone and point of view, I hope I have become a more curious and astute prepared listener. ("Afterword" *FS* 139)

While Baruch foregrounds "character, desire, and conflict" as the key elements that constitute the "anatomy" of his stories (41), we want to follow Frank's lead and consider the broader narrative structure of these stories of the emergency room. Indeed, Baruch's own reflexive consideration of his clinical and creative work reveals certain narrative patterns that we tentatively call *the narrative structure of the emergency room*.<sup>12</sup>

To begin, Baruch suggestively describes the Emergency Department as "*narrative's disaster zone*" (*FS* 139, original emphasis). Note the possessive here. With this phrase, Baruch not only acknowledges the popular conception of the hospital emergency as a site of countless stories of disaster and crisis, but also that the narratives which treat such disasters are shaped by and through this exposure. In other words, the emergency room is not only a site of creativity and narration, it is also a unique narrative environment. Furthermore, what marks this particular "disaster zone" is the difficulty of listening to "stories . . . told by people I'd never met before, at a heightened moment when the problem could no longer be ignored or the internal pressure could no longer be contained" (*FS* 138), in an institutional setting that is both "overcrowded and understaffed" (*FS* 139). In emergency, disaster is treated both as content and form: a space of continuous and perpetual crisis that must be addressed to some extent through storytelling, narrative, and creative attention.

Two associated formal components of this narrative disaster emerge throughout *Fourteen Stories*: first, a tendency for narratives to begin *in media res* (in the middle of things). Baruch likens the experience of storytelling and listening to "opening *Anna Karenina* in the middle and getting your footing. That's where I enter patients' stories - in the middle . . . The stakes are high" (*FS* 138). Coupled to this is the associated tendency for the stories to be constructed by and through a series of interruptions, in so far as "interruption is the hallmark of the encounter. One study revealed that ED [emergency department] physicians were interrupted approximately 10 to 11 times per hour" (*FS* 139). Interruption, the emergency department's hallmark encounter, becomes a formal attribute not only of the clinical encounter, but also of *Fourteen Stories*. Take the galloping opening of "Dissections" as a representative example: "After drawing blood from her patient who was dying of AIDS, Sophie Davitt, third-year medical student, accidentally stuck a needle into her own sweaty palm" (*FS* 91). Here the reader is introduced to a clinician-in-training tending to a dying patient, only to have this narrative thread abruptly broken. No sooner are we introduced to one unfolding story—the

dying patient—does a second one—the medical student’s exposure to HIV—interrupt and re-orient the narrative focus toward Sophie and her eventual withdrawal from medical practice. Thereafter, as though following a peculiar form of narrative triage, the patient drops out of the story entirely.

If these formal characteristics constitute emergency as a narrative disaster zone, Baruch believes that creativity and the tools of the humanities can prepare a physician to hear, listen, and comprehend the complexities and nuances of a given patient’s story, even in the most pressured of environments. Rather than shoehorning the narrative wreckage of an ill person’s story into something that resembles a “recognizable story [which] ... may be totally different from the one the patient is telling” (FS 141), it is the tools of humanities, literature and creativity foremost among them, which prepare physicians to more conscientiously encounter these pressured storytellers.

However, if we closely attend to Baruch’s stories, we can also identify a third formal characteristic of his stories of the emergency room: namely, a curtaining of cause. By this, we mean the tendency for such narratives to present crisis or emergency with limited or no accounting for the disaster’s etiology. Much like the excerpt from *White Noise* that opens this essay, such stories of emergency present crisis as a sort of inevitable background condition, a sudden irruption into the present which can only be prepared for in advance and responded to in the moment. Baruch’s “Dissections” again serves as a representative example of this formal characteristic. Following Sophie’s withdrawal from medical school, the narrative abruptly jumps several years into the future, where the one-time medical student is now a creative writer and single mother. This interruption both in characterization and time is represented textually by a dinkus (\*\*\*) , after which the reader is presented with what effectively reads as a non-sequitur: “Blood poured from Anton’s scalp and under the neck of his T-shirt” (FS 94).

Once again we encounter the formal components of a emergency room narrative, one that mirrors the narrative state of confusion and uncertainty that Baruch identifies as characteristic of the emergency room itself. Like an emergency clinician, readers of *Fourteen Stories* are constantly presented with sudden arrivals. In “Dissections,” a series of questions quickly arise: who is Anton, and why is blood pouring from his scalp? While the answer to the first question is revealed soon enough—Anton is Sophie’s six-year-old son—the answer to the second—the cause of Anton’s injury—remains unclear. In fact, within the narrative, these questions cannot be answered in any satisfactory or authoritative way by Sophie. While she suspects he was hit by a car, she “didn’t actually see it happen” and, “Truth be told, she couldn’t remember if Anton was wearing his helmet. More troubling to Sophie, she had no idea where her six-year-old son, his scalp oozing blood, was before he found her working in the garden at the front of the house” (FS 96). The whole car crash scenario is conjectural, a response Sophie constructs in the face of a “nurse named Mrs. Randolph [who] pestered Sophie to retell

the story” (FS 95). Here, we have a neat encapsulation of the qualities of an emergency room narrative. The exact cause of the emergency is obscure and, in a certain sense, unimportant to solving the crisis at hand: while Sophie is ultimately found not-responsible for Anton’s injury, the narrative occludes the police investigation which ultimately finds that a car *did* hit her son. It is telling that when Sophie summarizes her experience near the end of “Dissections,” she does so by claiming that “[t]ragedy finds you, that’s all ... not everything happens for a reason.” (103). Sophie not only articulates a formal notion of crisis that shares much with *White Noise*—whereby crisis is “something that just happens”—but her summary (“that’s all”) consolidates the formal characteristics of these emergency narratives: curtaining, interruption, *in media res*.

With this in mind, we want to expand on Baruch’s assertion that the emergency room is not only a space where narratives of disaster are told and heard, but also a space where something disastrous happens to narratives. When literary tools are deployed as a response to and preparation for “emergency,” what does their deployment reveal about the capacity and limitations of creativity in addressing such chaotic environments? What does the narrative structure of the emergency room tell us more broadly about the effects and potential side-effects of this creative treatment of crisis? Our point is not to criticize emergency room narratives or healthcare practice, nor to denigrate the creative work performed in responding to crisis. In the emergency room, crisis presents itself on the doorstep and healthcare providers are responsible for resolving it as best they can, be it in ad hoc or narratively creative ways. Their responsibility is to address the medical emergency, not redress the etiological causes of crisis. All this makes sense in the context of the emergency room, yet, we wonder what are the effects of such creative solutions beyond this setting, in institutions which are increasingly under the sway of the same creative turn.

Certainly, Baruch recognizes that storytelling and creativity is far from a panacea. *Fourteen Stories* is filled with misdiagnosis, improper care, broken lines, and missed veins. However, it is the curtaining of cause that Baruch’s work foregrounds as the limit of creativity. To clarify this claim, we turn to Baruch’s twelfth story, “Frozen.” As with “Dissections,” the formal elements of the emergency room narrative are evident, not least of which its opening line, which once again immerses the reader in the midst of a medical emergency, an already-dying patient whose identity and affliction are occluded (“David Coyle, a third-year medical student, searched ice-man’s neck for a pulse” [FS 107]). But rather than reiterate the ways “Frozen” abides by the narrative structure of the emergency room, we now consider how this text serves as a kind of meta-fictional representation of, even reflection on, the foreclosures of curtaining and the limits of creativity described thus far.

While treating the “ice-man”—a victim of exposure who is later revealed to be a homeless man named Clyde—David disagrees with his supervising physician, Dr. Spencer, who insists that the patient is beyond medical care

(FS 107-8). Recalling those “hypothermic patients written off for dead who warm up and start moaning in the body bag,” David seeks to apply every potential remedy (FS 107). Eventually, Spencer intervenes to put an end to David’s treatment, asserting that the patient is dead. When David bristles at this, declaring that his supervisor’s premature closure is “contradicting what’s written in all the textbooks,” Spencer retorts that “[b]ooks don’t take care of patients” (FS 111). Reading this, it is reasonable to conclude that the problem represented here is a lack of compassion, a failure to care: if only the jaded doctor was as selfless, empathic and, indeed, creative as the young medical student, then perhaps a life could be saved. But another possible reading is available too, one that foregrounds the literary and textual implications of Spencer’s claim: that this lack of compassion is a reflection of the inability of Clyde’s story to be adequately represented by the narrative structures of the emergency room, a form that presents crisis as an inevitability which must be prepared for rather than structurally addressed or forestalled.

Importantly, Clyde is one of the recurring characters in *Fourteen Stories*, and is represented throughout as a figure of perpetual crisis. As one intern puts it in “Road Test,” when he is admonished that Clyde will freeze if he is allowed to leave the hospital, “[i]t’s an ER, not a bed and breakfast” (FS 58). A callous comment, of course, yet one that acknowledges an underlying reality: Clyde is in perpetual crisis because he is homeless, and what he really needs (as Clyde himself asserts in “House Call,” when he demands Spencer take him into his house to give him proper care) is not creative medical treatment but something mundane, simple, and uncreative: food and shelter. Clyde thus embodies a medical crisis that exceeds the capacity of emergency room narratives to address. His crisis is structural, and so cannot be adequately addressed in the textual constraints of the emergency room genre and its narrative conventions. Clyde, in other words, is the figure behind the curtain; it is not for nothing that one of his final acts in “Road Test” is to close the curtain on himself (FS 59).

We can turn to the final paragraphs of “Frozen” to elaborate this claim. After David admonishes Spencer’s apparent lack of concern for Clyde, Spencer asks if David believes he is a “compassionate person.” David responds that he is because he “care[s] about people” to which Spencer states, “That’s not compassion” (112). Later that evening, in response to Spencer’s distinction between caring and compassion, David opens a dictionary to discover the definition of the latter: not “only sympathy for the distress of others but a willingness to do something about it” (112). He circles this definition with a red marker, the ink of which “quickly bled through the onion-skin pages, scoring the words underneath. *Commoner. Commandant . . . Co-exist. Comatose*” (112). Tellingly, David’s immediate response is to slam the dictionary closed, “hoping some pressure would stop the hemorrhaging at the Cs” (112). In this moment—applying pressure to curtail the bleeding—David applies a trauma care response to a properly *textual* issue: namely, how language and books can tend towards a proliferation, and how compassion must be limited if it is

to be intelligible within the constraints of emergency care, clinical practice, and institutional life more generally. This moment of practical and textual convergence functions as a sort of (en)forced literary stoppage. Lest the bleeding ink—literally described as “hemorrhaging” in the text—becomes unmanageable, it must be stanching by a firm textual closure.

What we sense here is a structural limit to such narratives of emergency: particularly when, and if, they are applied to environments beyond the emergency room. If it is true that creative responses and preparations for crisis tend to inspire a certain curtaining of cause (as both *White Noise* and Baruch’s emergency room narratives indicate), then can we also expect a certain curtaining action to be occurring elsewhere as well? Clyde’s character, like the very real, all too common lives and deaths he signifies beyond *Fourteen Stories’* fictional universe, instantiates the limits of creativity discourse in the emergency room. To meaningfully address crisis, today’s creativity’s proponents cannot be satisfied by its preparatory capacity. Here lies the limit of creativity in the health crisis setting, if creativity is allowed to remain a reactive, ideological curtain to political action and intervention. As the dictionary scene in “Frozen” suggests, truly creative action—like “compassion” in the health care context—must be able to recognize and incorporate the complex factors crisis signals and inevitably bleeds into. Not surprisingly, “Frozen” bears out the challenge of this critical conclusion. As we might now expect given the conventions of the emergency room narrative, having confronted the limits of his tools and unable to reconcile his desire for creativity and clinical duty, David rushes outside to clear his head. Like the yeilding, compliant closure of Sophie’s “that’s all” in “Dissections,” the final line of “Frozen” offers one last, trenchant curtain. Freed from a web of insurgent complexities, the medical student recovers his steady grip on the future: “He braced himself, leaned forward, kept walking” (*FS* 113).

## Writing the Disaster Zone: Creativity and the Crisis of Literary Studies

**T**oday, creativity purportedly allows us to imagine and prepare for our future(s). Yet, it seems to us—as it seemed to a character in DeLillo’s *White Noise*—like “we’re seeing into the future but haven’t learned how to process the experience” (145). In this essay we have examined the ways in which we are attempting to see into our future: as scholars of literature working at the interface of critical health studies, as well as a consideration of what we have learned in processing these experiences. Like “empathy,” “compassion,” “ambiguity,” or even “humanities,” “creativity” has emerged in the health setting as something of a god term (to use Richard Weaver’s phrasing): a forcefully positive, charismatic ideal whose self-evident good makes it difficult, perhaps unnecessary, to dispute.<sup>13</sup> However, our diagnosis of creativity’s contemporary entanglements with an ideology of preparedness suggests how narratives of “the emergency room” reveal more about the

relationship between crisis, creativity, and narrative preparation than clinical practice alone. Crisis and emergency all too often foster a triage mentality, in which creative means of survival and stability effectively silence the articulation, or even exploration, of systemic contributing factors. Emergency room narratives, such as those portrayed in Baruch's short fiction, help us understand that the risk of uncritically celebrating the contemporary creative turn is twofold: first, because the causes of crisis remain largely untreated and, second, such creativity may be ready-made to serve, and ultimately benefit, the very systems that profit from such complexity and uncertainty. While we have focused on literary and textual sources to explore these phenomena, it is apparent that the emergency room—and the creative stakes it entails—is emblematic of a broader trend across a number of fields and practice environments.

For example, with respect to health (or “medical”) humanities itself, one might conclude that the comparatively recent emergence of this interdisciplinary field reflects a broader desire to imagine (that is, prepare for) our own respective futures of illness, disease, debility, and death. Texts like Frank's *The Wounded Storyteller*, and practices of narrative medicine and creative or reflexive writing more generally, are deeply reliant upon the enhancement of empathy as a form of clinical and/or illness preparedness. Creativity is key to catalyzing this orientation toward the future and its attendant complexities, and an increasingly robust basis of evidence demonstrates measurable benefits of individual creative engagement with a range of health professionals.<sup>14</sup> However, if we might also apply some gentle pressure to these truths, our analysis lets us articulate how the literary labour of close reading highlights a general truth about this field: that its conventional focus on the *individual* experience of health and illness (that is, precisely the epistemological orientation that distinguishes health humanities from, say, the big data approaches of epidemiology and public health) is precisely what allows its elision of political commitments, and, what this field might do to actually improve healthcare environments, delivery, and patient experiences.<sup>15</sup> Put differently: there exists a considerable gap between the desire to enhance individual creative practices in the health setting, and the system change required to permit the enlargement of such practices—above all, to remedy the structural factors that give rise to working conditions where creativity is deployed as a remedy for healthcare providers' experiences of compassion fatigue, addiction, and burnout. Just as Frank's *The Wounded Storyteller* thoroughly delineates the seductive power of illness story structures, so should we should consider how a valuable and well-intentioned emphasis on patients' and health professionals' individual experiences of health-related crisis has contributed to a habitual curtaining of the larger system issues that create the occasion for these very scenarios.

The “tools” of literary analysis are therefore crucial to our critical apprehension of creativity's role in the health context, particularly the crisis of preparedness generated in and by the emergency room. But how might

we invert this interdisciplinary exchange, to ask where we might locate the emergency room beyond the clinic? Not every site of crisis is an emergency room, of course. And yet, our delineation of creativity leads us to ask: what happens if the emergency room becomes a widespread, if not dominant, model for all forms of crisis? In so far as these narratives of emergency position crisis as something with an obscured etiology, as an event that strikes out of a clear blue sky, they represent crisis as events which require creative solutions rather than critical explanation and address. In so doing, while ostensibly preparing us for the future, they do so only by imagining and effectively expecting a future of perpetual crisis.

We conclude with our sense that one such misapplication of creativity should be considered in the ongoing “crisis” of the humanities and contemporary literary studies—where, just as in the emergency room, an ambient background and future of crisis is taken for granted. Over the past two decades, if not more, a significant body of literature has made it clear that the purpose of humanities in general and literature in particular has been rendered either obsolete or obscure—as these disciplines are conducted within the university, anyway. In response, creative, often interdisciplinary fields like health humanities have emerged as a moral imperative largely in response to this palliative disciplinary condition. At the same time, creativity (and other hallmarks of the arts and humanities, such as storytelling and narrative) has become legible to disciplines far removed from literature: most often, it appears, by the very disciplines that have long served as antagonists in the imaginations of literary studies and its practitioners.<sup>16</sup>

It would seem that nothing offers a more robust critique of the capacity of narrative and storytelling to address crisis than the experience of literature departments. If this particular setting is any indication, then we might say that the more intimate and reliant one is upon story and narrative for one’s livelihood, the more instability, the more insecurity, the more precarity, and the more crisis one can detect and come to expect in the world. What narratives of futurity all too frequently foreclose are accounts of the present conditions that give rise to instability in the first place, taking the present not as a site of reform or development, but as a site of “preparedness” to come. The conceptual anatomization of creativity therefore helps clarify the value of literature at the present time and why its healthy future is of critical concern. By understanding the ways health practices highlight the connectedness of creativity, preparedness, and narratives of the emergency room, it is clear that the “crisis” of the humanities is not merely some intrinsic or objective reality: it is the product of longstanding political and cultural forces that produce the very instability that “creativity” seeks to prepare us for. Without actively nurturing a clear political and ethical purpose that surpasses literary studies’ conventional attention to individual experience, we stand to lose it all: our tools, our methods, our place at the future table of the present.

## Endnotes

1 We acknowledge that Robinson's use of "applied imagination" is itself indebted to the 1953 work of Alex Faickney Osborn, one of the founders of creativity studies.

2 For further critical discussions of definitions of this field and its objectives, see Jones et al's introduction to the *Health Humanities Reader*; Crawford et al; and Charise.

3 Andrea Charise is a researcher with an award-winning track record in both health sciences and literary scholarship, as well as the founding director of Canada's first undergraduate program in Health Humanities; Stefan Krecsy is completing a doctoral dissertation on the contemporary deployment of storytelling and narrative as a means to manage uncertainty and risk. We both have formal experience collaborating and teaching within interdisciplinary clinical and/or university-based health research environments.

4 Robinson later broadened his audience beyond the United Kingdom with *Out of Our Minds: Learning to be Creative* and his series of online video series, and his 2006 TEDtalk, "Do Schools Kill Creativity?" which, as of mid-2020, has been viewed upwards of sixty-five million times.

5 Beyond these popular texts, there is a concurrent flourishing of "creativity" in fields as disparate as business management, disaster relief, and national security planning. The development of so-called "scenario thinking" provides something of a representative example in this "creative" response to complexity. Scenarios are not "forecasts," in so far as they do "not attempt to simulate a future reality" (Samimian-Darash 371); instead, they seek to provide a series of alternative possible futures. By most accounts, the technique was developed by the American and French governments at the beginning of the Cold War in an attempt to "think the unthinkable" of nuclear war. Its most famous practitioner is Hermann Kahn at the RAND corporation, who explicitly borrowed the term "scenario" in order to link it to the narrative work of Hollywood:

The term scenario was first used in this sense in a group (Kahn) worked with at the RAND corporation. We deliberately chose the word to de-glamorize the concept. In writing the scenarios for various situations, we kept saying 'Remember, it's only a scenario,' the kind of thing that is produced by Hollywood writers both hacks and geniuses (Kahn 6, cited in Gausemeier, Fink and Schlake 113).

6 Yet simulation-based scenario training in medical education has also been criticized for enabling the development of false confidence in medical

trainees and potentially sterile learning environment; see Walsh et al (2017), Quilici et al (2017).

7 Unless otherwise noted, citations are drawn from Frank's 2nd (2013) edition.

8 Such preparedness is facilitated by encountering and, ideally, generating one's own narrative of ill health. Take, for example, Frank's discussion of Gilda Radner, whose "creative response" to chemotherapy-induced memory loss is to videotape her experience. Frank describes how the video's content "fills in part of the hole in her life," and that in doing so, Radner's illness story "is told around the edges of that hole" (100). Memory, Frank writes, "is not only restored in the illness story; more significantly, memory is created. If the story being told is . . . something to live up to, then a future is also being created, and that future carries a distinct responsibility" (61). For Frank, as for literary theorists like Paul Ricoeur, the creative generation of self-identity made legible through narrative is inseparable from the morality of illness storytelling. The ideal scenario, evident throughout Frank's work, is for the transformation of a better defined, singular narrative identity into a moral and indeed political state of communion (no wonder, perhaps, that György Lukács is cited throughout *The Wounded Storyteller*, and that Frank discusses at length their shared interest in "the mysterious reciprocity between creative activity and the primacy of ethics in life" [153]).

9 See <http://www.jaybaruch.com>.

10 For consistency's sake, throughout this essay we employ the more familiar phrase "emergency room" in place of Baruch's "emergency department" or "ED." The setting for and textual uptake of creative discourse is identical in either case.

11 References to Baruch's short story collection *Fourteen Stories* will be designated by *FS* followed by page number (e.g., *FS* 139); references to Baruch's other critical writings will appear by referencing their year of publication and page number (e.g., 2017, 49).

12 This contention, that Baruch's work serves as a representative example of an emergency narrative, is further influenced by Priscilla Wald's work *Contagious: Cultures, Carriers, and the Outbreak Narrative* (2008). In this work, she argues for the existence of "outbreak narratives" – formulaic plots which structure and inform a variety of scientific, journalistic, and fictional accounts of disease outbreaks (Wald 2008). Wald's work demonstrates that ostensibly objective narratives of outbreaks are never simply accounts of epidemiological facts, but also frequently adhere to a generic pattern, a pattern which begins with "the identification of an emerging infection, includes discussion

of the global networks through which it travels, and chronicles the epidemiological work that ends with containment” (2). For Wald, such outbreak narratives are as much about epidemiology and disease spread as they are about the “changing social formations of a shrinking world” (2).

13 In a chapter entitled “Towards a Medical Ethics,” Bleakley describes creativity, like empathy, as a “weasel word, concealing more than it reveals” (107). We gesture here to other considerations of other such keywords in medical education and health humanities that are redolent with “humanistic” values, and which scholars have begun to more critically consider. See, for example, Rebecca Garden’s “Who Speaks for Whom? Health Humanities and the Ethics of Representation” and “The Problem of Empathy: Medicine and the Humanities,” Lowenstein’s “Can You Teach Compassion?”

14 To cite just a few representative examples see Winkel et al, Adamson et al.

15 For a discussion of distinct epistemological approaches taken to interdisciplinary health studies, including arts- and humanities-based interventions, see Barrish (2016, 2020), Charise.

16 Creativity is part of our disciplinary history yet it no longer seems accessible, or feasible, or desirable. Even the digitization of literary scholarship and the growth of Digital Humanities’s constant reference to its creative ethos seems to have reached its zenith, its institutional appeal and healthy funding the target of enthusiasts and sceptics alike. One of the reasons DH has earned its sceptical reception is for the ways its emphasis on creative engagements with the digital rarely acknowledges its (a)political positionality with respect to matters of ethics, representation, and its role in enabling longstanding patterns of marginalization to perpetuate under the guise of creativity and maker culture—a digitally enabled correlative of curtaining, perhaps. If the future of the humanities is to be creative in the ways that interdisciplinary fields like Digital Humanities or Health Humanities are at the current time, it is time to heed the wake-up call – if we have not already missed the opportunity.

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