Chronicles of the Senses: Examining the Role of Sensory Perception in the Lived Experience of Illness in Cancer Memoirs

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Abstract This paper examines how sensory interactions contribute to patients' experiences within healthcare contexts, with a specific emphasis on the five fundamental senses: vision, smell, taste, sound, and touch. Drawing on the cancer memoirs *Close to the Bone* (2019) by Lisa Ray and *Dying to Be Me* (2012) by Anita Moorjani, it positions these texts as case studies to illuminate the role of sensory perception in the lived experience of illness. The paper emphasizes the critical role of visual perception in healthcare, influencing comprehension, emotions, and connections. It explores the evocative capacities of smell and taste, their interrelatedness, and their effect on the experience of illness. Sound is analysed as a symbol of triumph and communal experience, while touch is examined for its capacity to elicit memory and promote well-being. By investigating the dynamic relationships between sensory modalities, this research aims to enhance our understanding of illness narratives and embodied experiences in healthcare. Crucially, it advocates for the integration of sensory awareness into clinical practice, positing that such an approach not only enriches patient-centred care but also cultivates healing environments that attend to the totality of human perception.

Keywords senses; healthcare; illness experience; perception; Cancer memoirs

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Introduction

In *Close to the Bone*, Lisa Ray recounts an episode that draws attention to the role of sensory perception in shaping how we notice and respond to illness. As she weighs the decision to have her blood tested at *Medcan*, an executive health centre, she catches a glimpse of her reflection in the car's side-view mirror. The image that meets her eyes is pale and drawn, at once unfamiliar and telling. This brief act of seeing prompts a recognition of bodily fatigue that had, until then, remained unspoken. The moment becomes a turning point, leading her to accept the need for medical attention. She writes:

> I caught a glimpse of myself in the side mirror of the car. I was transparent, and I was exhausted. What did they say during the Moksha training again, I thought to myself. Was it: your biography is your biology, or your biology is your biography? I closed my eyes and agreed to the appointment. (Ray 278)

Ray's account suggests that perception is not only passive but a form of awareness that precedes thought. It shows how sensory encounters can shape decisions and actions, especially in matters of health. The reflection does not simply reveal fatigue; it gives shape to an internal state not yet fully acknowledged. The visual moment enters the decision-making process, not as diagnostic proof but as a prompt for reflection and action. Her experience points to a broader truth: that the senses

can reveal what the mind resists, and that moments of attention, however brief, can shift the course of care.

This paper explores the impact of sensory encounters on patients' healthcare experiences, focusing on visual perception, olfactory and gustatory experiences, auditory stimuli, and tactile sensations through an analysis of the cancer memoirs of Lisa Ray (*Close to the Bone,* 2019) and Anita Moorjani (*Dying to Be Me*, 2012), which shed light on the critical role of sensory experience in the context of illness and care. Ray's memoir chronicles her battle with multiple myeloma, including a stem cell transplant and subsequent remission. Her story details her successful career, a captivating Bollywood expedition, and a courageous cancer struggle. The second memoir, *Dying to Be Me* (2012) by Anita Moorjani, recounts her experience with lymphoma. The narrative traces her journey from the depths of severe illness and near-death to healing and spiritual liberation.

According to the French philosopher Michael Serres, "if a revolt is to come, it will have to come from the five senses!" (Serres 71). Serres' claim draws attention to the foundational role of sensory experience in shaping perception and thought. In recent years, what has been termed the 'sensory turn' has catalysed the emergence of sensory studies, a field that examines the cultural, historical, and epistemological dimensions of the senses across disciplines. This paradigm shift echoes "linguistic, pictorial, corporeal, and material turns," reshaping academic discourse (Howes, *The Sensory Studies Manifesto* 10). Sensory experiences are not isolated phenomena but are "produced, enacted, and perceived" through their interaction with one another and are grounded in "emotion, meaning, and memory" (Hsu 440). Philosopher of history Frank Ankersmit describes sensation as "the most intimate contact with reality that we can have," distinguishing it from the detachment of observation and the subjectivity of impression (130).

In the context of health and illness, recognizing the interrelation between sensory perceptions and understanding, interpreting, and responding to illnesses becomes paramount. Andersen et al. argue that the historically and socially constructed sensorium influences our engagement with matters of health and illness, noting that "sensory perception is a cultural as well as a physical act" (2). Sensory perception significantly shapes the experience of illness, impacting health, quality of life, and recovery prospects. Visual cues facilitate the interpretation of bodily changes; auditory stimuli shape the emotional contours of illness; alterations in taste affect both appetite and emotions; and tactile sensations are closely tied to treatment and caregiving practices. Within clinical environments, olfactory experiences evoke "emotion" and "memory recall," underscoring the sensory dimension of healthcare

(Kadohisa 2; Engen 11). This essay examines how sensory encounters in the memoirs of Ray and Moorjani shape illness experiences, informing care practices, adaptive responses, therapeutic perspectives, and a sense of wellness. The first section examines visual perception, drawing from the memoirs to illuminate human experience during illness and exploring technology's impact on vision in healthcare settings. The second section analyses emotional and physiological responses evoked by olfactory and gustatory stimuli, emphasizing their interdependence and the need for positive sensory environments. Finally, the third section investigates auditory and tactile influences on patient well-being, highlighting the significance of therapeutic soundscapes, compassionate touch, and empathetic communication in strengthening care relationships.

Sight and Insight: Visual Perception in Shaping Illness Experience

Our perception of the world is fundamentally shaped by our vision. As the most vital and refined sensory modality, vision holds "the most complex, highly developed, and important" role in human experience (Hutmacher 2). Sight has persistently held a dominant position in Western thought and research, often perceived as "the star of academic research on the senses" (Howes, *Sensual Relations* xii). Pike et al. highlight the extensive research on vision and its central role in moulding our interactions with the external world, noting that "when we interact with the world, we rely more on vision than on our other senses" (74). Early depictions of hospitals prominently feature the visual aspect, involving acute observation and sight as integral components, with emphasis on the building's "visual impact" (Reinarz 507). The prevalence of visual observations in historical accounts of hospitals parallels the enduring emphasis on vision in various domains, as noted by scholars such as Constance Classen (*Worlds of Sense*), Anthony Synnott (*The Body Social: Symbolism, Self and Society*), and David Howes (*Sensual Relations: Engaging the Senses in Culture & Social Theory*). This trend particularly manifests in the context of hospitals, as evidenced by Michel Foucault's analysis of the emergence of clinical medicine and the pivotal role of the "doctor's gaze" in *The Birth of the Clinic* (8).

In Lisa Ray's memoir *Close to the Bone*, visual perception assumes a significant role, acting as a transformative lens through which her first experience of the chemo day care setting is rendered. She writes, "When I look around, I notice some people who refuse to make eye contact" (296). Lisa's remark encapsulates the importance of eye contact in establishing connections and conveying messages, while also illuminating the intentional avoidance of such contact, symbolizing the immense weight of individual experiences. As she scans the room, she encounters

a woman discreetly wiping away tears, reflecting deep anguish. In a distant corner, a man remains defiantly secluded, embodying inner turmoil. In contrast, a lively group from the East Coast engrossed in a card game blurs the boundaries between patients and companions, projecting an air of normalcy and relaxation. Lisa thoughtfully contemplates, "In all the faces around me, I see the desire for things just out of reach. Recovery. Comfort. Safety. Empathy. Control. Normalcy. Escape. Luck" (296). Through this introspection, Lisa's visual perception allows her to discern unspoken desires, revealing depths of human longing and the universal quest for understanding. In *The Senses in Self, Society, and Culture*, Vannini et al. argue that sensory experience is a primary mode through which meaning is constituted, stating "We understand, and indeed make sense out of, sensory experience by creating distinct mental clusters" (7). Ray's acute visual sensitivity thus becomes a means of apprehending the chemo day care as a microcosm of collective emotional experience. Her realization of a shared estrangement finds articulation in the line, "In this room, as in our bodies, the rest of the world is excluded from our battles" (296). Here, vision is not passive reception but an active force that engenders solidarity, transforming a sterile medical environment into a site of communal recognition and belonging.

The mediation of vision by technology further complicates our sensory encounters with the world. Among the senses, sight has been most radically transformed by technological innovation. Advances in high-resolution screens, virtual and augmented reality have altered our engagement with visual information. Stanley Reiser highlights the growing importance of visual representation in twentieth-century medicine. He notes the mounting utilization of instruments like the ophthalmoscope and the x-ray by physicians to observe the internal mechanisms of living bodies and "evaluate the pathology firsthand" (47). Similarly, Fredriksen contends, "technological advances such as stethoscopes, microscopes, and x rays overstep the boundaries of human perception. They enable us to see what is invisible to the unaided senses" (71). Ray's narrative regarding her experience with a stem cell transplant at the Princess Margaret Hospital's stem cell unit serves as an example for how technology extends human capabilities beyond innate senses, enabling unparalleled access to and processing of information. She recounts,

> I leaned back and watched as the blood was pulled from my body. I watched dials turn steadily on the impressive looking COBE Spectra cell separator machine I was hooked up to. I was in a close relationship now with this machine. I looked upon it as metallic transcendence. (Ray 326)

In Lisa's notable engagement with the COBE Spectra machine during the blood extraction process, her visual experience resonates with the sentiments conveyed by John Berger in *Ways of Seeing*. Berger posits, "but there is another sense in which seeing comes before words. It is seeing which establishes our place in the surrounding world; we explain that world with words, but words can never undo the fact that we are surrounded with it" (1). Berger's notion that sight precedes words and establishes our relationship to the surrounding environment finds relevance in Ray's unique interaction with the machine. Ray's perceptual encounter with the machine, grounded in visual observation, transforms a clinical procedure into a scene of affective and existential significance. As she reclines, watching the dials rotate, the visual data externalizes the otherwise invisible processes occurring within her body, thus translating physiology into a comprehensible, almost sublime, sensory experience. This moment of interaction exemplifies how technology, far from being neutral, mediates and magnifies embodied awareness. It becomes both instrument and interlocutor. As Velasco and Obrist note, technology "not only change the experience, but become the experience itself" (31). Victoria Bates similarly contends that in clinical settings, "technology is part of the material environment...a space or place in its own right" that "shapes and responds to embodied experiences" (3). Ray's depiction of forming a 'close relationship' with the COBE Spectra machine implies a deep emotional attachment, attributing qualities that extend beyond its mechanical attributes. This emotional affiliation underlines the influence of technology on our senses, evoking emotions of trust, dependence, and even reverence.

Lisa's characterization of the machine as 'metallic transcendence' represents the transformative nature of human-machine encounters in contemporary healthcare. By ascribing spiritual qualities to technology, Lisa imbues the experience with awe and wonder, highlighting technology's ability to enhance sensory perceptions and stimulate contemplation of the mysteries within the human body. In this context, the symbiotic relationship between sight and insight becomes central to perception. Saab, drawing on Denis Diderot, explores this connection: "sight and insight [are] both linked to the senses" (*Objects of Vision* 13). His analysis emphasizes how visual perception shapes and deepens cognitive understanding. Ray herself evokes the sanctity of the moment as she describes watching the mesmerizing journey of her blood, its force separating stem cells, and its eventual return. She articulates, "Something close to sacred was taking place as my blood travelled out of my body, spun with a force strong enough to separate the stem cells, and then

flowed back into me" (326). Ray's portrayal captures the dynamic fusion of the human and the mechanical, revealing how medical technology elicits wonder and spiritual resonance through the act of visual perception. In rendering a moment of physiological intervention as sacred, Ray reframes the healthcare setting as a space of reflection, where technology not only extends sensory awareness but also participates in the production of meaning.

Within the broader framework of sensory experience, vision emerges as a critical modality through which meaning is made. As Kandel et al. explain, "most of our impressions about the world and our memories of it are based on sight" (492). David Howes affirms, "the senses are everywhere. They mediate the relationship between idea and object, mind and body, self and society, culture and environment" (*The Sensory Studies Manifesto* 13). A compelling example of vision's significance during illness can be found in Anita Moorjani's memoir, *Dying to be Me*. Within the clinical space, Moorjani's vision becomes an active hermeneutic tool as it decodes medical authority through doctors' guarded postures and the ominous presence of IV bags. As she tracks chemotherapy's path from bag to vein, looking becomes agential: a means of confronting vulnerability while asserting presence. Moorjani writes,

> The doctors were being cautious about my healing, particularly because of the state I was in when I entered the hospital. They wanted to adjust the mix and dosage of the chemotherapy they were giving me—which, at one time, I'd greatly feared. I watched as the nurses came in to administer the chemo. They hung the bag of drugs on the IV stand. Each bag, which they were feeding directly into my veins, was labeled "POISON" in huge, red capital letters. The nurses wore masks and latex gloves so that they couldn't accidentally have contact with any of the dangerous chemicals. Strangely, it seemed that it was acceptable for these drugs to be introduced directly into my bloodstream. (86)

The label *'POISON'*, prominently printed in bold red capitals, operates as a visual and rhetorical device that provokes immediate recognition of pharmacological danger. This typographic and chromatic coding belongs to a broader regime of toxic legibility, where colour and language function as tools of biopolitical governance. The visual stimulus heightens Anita's emotional responsiveness, deepening her apprehension toward chemotherapy. In this sharpened state of awareness, she registers the nurses' protective gear as more than procedural necessity. The gloves and masks function as visible barriers, reinforcing the latent peril of the substances

in use. What emerges is not confined to clinical routine but becomes a performative expression of institutional caution, where therapeutic care is inseparable from risk and the aesthetics of medical practice reflect its underlying anxieties.

German psychologist Rudolf Arnheim's seminal work *Visual Thinking* (1969) transformed scholarly conceptions of perception and cognition. Rejecting the traditional view that cognition precedes vision, Arnheim argued that thinking emerges from seeing. He emphasized the essential role of sensory perception, particularly sight, in shaping cognitive processes, asserting their fundamental unity: "Visual perception is visual thinking" (14). This theoretical intervention redefined academic discourse by centering embodied perception in the construction of knowledge. Moorjani's experience demonstrates Arnheim's framework in action. Her bodily and sensory interactions within the clinical setting form the basis of her cognitive and emotional responses. As Jackson eloquently puts it, "what is done with the body [and senses] is the ground of what is thought and said" (131). This dynamic becomes especially poignant when, after a chemotherapy session, a nurse encourages Moorjani to look out her hospital window. Leaning on the nurse for support, Moorjani gazes outside, her eyes filling with tears. She reflects: "The moment I looked out the window, my eyes welled up. I couldn't keep myself from crying. It hadn't registered until that moment that the hospital was located only a few blocks away from my childhood home in Happy Valley" (84). Moorjani's vision bridges past and present, as the hospital's proximity to her childhood home triggers a flood of memories, dissolving temporal boundaries. This visual moment carries deep emotional weight, reawakening joy.

Lisa Ray's and Anita Moorjani's memoirs both showcase how the narrator-protagonists' heightened visual discernment enhances their accounts of illness, promoting comprehension, emotional resonance, and cognitive immersion. Their acute perceptual awareness discloses unspoken desires, potential risks, and the formation of shared identities within clinical spaces. By integrating sensory perception with reflective thought, their visionary encounters highlight the epistemological and affective significance of sight. These moments of visual intensity do not simply describe but actively construct a sensory narrative that reconfigures the healthcare environment as a site of embodied knowledge and meaning making.

Scented Symmetry and Flavour Fusion: The Harmonious Integration of Smell and Taste during Illness

The sense of smell plays an essential role in shaping our perceptions, triggering

memories, and stirring emotions. Among the various human sensory modalities, olfaction, or the sense of smell, holds a distinctive capacity to evoke past experiences due to its "power" (Schab and Crowder 7) and its ability to "revive" the past (Engen 80). Uri Almagor draws attention to the evocative potency of familiar scents, observing that they can "transport a person instantaneously to a specific point in the past" (267). In healthcare environments, the olfactory ambiance emerges as a formidable tool capable of shaping patients' experiences. As one enters a hospital, the prevailing scent captures attention, shaping the layout of wards and deeply impacting patients. For instance, most general hospitals feature a distinct ward for venereal cases. Regardless of whether the smell is benign or noxious, it "directly affects" the hospital ambiance, thus impacting experiences and outcomes (Reinarz 509).

In contemporary scientific inquiry, the sense of smell intermingles with taste, constituting one of the chemical senses. A comprehensive taste experience is almost unimaginable without the "olfactory component" (Korsmeyer 4). This sensory interdependence becomes evident in Lisa's narrative of her stem cell transplantation, where smell and taste actively shape her phenomenological engagement with clinical space. Lisa's chemotherapy sessions, framed as visceral ordeals, reveal the body's vulnerability to sensory intrusion. During one such session, as Lisa lies in her bed, the haematologist depresses the syringe plunger, triggering an abrupt and inescapable onslaught of chemical sensations. She narrates,

> I lay in my bed, and as soon as the haematologist hit the plunger, the taste of creamed corn welled up in the back of my throat and flooded my mouth. I could smell it too, so vividly that I looked around the room to see if anyone else had registered it. (Ray 328)

The taste of creamed corn wells up in the back of Lisa's throat, flooding her mouth with its unmistakable flavour, while simultaneously, a strong olfactory sensation envelops her, prompting an instinctual scan of the room, searching for others who might have shared this sensory experience. The sensory encounter not only affects Lisa's physical sensations but also sets in motion a fervent quest for affirmation from those present. Moreover, it adeptly interlaces olfaction (smell) and gustation (taste), subverting conventional notions of separate sensory channels. According to Howes, "the senses are not simply passive receptors. They are interactive, both with the world and each other. The senses overlap and collaborate" (*The Sensory Studies Manifesto* 12). The English term 'flavour' encapsulates the fusion of oral and

olfactory experiences that arise when consuming various food items. One definition in the Complete Oxford English Dictionary states that 'flavour' is the element in the taste of a substance which depends on the cooperation of the sense of smell. Psychologist Paul Rozin argues that the perception of flavour relies on the merger of the senses of smell and taste, as well as whether an olfactory stimulation pertains to the "body (mouth)" or the "external world" (397). This phenomenon is known as "odour-taste synaesthesia" (Howes, *The Sensory Studies Manifesto* 87). The concept of synaesthesia reveals the complex link between distinct sensory modalities, where the activation of one, like vision or smell, can trigger another, such as hearing or taste. In this multisensory encounter, Lisa is enveloped in heightened perception that surpasses the ordinary, exemplifying the influence and synergistic dynamics orchestrated by these senses. Thus, she immerses herself in an intersensory fusion where smell and taste harmoniously converge.

Lisa's sensory experience further highlights the emotional and psychosocial impact of smell in healthcare. In *Aroma* Classen, Howes, and Synnott aptly observe, "Smells resist containment in discrete units, crossing borders, linking disparate categories, and confusing boundary lines" (204). Their analysis captures how olfactory stimuli rises above physical sensations, eliciting deeply layered responses from Lisa. The aroma of creamed corn intensifies Lisa's sensory awareness, prompting a desire for affirmation and a longing for shared experience and reassurance. Her response exemplifies the capacity of smell to evoke memory, establish associations, and sustain social bonds even inside the cold architecture of a stem cell unit. According to Classen et al. "odours form the building blocks of cosmologies, class hierarchies, and political orders; they can enforce social structures or transgress them, unite people or divide them, empower or disempower" (*Aroma* 1). This notion reinforces the significance of Lisa's sensory episode, reminding us of the unique and subjective experiences patients face during medical interventions. It highlights the importance of recognizing and validating these sensory encounters as integral components of the patient's journey. While taste is inherently subjective and rooted in "individual experience" (Korsmeyer 43), smell possesses a social valence, enabling a shared sensory experience that cultivates collective awareness. By acknowledging both taste and smell, Ray gestures toward a sensory epistemology of illness, one that reveals how such impressions shape her understanding of treatment and her relation to the clinical environment. This recognition urges a more holistic approach to care, where sensory perception is not incidental but central to the lived experience of healing.

In her cancer memoir, *Dying to be Me*, Moorjani recounts an episode involving

her experience with medical procedures. The narrative unfolds as Anita is subjected to a physician's decision to mark a lymph node on her neck, despite its lack of visible enlargement. She subsequently undergoes surgery under local anaesthesia, during which a small incision is made on the left side of her neck to extract the lymph node. Because she remains conscious throughout the procedure, she becomes acutely aware of various discomforting sensations, including the incision itself and, more disturbingly, the smell of her own burning flesh as the surgeon cauterizes the wound. Moorjani reflects:

> I really disliked the discomforting sensations I felt on my neck as the doctor cut the lymph node. I still remember smelling my own burning flesh as the surgeon cauterized my wound. I thought that maybe agreeing to let them do this wasn't such a good idea after all! (Moorjani 90)

Anita's recollection highlights how sensory experience is present within the routines of medical care, not as an afterthought but as something central to how the body is handled, observed, and remembered. Her narrative aligns with Howes and Classen's view in *Ways of Sensing*, where they suggest that acts of sensing carry with them varied and often conflicting meanings:

> The significance of a sensory act is not necessarily unitary. The way in which a doctor touches a patient during a physical examination, for example, may be taken as primarily a data-gathering process or may have personal meaning for the participants ('This doctor has a caring touch'). It also has a…symbolic significance. Even sensory acts…have many shades of meaning. (4)

Even ostensibly routine sensory encounters possess subtle affective and symbolic dimensions. Anita's sensations, her physical discomfort, her sense of vulnerability, and the olfactory engagement with her own burning flesh, coalesce into a narrative of the senses that highlights how clinical procedures can become fraught, emotionally charged experiences. Her moment of doubt, expressed in the aftermath of the surgery, further reveals the psychological toll such interventions can exact. The olfactory perception of burning flesh serves as a particularly potent sensory marker, intensifying Anita's embodied experience and triggering a visceral emotional response. As Vannini et al. assert, "humans' sense as well as make sense" (15), and Anita's adverse reaction to the odour magnifies her unease, compelling her to question the decision to undergo the procedure. Smell, in this context, becomes

a channel for anxiety, fear, and a sense of distress, emotions that are frequently marginalized in biomedical discourse.

According to Howes and Classen "what makes sensations so forceful is that they are lived experiences, not intellectual abstractions" (7). Within healthcare environments, the sensory faculties, particularly smell and taste, deeply impact how patients feel, heal, and respond to care. The experiences recounted by both Ray and Moorjani advocate for a more expansive, multisensory understanding of illness, one that compels healthcare providers to acknowledge and respond to the corporeal realities of patients. A more intentional and sensitive engagement with olfactory and gustatory stimuli could establish therapeutic environments that are not only clinically effective but also emotionally attuned.

Sonic Symphony and Tactile Terrain: The Impact of Sound and Touch on the Experience of Illness

In recent years, the study of acoustical environments in healthcare settings has garnered considerable attention from both clinical and literary scholars. Taking a broader approach to understanding the impact of sounds, researchers recognize its influential role in shaping individual identity and social connections, as well as its implications for "well-being" and "health outcomes" (Graham 175). In Ray's memoir, the resounding echoes of the brass bell reverberating through the chemotherapy day care resonate with a significance that cannot be ignored. The delicate chimes encapsulate the culmination of her arduous chemotherapy cycles, emerging as a symbol of triumph and hope. With the melodic tones filling the space, they evoke a range of emotions within Lisa, eliciting feelings of joy, relief, and a reminder of her inner strength,

> On my last day at chemo day care, I rang a brass bell by the door, which all patients ring once you've completed your cycles of chemo, once the requisite toxicity has dripped through your veins. For me it signalled a chance for renewal in the form of a stem cell transplant. (Ray 317)

The auditory environment in healthcare plays a vital role in shaping subjectivity, selfhood, and social agency. As Rice notes, it forms a "sonically constituted sense of self" (4). Audible expressions of care awaken emotion, while, as Denora writes, music can "shape our capacity to...relate to others" (97). The resonance of a bell within a medical facility carries significance beyond emotional impact; it establishes a psychological association with healthcare and treatment, instilling a sense of

optimism and progress. In Lisa's case, the sound of the bell becomes "a means to establish camaraderie in an environment of alienation" (Graham 184). Echoing through the corridors, the bell in Ray's narrative serves as a unifying force, uniting individuals in their triumphs and tribulations, thus amplifying their collective strength and determination.

The bell's significance extends beyond sound and into the experience of touch. Ringing it involves physical contact, Lisa feels the cold metal, the smooth cord, and the gentle resistance as she pulls. This tactile element adds meaning to the act, linking touch with a sense of achievement. Touch shapes social identity and bodily awareness, serving as the "channel through which physical co-presence is most directly embodied" (Finnegan 194). In Ray's account, sound and touch become sensory markers that shape her understanding of illness and recovery, offering emotional release and encouraging shared strength among patients undergoing similar forms of treatment.

The sensory modalities of sound comes to the forefront once again in Ray's story as she moves through her kitchen, preparing fruit before her chemotherapy treatment. Through her kitchen window, she hears the "muffled cries of children and street noises," crafting a soundscape that delicately anchors her in the external reality beyond her immediate experience (Ray 308). This rich sensory experience highlights the value of incorporating pleasant sounds into healthcare spaces, where patients often respond positively. For Lisa, the shouts, the laughter, the faint movement from the street do not blur into background. They are signs that the world goes on. In these brief sounds, she finds small ties to what is shared, to what still flows, and to the rhythm of a life that has not wholly left her. They do not cure, but they comfort, and in times of strain, that is no small gift.

In his book *The Proust Effect: The Senses as Doorways to Lost Memories*, Cretien Van Campen investigates the connection between our senses and the recollection of past experiences. Among the senses, touch emerges as a particularly powerful medium for accessing deep-seated memories. During her illness Lisa discovers the therapeutic potential of tactile memory when she peels a papaya. This simple act triggers recollections of her interactions with her Indian maid, highlighting the significance of touch in her sensory experiences. She recalls, "I was stripping the skin, trying to remember how my maid in India did it, turning the fruit, the skin falling off in one long, unbroken peel" (Ray 308). Each stroke of her fingers against the fruit's skin becomes a deliberate effort to tap into her tactile memory. This engagement goes beyond a physical act; it becomes an embodied practice, seamlessly blending texture, pliability, and slicing motions.

As she grips the knife's handle and slices through the fruit, Lisa becomes fully engrossed in the tactile experience. The texture, softness, and the act of cutting through the fruit contribute to her heightened connection with her body's sensations. In this intimate communion with touch, she not only peels the fruit but also sheds layers of her illness, momentarily escaping its grip. Lisa ponders the significance of this action, acknowledging its hypnotic quality and the heightened observation that arises when one slows down. She writes, "There is something about this action that is hypnotic, or maybe it's just the things you notice when you slow down. I watched my hands gripping the handle, the tip of the blade slicing cleanly through flesh" (308). The stillness and attention Ray brings to these seemingly ordinary gestures mark a perceptual shift. Through touch, she not only resurrects memories that might have been obscured by illness but also finds solace and connection in the present moment. Hutmacher and Kuhbandner's challenge reductive conceptions of touch as merely sensory, demonstrating that "humans form detailed and durable long-term memory representations for a high number of their haptic experiences, even if there is no intention to memorize them" (2035). For Lisa, touch becomes a method of repair, one that allows her, if only briefly, to step beyond the narrow limits of illness and return to a world coloured by memory, feeling, textures of ordinary life, and the details of sensation.

Ray's attentiveness to the soundscape and her keen observation of seemingly mundane actions in fruit preparation reflect her pursuit of meaning and preservation within the narrative of her cancer journey. By intentionally slowing down her pace and immersing herself in the present moment, a remarkable transformation unfurls. She narrates, "This stillness, this attention I found myself bringing to the most mundane gestures; there's no shortcut to that place. The place I now found myself in. I knew there was something that must be preserved about my cancer experience." (Ray 308). In acknowledging the inherent rhythmic and hypnotic quality of her actions, she moves toward a deeper understanding of the self, one that reveals the subtleties of embodiment and draws together sensory perception with the elusive complexity of the human condition.

During her first day at chemo day care, Lisa shares with the nurse her habit of singing 'Hey Jude' to alleviate anxiety during medical procedures. She explains, "You know, most times I get poked, I normally sing "Hey Jude" - it's that whole times of trouble line that helps calm me down…It helps. A lot." (Ray 298). Research reveals that melodious sounds positively impact "pain, anxiety, and mood," contributing to an improved quality of life for cancer patients (Archie et al. 2620). Later, during a long and painful biopsy at North York General Hospital, Lisa

again resorts to singing. She notes, "Meanwhile, the doctor couldn't get a decent sample, so down he went into my hip with his electric drill over and over, while I sang 'Hey Jude' at the top of my lungs. Those high notes really dissipate the pain," emphasizing the transformative power of sound in mitigating her suffering (Ray 282). The song masks the hard clang of hospital tools and acts as a buffer against distress. Sound, in such moments, does more than distract. It shapes the texture of the experience itself, lowering fear, helping the mind detach, and even improving the tempo of those who work around the patient. As Ullmann et al. observe, music has a "positive effect" on staff working in operating rooms (596). "Soon enough," Ray writes, "I had half the nurses singing along with me" (Ray 283). Such small gestures, half-spoken lyrics and shared smiles, carry more than comfort. They build brief communities and remind us that even in pain there can be moments of rhythm, harmony, and quiet human connection.

The patient's disease can amplify feelings of confusion, powerlessness, and isolation, particularly during medical examinations and hospital admissions, where they are identified, undressed, and subjected to potentially dehumanizing procedures. In such settings, touch, often regarded as the way we reach into the world, takes on another role. It becomes the gateway by which the world enters us, exploring places we had never imagined as sites of sensation, undoing the illusion that our inner spaces are hidden and untouched. Lisa's account of her biopsy, where a drill was used to remove a sample from her hip, captures this unsettling reversal with startling clarity. The experience calls attention to how medical touch, though carried out in care, can disturb our sense of autonomy and shift the emotional texture of the body. "I never knew that we have sensation inside our bones; they're a part of the body we never touch. During the biopsy, I felt a sense of violation" (Ray 283). Lisa's reflection on feeling violated draws attention to the fragile line that separates medical necessity from personal vulnerability. When she likens the extraction of bone marrow to "trying to pull out steak," the image is not just vivid but unsettling, giving voice to a form of discomfort that is both physical and emotional, a moment that underlines the deep loss of control so often felt in medical settings (Ray 283).

Touch, which might seem at first a simple act, plays a far more complex role in shaping the relationship between caregivers and those in their care. Its impact depends not only on where or how it is applied, but on the feeling behind it. If touch feels intrusive or is received with discomfort, it can cause more harm than care, for, as Henricson observes, "every patient reacts uniquely to touch and the personal integrity can be exceeded if the patient experiences the touch as unexpected or uncomfortable" (22). Ray's experience within the hospital invites us to think more

carefully about the role of empathy and attentiveness in clinical spaces. It suggests that the smallest of gestures, when done with care, can help ease the sensory and emotional weight of treatment, pointing the way toward a gentler, more humane approach to healing.

As embodied beings, we live in gentle dependence on the warmth of others. In our daily lives, touch plays a subtle but central role in how we connect, offering a form of closeness that words cannot always reach. For clinicians, touch becomes a kind of silent language, one that carries presence, care, and a sense of shared humanity. A gentle hand or steady embrace can evoke more than reassurance; it can restore a feeling of being seen. The experience of touch can never be wholly "objective or unidirectional. Every time a professional touch a patient, they are themselves touched" (Kelly et al. 201). This reciprocity gives rise to what Fredriksson calls a "flow of feelings" (1170), allowing "therapeutic relationships" to emerge within "disclosive spaces" between patient and professional (Benner 347). During her visit to the chemotherapy care unit, Lisa shares her fear with the nurse, admitting, "I have bad veins" (298). The nurse pauses, then returns with a soft flannel blanket, which she drapes gently over Lisa's shoulders. This small act of warmth, while modest in appearance, carries deep meaning. Lisa recalls, "Something about this gesture touches me deeply. She silently hands me a paper cup of water. I anoint her ninja of my veins" (298). Such gestures remind us that caring touch often reaches beyond words. It offers calmness, reassurance, and presence, and in doing so, becomes a language of emotional connection. Drew Leder, writing on the body in illness, speaks of this need for touch during illness, noting that healing is not a task performed by one person upon another: "healing touch is not something the clinician does or the patient. Touch unfolds in the reciprocal space between the I-Thou relationship" (Leder 55). In Lisa's story, the nurse's touch becomes more than clinical. It becomes a way of listening. It speaks of empathy, care, and attention, forming a bond between two people meeting each other not as roles, but as selves.

The act of touch, in both reaching out and receiving, is fundamental to the construction of subjectivity and intersubjectivity. As Lisa Guenther writes, it is "the absence of regular bodily contact with others, the absence of even the possibility of touching or being touched," that threatens to unhinge the stability of the individual subject (xiii). The importance of touch becomes evident in Moorjani's account of illness, where moments of contact carry both the weight of connection and the pain of distance. In one of her most intimate recollections, she describes her husband holding her limp hand, his voice filled with helplessness: "My husband held my

limp hand tightly as I lay there, and I was aware of the combination of anguish and helplessness in his voice. I wanted more than anything to relieve him of his suffering" (4). In the grip of his hand, Anita searches for comfort and strength, a shared gesture that grounds her amid the uncertainty of her illness. However, even as their hands meet, she becomes aware of the limitations of touch as a means of expression, the inability to truly show him that she is still there and that, in some quiet way, she is at peace.

French philosopher Maurice Merleau-Ponty emphasizes the inherent duality of the lived body, serving as both an experiencing subject and a tangible entity within the world. He elaborates that "the objective body belongs to the realm of 'for others', and the phenomenal body to that of 'for me'," thus capturing the double-sided nature of embodiment (Merleau-Ponty 106). This concept of a dual existence, likely exclusive to humans, becomes evident through touch, which not only connects us with others but also deepens our connection with our own corporeal presence. Merleau-Ponty posits that the body and mind are intimately interconnected; our physicality, what he terms the 'flesh', enables us to experience and make sense of the world subjectively. Recognizing this embodied condition challenges clinicians to look beyond clinical detachment and resist treating patients' bodies as objects of intervention. Within this framework, Anita's experience resonates deeply. After her chemotherapy, she recalls a moment of self-recognition: "I felt as though I'd done it to myself. I reached my hand up toward the mirror, and as I touched the image of my tearful face, I made a promise that I'd never hurt myself so badly again" (Moorjani 86). This tactile act holds deep symbolic significance, representing a crucial turning point in her illness journey, reaffirming her autonomy and commitment to self-care. In placing her hand on her own reflection, she reclaims her body as something to be cared for, not fought against. Her gesture holds within it the idea that touch is more than contact; it can be a form of knowing, of forgiving, of beginning again. It is here that Merleau-Ponty's insight returns; touch can draw us back into our own skin. Anita's story is not only a moment of private healing, but also a gentle rebuke to the habits of modern medicine. She reminds us that bodies are not puzzles to be solved but lives to be heard and held. By honouring touch as a way to build trust and support, caregivers can shape forms of healing that speak to both flesh and feeling. In doing so, they may offer something rare and essential: a care that attends to the whole person.

The narratives of Ray and Moorjani offer a lens into how sound and touch shape who we are, draw us closer to others, and influence how we live through illness. These senses do not simply register the world; they give it weight, texture,

and emotional tone, making healing less about procedures and more about presence. Looking ahead, there is still much to be understood about sound, how tones, silences, and ambient noise form a kind of atmosphere that blends with other senses to shape care. Touch, too, calls for careful attention. To explore how it calms, anchors, and builds trust is to move closer to a form of care that listens rather than simply treats. These reflections are not abstract; they speak to how we shape rooms for healing, rethink the habits of the clinic, and stand beside those in pain. When the gentle pull of sound and the grounded weight of touch are taken seriously, care begins to shift towards a way of seeing the patient not as a case to solve, but as a life to meet.

Conclusion

The exploration of sensory experiences during periods of illness and hospitalization remains a critically understudied area within contemporary medical humanities. Current focus has predominantly centred on the evolution of the medical gaze and advancements in medical facilities, geared towards incorporating technology and accommodating patients. George Roeder advocates the importance of discussing "the senses" with the same rigor as topics like "politics, philosophy, or social movements" (1122). Similarly, Feldman urges us to excavate the "vast secret museum of historical and sensory absence," inviting renewed analytical attention to what has long remained unspoken and unfelt in historical and clinical narratives (104). In this context, the narratives of Ray and Moorjani emerge as exemplars of the transformative power of sensory experiences in illness, challenging conventional healthcare perspectives. Through their personal narratives, these authors demonstrate the multisensory nature of healthcare, where even subtle sounds, like the gentle chime of a brass bell, build camaraderie, and tactile interactions strengthen a sense of self amid illness. These memoirs offer persuasive evidence that sensory experiences significantly influence healthcare interactions, shaping emotional engagement and contributing to a more attentive and humane approach to patient care. Both viewpoints align in suggesting a shared understanding: healthcare emerges as a perceptual environment in which sensory experience extends the scope of care beyond medical interventions. This layered path through the senses may not only inform one's understanding of illness but could potentially infuse the process of healing with an emotional depth that slips past the boundaries of conventional medical discourse.

While these memoirs offer thought-provoking insights, their anecdotal nature may limit comprehensive generalizations for the broader healthcare context.

Therefore, it becomes essential to consider the individual differences and contextual factors when attempting to understand the impact of sensory impressions on patients' experiences and outcomes. However, these memoirs serve as reminders that healthcare is a multidimensional encounter, an intermingling of sensory experiences resonating within our conscious and subconscious selves. Recognising the role of senses in illness and healing creates opportunities for more thoughtful engagement with patients and contributes to both the quality of care and the patient's sense of well-being. In the end, these memoirs remind us that medicine, at its best, is not only a science but an art of noticing. They ask us to look again at what lies in the margins: the murmur of a voice, the warmth of a touch, the comfort of rhythm and light. To take these seriously is not to lose rigor. It is to widen the frame. This may be one of the few ways *care* can feel, once more, like a truly human act.

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