

MAŁGORZATA SKRZEK-WIELMOWIEC*

Application of Literature in Health Sciences. Memory Loss in Lisa Genova’s *Still Alice*

Abstract

Scientists were interested in better patient care and sought the best measures to achieve this goal. One path is through incorporating humanities into medical and healthcare practitioners’ education. The really big idea is that one studies humanities to become a better human, and while there are a billion reasons to study humanities, this paper focuses on how, through art and humanities, people can comprehend health, illness, and disability, namely how literature can be used to raise awareness about Alzheimer’s disease. This paper introduces the notion of medical and health humanities, briefly summarises their beginning, and how, so far, the applied literature in health sciences has been used. Next, the idea is illustrated in the example of Lisa Genova’s novel *Still Alice*. This part analyses how sickness and its impact on people’s lives is portrayed. Finally, the article proposes an original mode of application to acquire a deeper insight into illnesses, well-being, and pain that might be fostered in future healthcare providers, as well as a better understanding of patients and their caregivers.

Keywords:

health sciences, health humanities, literature, Lisa Genova

* Faculty of Social Sciences, The John Paul II Catholic University of Lublin, Poland, e-mail: gosiaskrzek@student.kul.pl.

1. INTRODUCTION

Scientists were interested in better patient care and looking for the best measures to achieve this goal. However, with the progress of modern medicine and the commercialisation of the health care system, medical professionals have been facing the risk of developing dehumanising tendencies (Cole et al., 2014). The causes of this might be the mode of reductionistic thinking manifested by the explanation of the phenomena on the most elementary level; reducing patient to a sick organ; hyper-specialisation that only enhances the mentioned reduction to one organ (Pawlikowski, 2002); biomedical reduction that eases pain but not suffering; and not enough time to see the patient (Cole et al., 2014).

The Latin maxim says: *Medice, cura te ipsum*; medicine whose purpose was to cure others needed a cure as the “biological approach alone cannot address the various human phenomena that physicians encounter in their everyday practice” (Puustinen et al., 2003, p. 77). One of the suggested postulates was the humanisation of the medical fields (Pawlikowski, 2002; Cole et al., 2014; Crawford et al., 2015). By incorporating humanities into medical education, future medical professionals could preserve values and goals of medical practice while examining patients (Fitzgerald, Callard, 2016). That is how medical humanities came to life. However, with the rapid growth of medical humanities, the demand from professions outside medicine to become involved has increased. “There are important cohorts of personnel in healthcare, a whole army of ancillary workers, as well as informal carers and patient themselves who have been largely left out of the medical humanities so far” (Crawford et al., 2015, p. 1).

Contrary to popular belief, it is not only medicine and medical professionals that are responsible for health and well-being. Some researchers (Crawford et al., 2010) suggest that most healthcare activities are performed not by medical practitioners but by non-medical staff, e.g., care assistants, catering and cleaning staff, volunteers and family members. Health does not belong to medical professionals; “we are all patients, future patients, or lay caregivers of patients” (Klugman, 2017, p. 2). Hence, the field of medical humanities was not enough as it excluded many of the mentioned groups involved directly or indirectly in health, healthcare, and well-being. The need to broaden the field arose, and thus, more inclusive health humanities came into existence, overshadowing its predecessor, and began to expand.

Medical and health humanities and their purpose in healthcare might be ambiguous. However, after closer examination, it becomes quite clear. They tackle the issue of existential questions about the meaning of life and death, which is essential

to healthcare (Cole et al., 2014), and help health professionals to understand “what the patients and their relatives feel, what they might expect and are perhaps anxious about” (Pawlikowski, 2002, p. 7). It is a tool that helps us comprehend what it means to experience certain illnesses or what it does to one’s body, relationship, and life. Being sick might be isolating, “especially in a culture that focuses [...] on health and wellness” (Klugman, 2017, p. 7).

The paper aims to understand how art and humanities, especially literature, can benefit healthcare practitioners’ empathic and interpersonal capabilities and help cope with sickness and its symptoms. Finally, the article proposes an original mode of application to acquire a deeper insight into illnesses, well-being, and pain that might be fostered in future healthcare providers, as well as a better understanding of patients and their caregivers.

2. APPLIED LITERATURE

Literature and medicine are centuries-old allies, but in our day, they are often represented as opposite approaches to truth and well-being. Medicine, after all, is a science, or closely allied to it, and literature is an art; and all the talk of the “art of medicine” cannot disguise the fact that to some people, literature is about as far from medicine as you can get (Trautman, 1982, p. 23).

Clinical and cultural knowledge cannot be separated as the patient and the physician must understand “what is meant by a description of the symptoms” (Puustinen et al., 2003, p. 79). Literature provides an insight into suffering, recovery, or emotional distress that might occur. Humanities enrich the understanding of the events through attentive and reflective consumption of art, strengthen perception, and deepen self-knowledge (Cole et al., 2014). All of that is available – through health humanities – for everyone, starting from medical professionals and professionals working in the healthcare environment, through caregivers of patients, and ending with patients themselves.

One of the ways of approaching literature is pathography¹, which focuses on how the narrative, represents madness and mental illnesses. Anne Hunsaker Hawkins (1999, p. 28) might be useful for understanding narratives about personal illness, medical interventions, recovery, or death. She introduces four paradigms in literature interpretation: battle, journey, rebirth, and “healthy-mindedness”.

¹ Pathography is a literary genre that focuses on person’s illness (Crawford et al., 2015; Merriam-Webster, n.d.).

Every person's story takes its own path, not necessarily in a logical sequence. Nevertheless, its main goal is to give a voice to the patients, who are drowned out by medical jargon and classifications of diseases.

The narration of one's illness can be described as giving a voice to the body. Despite not using any language, the body is not mute; it uses the language of pain, limitations, or symptoms. However, "observing what stories say about the body is [...] familiar; describing stories as told through the body requires another level of attention" (Frank, 1999, p. 2). The way a storyteller talks about their body is moulded by how their relatives, social circles, and commercials talk about illness. The disease changes how a person sees their body and experiences the world, and how they talk about their body is also shaped by the social context they are immersed in. For instance, Teske (2009) argues that in the modern history of the English narrative, certain conventions are used to depict certain mental conditions so that realism depicts sanity, modernism neurosis and postmodernism psychosis.

Literature can sensitise and educate healthcare practitioners to be better attuned to how patients experiencing domestic abuse talk. As a literary example, they use Dorothy Allison's Novel *Bastard out of Carolina*. Reading a novel such as this can help better understand how patients narrate their domestic lives and what body and verbal language they use (S. Vannatta & J. Vannatta, 2013). According to the authors' research, "eighty percent of the patients who explained their domestic living arrangements past the point go ten minutes eventually revealed a physically abusive domestic environment" (S. Vannatta & J. Vannatta, 2013, p. 35). Narratively competent clinicians would have tools to detect "unsaid" information.

Charley Baker's experience of teaching mental health nursing students about self-harm can be seen as yet another example. Students have to face myths that one should not ask about a person's self-harm and that self-harm is carried out for attention, but they do not know how to challenge those myths. Baker uses Caroline Kettlewell's autobiography *Skin Game* or Rebecca Ray's novel *A Certain Age*. These stories enable the students to consider emotional and psychological context and that sometimes self-harm seems to be the only solution that eases the pain. It is also a tool to put a person and their distress and experience, not wounds, first (Crawford et al., 2015).

Dosani (2020, p. 274) writes about her experience and how applying techniques from literary studies helps her understand a patient's story better. She argues that language, metaphors and form are guidelines one should follow to comprehend the context of their distress. She brings the example of her patient using a Biblical

metaphor. Noticing that and joining the patient in the allusion allowed her to notice “unspoken fears of divine punishment and [...] hope for a miracle cure”.

Another example of implementing literature is the analysis of Sophocles’ *Philoctetes* (Kampourelli, 2022, p. 568). The author combines literary reading and fostering empathy in healthcare professionals; the “main themes of the play are illness and chronic pain, abandonment and isolation, and [...] ethical dilemma”. Those themes are no strangers to (future) doctors, nurses, and other health providers. It tackles the dehumanising tendencies, whose origins have been mentioned in the “Introduction” section. Kampourelli confronts the world of medical efficacy with the attitude towards patients, using the universality of the ancient text. Moreover, it might be comforting for healthcare practitioners not to be “broken” or “alone” in their moral dilemmas. Especially from the perspective of the recent global pandemic, when many difficult decisions had to be made in little to no time.

Moreover, a discipline called Narrative Medicine connects humanities, the arts, clinical practice and health care to improve health care from the point of view of patients and providers (Columbia, 2023). It is a pedagogic strategy, similar to health humanities, that teaches future healthcare providers how to approach patients with more understanding and compassion. It focuses on discovering not only how a patient narrates their story about symptoms but also the understanding of illness that encompasses therapeutic measures that should be taken (Charon, 2012). Kazuo Ishiguro’s book *Never Let Me Go* can be used to answer questions about self and identity. The novel follows clones’ lives, created solely to donate organs to their non-cloned counterparts. It tackles the issues of cloning, organ transplantation or genetic engineering. Readers can be amazed how the novel mirrors the real-life story of Adam Nash (saviour sibling), conceived through in-vitro fertilisation so he could donate blood to his sick sister, Molly (Steinbock, 2003).

Currently, numerous universities offer master’s programs in medical and health humanities, e.g., Tilburg University (2023), University College London (2023), University of East England (n.d.), Durham University (2023), Birkbeck University of London (n.d.); authors can publish in the “Health Humanities” Section offered by “Medicina” (b.d.) or in the independent “Medical Humanities” international journal; there is also The Health Humanities Consortium LLC (n.d.), associating scholars and educating healthcare professionals. In Poland the Medical Humanities Science Club (*Koło Naukowe Humanistyki Medycznej*) functions at the Jagiellonian University. However, this field is still in need of further exploration and popularisation.

3. LISA GENOVA'S *STILL ALICE* IN THE SERVICE OF HEALTH HUMANITIES

Lisa Genova graduated from Bates College with a Biopsychology degree and a Ph.D. in Neuroscience, which she obtained at Harvard University. Her novel, *Still Alice*, was adapted into a film (the lead actress, Julianne Moore, won the 2015 Best Actress Oscar for her role as Alice Howland). The novel is about Alice Howland, a 50-year-old cognitive psychology professor at Harvard diagnosed with early-onset Alzheimer's disease. The book tackles the problem of Alice's slow regression, as she gradually loses her vocabulary range, forgets topics of her lectures in the time it takes to walk from her office to class, forgets a recipe she has made from memory ever since she was a child, loses the sense of direction in her neighbourhood or house, and eventually she does not recognise her own children and husband.

On top of that, *Still Alice* portrays the emotional burden of such a diagnosis and the different ways people react and cope with it. Alice is afraid of losing herself; John (her husband), who represses his wife's disease, only later devotes all energy to the frantic search for a potential cure. Finally, her kids, who have a 50% risk of developing Alzheimer's disease, face the dilemma of whether to get tested or not. The novel shows how the family learns to cope with Alice's disease and how Alice herself learns to accept it.

It is worth explaining the novel's title as its presence is noticeable throughout the book. When Alice heard her diagnosis, she was devastated as "everything she did and loved, everything she was, required language" (Genova, 2009, p. 82). She worried that her husband would not recognise her someday and that she would not be Alice anymore. Reading a book that she wrote with her husband and not remembering it, made her say, "I miss myself" (Genova, 2009, p. 319), to which her husband replied, "I miss you too, Ali, so much" (Genova, 2009, p. 319).

What Alzheimer's disease does (and what terrifies people) is that it slowly takes away one's memories of their family, who they are, and what they do or love; people suffering from AD slowly become paranoid and distrustful as they do not remember their interactions with people, whether they agreed to something or not (Alzheimer's Association, n.d.). They are labelled as "people with dementia". Hence, the question arises whether one can talk about oneself if they do not know who they are, and those surrounding them no longer recognise them. Alice answers that question during her speech at the Dementia Care Conference:

Being diagnosed with Alzheimer's is like being branded with a scarlet A. This is now who I am, someone with dementia. This is how I would, for a time, define myself and how others define me. But I am not what I say or what I do or what I remember. I am fundamentally more than that (Genova, 2009, p. 282).

She then names all the roles she is involved in, e.g., mother, wife, and friend. Even if she will not remember with whom she was talking, she still feels, understands, is still worthy of love and being listened to. She is still living. Her memories disappeared, and she might not remember them today, but that does not mean they were not meaningful, regardless of whether she will remember them or not.

Like in the original book *The Scarlet Letter*, the letter A carries more than one meaning, namely Alzheimer, Adjudication, Acceptance, Alive. At first, the diagnosis of Alzheimer's Disease is an Adjudication, a sentence announcing the end of Alice's life. She will lose everything she loves and cares for, her job as a researcher and a Harvard professor, memories of people she loves and cares for, even their names and faces. However, as time passes, she and her family learn how to accept the disease, how to cope with it, and that, in fact, Alice is still Alive. She is *Still Alice*.

In the beginning, the novel presents Alice as highly competent and having an extensive memory capacity, e.g., she knows by heart the details of the experiments, the years of the published studies, and their respective authors. The perfect image is disturbed by inconspicuous occurrences that expand, affecting six cognitive domains: Language, Learning and memory, Perceptual-Motor, Executive function, and Complex attention. However, Alice puts first symptoms down to her being menopausal.

In the domain of Language, the disturbance begins with the word-finding difficulty and replacing it with a "vague and inappropriate *thing*" (Genova, 2009, p. 12), then using the word *that* instead of *cream cheese*, and forgetting the "intention behind words she wrote in the morning on her to-do list by the middle of the afternoon" (Genova, 2009, p. 90) or forgetting names. Moreover, the novel prioritises Alice's perspective through a third-person narrative, allowing the reader to observe how the vocabulary slowly diminishes, leading to co-experiencing her confusion. For instance, during an annual holiday party for the psychology department, Alice's colleague, Dan, introduced his new wife, Beth. The narrator describes Beth's floor-length red dress and explains that Alice knew a little about Dan's new wife from Dan himself. However, after some time, the reader is informed that Alice had noticed a young woman in a red dress standing next to Dan and introduced

herself, asking whether she [the young woman] was a new postdoc. Gazes were exchanged, but the confusion was put down to too much wine. This time, Alice forgot the name and face, which is linked to the next cognitive domain.

The perceptual-motor domain is also affected by dementia; it is responsible, *inter alia*, for the recognition of faces. It begins with the wife of a colleague, but eventually, it spreads to the point of Alice not recognising her own daughters or husband. However, struggling with face recognition was not the first symptom of disturbance in this domain. Alice lost orientation in a familiar environment during her running routine, in which she had followed the same route to Harvard Square. She knew where she was, yet “didn’t know which way was home” (Genova, 2009, p. 24).

Another domain visibly affected by dementia is Learning and memory. For Alice, it has begun with forgetting the topic of the lectures she was supposed to give or even that she was supposed to give one after getting to the lecture hall, or asking the same question after a few minutes. The narration from Alice’s perspective also captures changes in this cognitive domain. For example, Alice had an argument with her husband about whether they discussed moving to New York or not; the reader does not have the opportunity to verify who is right, whether John tried to manipulate Alice using her Alzheimer or, in fact, she did not remember them talking about the subject matter.

In the domain of Complex attention, Alice had difficulty following and understanding conversations between people; she was losing track of what they were saying while trying to grasp the meaning of words. She also struggled with reading research papers, as the quite complex structure confused her. She had to reread the pages multiple times to retain the continuity.

Alzheimer’s Disease affects not only the biological sphere but also the emotional sphere of the diagnosed person. What is more, its range expands towards the sick person’s family, caregivers, and friends, leaving them confused, shocked, distressed, but also exhausted and hopeless.

For Alice, the first time she heard her diagnosis, she dissociated herself to the extent that she felt she had experienced an out-of-body experience, the “sound of her name penetrated her every cell and seemed to scatter her molecules beyond the boundaries of her own skin. She watched herself from the far corner of the room” (Genova, 2009, p. 79). Alice experienced depersonalisation – she became a detached observer of herself (Sierra & Berrios, 2021), and everything became less real. It was a defence mechanism that Alice’s brain used to protect her from the diagnosis.

Meanwhile, she was afraid of how her disease would affect her own family². She would be unable to recognise the faces of her husband, children, and grandchildren (they would no longer recognise her, either), and she would be unable to talk to them, feed them, and clean herself. Eventually, she would forget how to swallow and develop pneumonia. Her family would decide not to treat her sickness with a simple course of antibiotics and be “riddled with guilt over feeling grateful that something had finally come along that would kill [Alice’s] body” (Genova, 2009, p. 109). She was deeply aware that she would become a burden. She knew the cost of staying in a nursing centre, “two hundred eighty-five dollars a day” (Genova, 2009, p. 128). Alice did not want the burdens to outweigh the benefits of her staying alive, she felt guilty that her children might have the altered gene and suffer like her.

Alice wished she would have cancer instead. She felt ashamed for wishing it, especially that it was a pointless bargain. However, she felt that “with cancer, she’d have something that she could fight” (Genova, 2009, p. 131). Medicine offers different ways to fight cancer through radiotherapy, chemotherapy, and surgery. However, what is more, Alice would not feel isolated; as cancer has symbols – a bald head, ribbon, and what Alzheimer’s brings is awkwardness, vanishing memories, insanity. Family and her Harvard community would have supported Alice while she battled cancer and would have considered “it [the battle] noble” (Genova, 2009, p. 131); even if she had not won with cancer, she could have at least said the last goodbye. It was different with Alzheimer’s disease – there are no victories.

Alice was reluctant before she told John, her husband, about her sickness. She was afraid he would stop loving her as “he loved her mind” (Genova, 2009, p. 88) and having AD means that one day you will lose your mind. When he heard about Alice’s diagnosis, he could not comprehend what was happening, he denied the neurologist’s competence and diagnosis and put memory lapses down to stress or depression. John insisted on genetic screening, and it was only when it came out positive that he believed and “cried the whole way home” (Genova, 2009, p. 100).

² Emotional impact does not refer only to the person suffering from AD but also their family. This phenomenon is called a “caregiver burden”. Kasuya, Polgar-Bailey and Takeuchi (2000, p. 119) define it as a “multidimensional response to physical, psychological, emotional, social, and financial stressors associated with the caregiving experience”. The most frequent burdens that caregivers have to bear is anxiety and depression (Mahoney et al., 2005; Eters et al., 2008). Studies also suggest that kinship ties (spouse, child, sibling) are a predictor of a caregiver burden; most notably wives experience high levels of CB (Eters et al., 2008). NIK (2016) suggests that caregivers bear the costs of the provision of work, value of time dedicated or loss of income due to job resignation in order to take care of a sick person.

Once he could not deny Alice's disease, he started a desperate search for a potential cure. When he and Alice's neurologist discussed their options, John did not want Alice to decide which one to choose, saying she should trust him. It was palpable that he no longer trusted his wife's cognitive abilities to draw proper conclusions. In his eyes, she was mentally challenged already. The more he observed the symptoms of AD, the more he feared losing his wife because, just like Alice, he felt lost and uncertain about what the future might hold. It was difficult for him to manoeuvre between his job responsibilities and his sick wife. Still, he tried his best to be with and there for his wife. For instance, he had noticed that reading is difficult for Alice, so he came up with the idea to buy movie adaptations of her favourite books, as they might be easier for Alice to follow.

Alice had three children, who did not stay indifferent to their mother's sickness. When Anna and Thomas discovered the autosomal dominant character of their mother's mutation, Anna became frantic with worry about her future kids (she and her husband are trying for a baby; later on, they will have twins) and whether they can inherit the mutation. Tom tried to calm her down so that by the time any of their kids would need a cure, there would be one already. To this, Anna replied that she did not want to be a "mindless zombie" (Genova, 2009, p. 117). This exchange happened in the presence of Alice, a possible future "mindless zombie". Alice and Anna, a mother and a mother-to-be: the first cannot do anything about her children having the mutation, and the latter has to choose whether to risk it, not, or opt for in vitro fertilisation (she will choose the third option as Anna carried the mutated gene). This parallel shows the burden and the consequences of knowing and not knowing about autosomal dominant sickness that spreads within a family. Tom did not have the mutation, but Anna did. A situation like this puts the bond between siblings at stake; a sense of injustice that the other one is "clean", a sense of guilt, not a relief, that I am the lucky one. However, there is also a possibility that it would be a bonding moment for the two, and it was the case with Anna and Tom. "They sat closer now than they ever did, [...] Tom reached over and held her hand" (Genova, 2009, p. 121). After all, they are siblings, and this test proved that their love is stronger than genetic injustice.

Alice's story can be interpreted through Elisabeth Kübler-Ross' (1969) five stages of grief model. Alice's depersonalisation can be associated with the first stage of grieving, namely denial. Her anger towards her late father is stage two – anger. The bargaining stage took the form of wishing to have cancer so that she would be equipped with tools to fight it. Once her days lost meaning, her future lost meaning, she "tried to imagine tomorrow, next week, the coming winter. Nothing meaningful enough came to her" (Genova, 2009, p. 221); stage four –

depression – appeared. Eventually, Alice reached stage five, acceptance, which was transposed into reality by her speech.

4. MODE OF APPLICATION

The way of implanting literature into educating medical/health professionals, patients, family members, etc., is not simply by reading it. In this chapter, an authorial method for analysing literary works is being proposed.

1. Define Your Group of Interest

Firstly, we should know **who** we want to educate. It is natural that doctors, nurses, family members, and, finally, those who are affected will be interested in various aspects of an illness and how it affects a person. Depending on the group, we might change the approach to a literary work and emphasise different consequences.

2. Define the Topic

Once we define our target audience, we can plan **what** we want to focus on. Whether it will be criteria-oriented, concentrated on the role of informal carers, everyday struggles as the illness progresses, developing empathy by “experiencing experiences which may be unfamiliar to the reader” (Crawford et al., 2015, p. 48) or any other goal that we might want to achieve. It is also a step in which we should collect clinical facts. We should never undermine the importance of evidence-based practices; we should review and analyse the latest knowledge from clinical textbooks and articles.

3. Analyse the Literary Work

Reading a literary work is the heart of health humanities, thus it requires time and patience. One should focus on narrative techniques, characters, and relationships between them. Description of illness can be both different from and complementary to those found in clinical textbooks. It takes a moment to examine how accurate the representation of the diagnostic process, and symptoms is or whether diagnostic criteria are met, emotional reactions of the characters (highlighting coping mechanisms, caregiver burden, etc.) are being included, and what measures were used to present the above mentioned. While reading, focus on reoccurring themes, their importance, and how they connect with or impact the main storyline; how do they connect with knowledge from journals and clinical textbooks?

4. Application

Once you have examined a book, it is time to teach through its story. Make sure that your group has the adequate theoretical knowledge to analyse the book. Invite everyone to consider their own values based on a story they have read, how people come to the point where certain emotions are generated, why they cope in a certain way. They should be welcome to share their thoughts and interpretations to realise that there is not one proper answer and that every viewpoint is valid. This, hopefully, promotes an empathetic and considerate approach in the future.

How can we use the presented method in the example of *Still Alice*? First, it can be useful for a sick person and their caretakers, family, and friends as it presents not only the development of the disease but also its emotional impact. The novel presents the fear of being isolated and pushed away by people around out of fear; for a sick person, it can be a sign that it is expected to feel certain emotions, while for others, it can be a moment to reflect upon one's feelings and the way they treat sick or disabled people and what the force behind that behaviour is. *Still Alice* also takes up the topic of being a burden as a sick person and subtly touches upon the controversial idea of euthanasia. Although the book never calls the procedure by name, its presence is palpable, leaving space to reflect what the reader would do if they were a sick person or a sick person's relative.

Another important aspect of the novel is that it does not leave Alice in despair but rather shows that even through something that can seemingly be the end of the self, one can experience positive psychological changes. The crowning example is the relationship between Lydia and her mother, two women who could never agree upon anything, always torn by arguments, found one voice and bond, finding and rebuilding what was long lost. This approach widens the perspective and presents the ideas of post-traumatic growth through emotional regulation, heart-to-heart conversations and being open to others' viewpoints.

However, the most touching element of *Still Alice* is the notion carried by the title itself – one does not end when their memories disappear or they cannot remember the previous day. Despite Alzheimer's Disease, one is still worthy of loving and being treated with dignity, even though it is easy to manipulate someone into thinking that they, for instance, agreed on something. The book shows that it is something that should be avoided. People with AD should not be treated as a lost cause but rather should be taught how to function around losses in memory and cognition, how to accept them and how to live on.

5. CONCLUSION

It seems that Medical and Health Humanities still need time to be recognised as a useful tool in the education of future healthcare practitioners, and later in their clinical jobs. Literature and literary techniques enable them to better understand and empathise with patients, they can break the silence around disease or fight with myths surrounding specific phenomena. It encourages practitioners to look beyond a sick organ or disease classification, and allows them to see a person as their own story, experiences, and fears. It can also address professional responses to illness and suffering – anxiety, helplessness, frustration, and loss.

It has been shown that people and places already promote the implementation of literature and narrative techniques in healthcare. They want to show that to better understand a person, one must be attuned to more than the semantics of used words; we need to understand the context a person is immersed in, what language and metaphors they use, what emotions they might feel. Those skills might be developed through the close reading of literature.

This paper proposes an authorial application model and presents an example of a novel that can be included in the canon of Medical and Health Humanities novels. *Still Alice* is a mature and well-balanced book that entertains, moves, and educates on the issue that (considering a rapidly ageing population and the rise of life expectancy) concerns and will concern millions of people worldwide. The interpretation focuses on how the disease affects Alice, her personal and professional life, portraying the destruction such a disease can bring.

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